

Table 1C—Adjusted Operating Standardized Amounts for Puerto Rico, Labor/Nonlabor	payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).	any DSH, IME, and new technology add-on adjustments.
Table 1D—Capital Standard Federal Payment Rate		
Table 2—Hospital Average Hourly Wage for Federal Fiscal Years 2002 (1998 Wage Data), 2003 (1999 Wage Data), and 2004 (2000 Wage Data) Wage Indexes and 3-Year Average of Hospital Average Hourly Wages		
Table 3A—3-Year Average Hourly Wage for Urban Areas		
Table 3B—3-Year Average Hourly Wage for Rural Areas		
Table 4A—Wage Index and Capital Geographic Adjustment Factor for Urban Areas		
Table 4B—Wage Index and Capital Geographic Adjustment Factor for Rural Areas		
Table 4C—Wage Index and Capital Geographic Adjustment Factor for Hospitals That Are Reclassified		
Table 4F—Puerto Rico Wage Index and Capital Geographic Adjustment Factor		
Table 4G—Pre-Reclassified Wage Index for Urban Areas		
Table 4H—Pre-Reclassified Wage Index for Rural Areas		
Table 5—List of Diagnosis-Related Groups (DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay (LOS)		
Table 6A—New Diagnosis Codes		
Table 6B—New Procedure Codes		
Table 6C—Invalid Diagnosis Codes		
Table 6D—Invalid Procedure Codes		
Table 6E—Revised Diagnosis Code Titles		
Table 6F—Revised Procedure Code Titles		
Table 6G—Additions to the CC Exclusions List		
Table 6H—Deletions from the CC Exclusions List		
Table 7A—Medicare Prospective Payment System Selected Percentile Lengths of Stay FY 2002: MedPAR Update March 2003 GROUPE V20.0		
Table 7B—Medicare Prospective Payment System Selected Percentile Lengths of Stay: FY 2002 MedPAR Update March 2003 GROUPE V21.0		
Table 8A—Statewide Average Operating Cost-to-Charge Ratios for Urban and Rural Hospitals (Case-Weighted)		
Table 8B—Statewide Average Capital Cost-to-Charge Ratios (Case-Weighted)		
Table 9—Hospital Reclassifications and Redesignations by Hospital—FY 2004		
Table 10—Thresholds to Qualify for New Technology Add-On Payments: FY 2004		
Table 11—LTC—DRGs Relative Weights and Geometric and Five-Sixths of the Average Length of Stay—FY 2004		
Appendix A—Regulatory Impact Analysis		
Appendix B—Recommendation of Update Factors for Operating Cost Rates of Payment for Inpatient Hospital Services		

I. Background

A. Summary

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of

payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of hospital inpatient stays under a prospective payment system (PPS). Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located; and if the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculations.

If the hospital is an approved teaching hospital, it receives a percentage add-on payment for each case paid under the IPPS (known as the indirect medical education (IME) adjustment). This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies that have been approved for special add-on payments. To qualify, a new technology must demonstrate that it is a substantial clinical improvement over technologies otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any outlier payment due is added to the DRG-adjusted base payment rate, plus

any DSH, IME, and new technology add-on adjustments.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid the higher of a hospital-specific rate based on their costs in a base year (the higher of FY 1982, FY 1987, or FY 1996) or the IPPS rate based on the standardized amount. For example, sole community hospitals (SCHs) are the sole source of care in their areas, and Medicare-dependent, small rural hospitals (MDHs) are a major source of care for Medicare beneficiaries in their areas. Both of these categories of hospitals are afforded this special payment protection in order to maintain access to services for beneficiaries (although MDHs receive only 50 percent of the difference between the IPPS rate and their hospital-specific rates if the hospital-specific rate is higher than the IPPS rate).

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services "in accordance with a prospective payment system established by the Secretary." The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital PPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Similar adjustments are also made for IME and DSH as under the operating IPPS. In addition, hospitals may receive an outlier payment for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, Subparts A through M.

2. Hospitals and Hospital Units Excluded From the IPPS

Under section 1886(d)(1)(B) of the Act, as amended, certain specialty hospitals and hospital units are excluded from the IPPS. These hospitals and units are: psychiatric hospitals and units, rehabilitation hospitals and units; long-term care hospitals (LTCs); children's hospitals; and cancer hospitals. Various sections of the Balanced Budget Act of 1997 (Pub. L. 105-33), the Medicare, Medicaid and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106-113), and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) provide for the implementation of PPSs for rehabilitation hospitals and units (referred to as inpatient rehabilitation