MEDICARE HOSPITAL PAYMENT MODELS

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With nearly 70 million beneficiaries nationwide in 2025,[1] Medicare is a critical source of revenue for hospitals. That gives the federal government leverage to influence provider behavior and healthcare market conditions via Medicare payment models. Medicare has three basic payment models for hospitals,[a] each with its own benefits and tradeoffs.

Highlighted terms are defined on the next page.

Inpatient Prospective Payment System (IPPS)

Medicare pays a fixed rate per discharge, depending on a patient's Medicare Severity Diagnosis Related Group (MS-DRG).

Example: A patient presents with a heart attack. The patient receives imaging services, undergoes surgery, and stays in the hospital for several days. After discharge, Medicare pays the hospital the standard rate for treating one heart attack.

1. A hospital assigns each visit to an MS-DRG and submits a claim to Medicare.
2. Medicare adjusts the national base rate for local labor costs using an area wage index.
3. Medicare multiplies the adjusted rate by the MS-DRG's weight — a multiplier reflecting typical resource usage — to determine the standard payment.
4. The standard payment is adjusted for hospital type and other factors, then paid to the hospital.

Benefits

- Encourages efficiently treating as many patients as possible, at the lowest cost.[2]
- Makes per-patient spending predictable for Medicare.[2]
- Subject to various value-based programs that tie payment to quality of care.[2]

Drawbacks

- Places financial pressure on hospitals to discharge patients quickly.[3]
- Relies on accurate clinical coding, vulnerable to upcoding.[4]
- Shifts financial risk associated with long inpatient stays from Medicare to hospitals.[5]

Outpatient Prospective Payment System (OPPS)

Medicare pays a separate fixed rate for services, weighted for cost using an Ambulatory Payment Classification (APC).

Example: A patient goes to a hospital outpatient department for a colonoscopy. During the procedure, the doctor removes a polyp and examines it for cancer. When billed, Medicare pays separate rates for the colonoscopy, anesthesia, and examination.

1. A hospital assigns a procedure code to each service in a visit and makes a separate claim to Medicare for each.
2. Medicare groups the claims into one or more APCs and multiplies each APC's weight by a conversion factor to determine the standard payment.
3. Medicare adjusts the standard payment using an area wage index.
4. The adjusted standard payment is subject to a multiple procedure payment reduction (MPPR) and then is paid to the hospital.

Benefits

- The MPPR encourages efficient use of resources.[5]
- Generally reimburses hospital outpatient departments[b] more generously than the fee schedule systems used by outpatient physicians' practices, for the same services.[6]

Drawbacks

- Generates a high volume of claims, all requiring complicated APC coding.
- Incentivizes upcoding and overtreatment.[4]
- Not subject to value-based programs, and therefore lacks direct rewards for high-quality care.

Cost-Based Reimbursement (CBR)

Medicare reimburses qualifying hospitals[c] for 99%[d] of estimated allowable fixed (i.e., overhead) and variable (i.e., patient care) costs.

Example: A hospital charges $5,000 for a service. Medicare estimates the cost as $3,000 and pays $2,970. The hospital later reports the real cost as $4,000. The hospital should have been paid $3,960, so Medicare pays $990 to settle the difference.

1. Patient receives services, Medicare is billed the hospital's standard charges.
2. Medicare calculates a historical cost-to-charge ratio using the costs listed in the hospital's most recent Medicare cost report.
3. Medicare multiplies the current charged amount by the historical ratio, then pays this amount as an "interim" payment.
4. At the end of the year, Medicare and the hospital settle the difference between the interim payment and the real cost.

Benefits

- Reduces potential for Medicare patients to be treated at a substantial loss to hospitals.[7]
- Pays for certain overhead costs, ensuring cash flow even when patient volume is low.[2]
- Supports access in areas with low patient volume.[8]

Drawbacks

- Reduces potential for Medicare patients to be treated at a substantial profit.[7]
- Requires extensive documentation and cost reporting, and has potential for over/underpayment.[2]
- Provides little incentive to control per-patient costs.[2]

[1-12] For references, see www.achi.net/publications/medicare-hospital-payment-models

[a] Certain expenses, such as ambulance services, laboratory services, and physicians' professional fees, are paid based on a variety of Medicare fee schedules.

[b] For a given visit, a hospital generally receives both OPPS payments and a small payment for physician services under a fee schedule. Instead of OPPS payments, an outpatient physician's practice receives a larger fee schedule payment, although this tends to be smaller than the hospital's combined payments.

[c] Specifically, facilities designated by Medicare as critical access hospitals or rural community hospitals.

[d] The reimbursement rate was 101% prior to 2013, when it was reduced to 99% due to sequestration.

GLOSSARY OF TERMS

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- **Ambulatory Payment Classification (APC)**: A group of services, procedures, or products signified by a single code. Associated with each code is a weight, a multiplier reflecting typical resource usage. The weight is multiplied by the OPPS conversion factor to determine the standard rate for an APC, and this standard rate is then adjusted for local labor market conditions using an area wage index.

- **Area Wage Index**: An adjustment applied to hospital payments under the IPPS and the OPPS to account for geographic variation in labor costs. Areas with lower wage indexes receive lower Medicare payments under these models. Arkansas has some of the lowest wage indexes in the country, which contributes to lower Medicare payments, particularly in rural areas.[9]

- **Conversion Factor**: A multiplier used by the Centers for Medicaid and Medicare Services as the basis for calculating payments under the OPPS. The conversion factor is calculated annually based on a hypothetical "market basket" of healthcare services.

- **Cost-to-Charge Ratio**: A hospital-specific ratio used in the CBR payment model to estimate the current cost of services based on past reported charges. Interim payments are calculated using this ratio and later reconciled to actual costs through the Medicare cost report.

- **Fee Schedule**: A list of maximum prices that Medicare will pay for services under a simple fee-for-service model, typically with adjustments for local market conditions. Medicare maintains separate fee schedules for ambulance services, medical devices, clinical laboratory services, and physician professional fees.

- **Medicare Cost Report**: An annual report submitted to Medicare by a Medicare-certified facility detailing the facility's operating costs, charges, financial statements, and other administrative information. Medicare cost reports are used in aggregate to calculate the conversion factor and the national base rate. The reports are also used to calculate reimbursements to hospitals under the CBR model.

- **Medicare Severity Diagnosis-Related Group (MS-DRG)**: A group of diagnoses or procedures that consume a similar amount of hospital resources, signified by a single code. Associated with each code is a weight — a multiplier reflecting typical resource usage — that is reassessed annually. The weight is multiplied by the national base rate to determine the standard payment for a given MS-DRG.

- **Multiple Procedure Payment Reduction (MPPR)**: A payment policy under the OPPS that reduces reimbursement when multiple procedures are claimed on the same date of service. Under this policy, Medicare pays 100% of the largest claim during a visit, but only 50% of any additional claims, encouraging efficient use of resources within an individual visit. The MPPR was implemented under the argument that APC weights consider setup time, clinical and administrative labor, and equipment costs that are incurred once per visit, and thus multiple full APC payments were duplicative.[10]

- **National Base Rate**: A standardized amount set by the Centers for Medicare and Medicaid Services each year based on nationwide average hospital operating costs. It is used as the basis for calculating payments under the IPPS. It is split into operating (labor and procedure expenses) and capital (overhead) cost components. The operating component is adjusted by the local area wage index to reflect local labor market conditions.

- **Overtreatment**: Performance of treatment exceeding the optimal level necessary for a patient's health, sometimes to inflate the number of individual claims payable.

- **Procedure Code**: An alphanumeric code signifying a specific item or medical procedure. Medicare primarily uses two sets of procedure codes, Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes. CPT codes represent physician services, and HCPCS codes represent non-physician services and certain products and supplies. Procedure codes are used to assign APCs for the purposes of calculating OPPS reimbursement amounts.

- **Sequestration**: A 2% reduction in payments to providers through Medicare mandated by the Budget Control Act of 2011. It went into effect in 2013 and has at times been temporarily altered or suspended by Congress. Sequestration was originally meant to extend through 2030, but the 2023 Consolidated Appropriations Act extended it through 2032.[11]

- **Upcoding**: The practice of intentionally assigning higher-weight MS-DRGs/APCs to visits/procedures than is justified by clinical documentation in order to secure larger Medicare payments.

Note on alternative payment models: Some states have obtained waivers from the Centers for Medicare and Medicaid services to test unique payment models, such as Maryland's All-Payer and Total Cost of Care models and the Pennsylvania Rural Health Model. Additionally, Medicare offers optional programs using alternative models, such as the Shared Savings Program, and temporary pilot programs in limited cohorts of hospitals, such as the Bundled Payments for Care Improvement and Accountable Care Organization REACH models.

[1-12] For references, see www.achi.net/publications/medicare-hospital-payment-models