

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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Acute Care Hospital Inpatient Prospective Payment System

PAYMENT SYSTEM SERIES



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Table of Contents

Background	3
Basis for Inpatient Prospective Payment System (IPPS) Payment	3
Payment Rates	4
Acute Care Hospital Inpatient Prospective Payment System: Operating Base Payment Rate	6
Acute Care Hospital Inpatient Prospective Payment System: Capital Base Payment Rate	7
How Payment Rates Are Set	8
Base Payment Amounts	8
Diagnosis-Related Group (DRG) Relative Weights	8
Adjustment for Market Conditions	8
Bad Debts	9
Policy Adjustments	9
Outlier Payments	12
Transfer Policy	12
Readmissions Adjustment	13
Hospital Value-Based Purchasing (VBP) Adjustment	13
Hospital-Acquired Conditions (HAC) Reduction Program Adjustment	14
Payment Updates	14
Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Meaningful User Incentive Programs	14
Resources	15



Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these Acute Care Hospital IPPS topics:

- ❖ Background
- ❖ Basis for IPPS payment
- ❖ Payment rates
- ❖ How payment rates are set
- ❖ Payment updates
- ❖ Hospital IQR and EHR Meaningful User Incentive Programs
- ❖ Resources

When “you” is used in this publication, we are referring to Medicare acute care hospitals.

Background

Hospitals contract with Medicare to furnish acute hospital inpatient care and agree to accept predetermined acute IPPS rates as payment in full.

The inpatient hospital benefit covers patients for 90 days of care per episode of illness with an additional 60-day lifetime reserve. Illness episodes begin when patients are admitted and end after they have been out of the hospital or Skilled Nursing Facility (SNF) for 60 consecutive days.

Basis for IPPS Payment

Generally, you receive Medicare IPPS payment on a per discharge or per case basis for Medicare patients with inpatient stays. The claim for the patient’s inpatient stay must include all outpatient diagnostic services and admission-related outpatient nondiagnostic services provided by the admitting hospital or an entity that is wholly owned or operated by the admitting hospital on the date of a patient’s inpatient admission or within 3 days immediately preceding the date of a patient’s inpatient admission. In addition, you must not separately bill these services to Medicare Part B.

Discharges are assigned to diagnosis-related groups (DRGs), a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. The patient’s principal diagnosis and up to 24 secondary diagnoses that may include comorbidities or complications will determine the DRG assignment. Similarly, DRG assignment can be affected by up to 25 procedures furnished during the stay. Other factors that may influence DRG assignment include a patient’s gender, age, or discharge status disposition.

The Centers for Medicare & Medicaid Services (CMS) reviews the DRG definitions annually to ensure that each group continues to include cases with clinically similar conditions that require comparable amounts of inpatient resources. When the review shows that subsets of clinically similar cases within a DRG consume significantly different amounts of resources, CMS may reassign them to a different DRG with comparable resource use or create a new DRG. To better account for severity of illness and resource consumption for Medicare patients, CMS uses the DRG system called Medicare Severity (MS)-DRGs.

These are the three levels of severity in the MS-DRG system based on secondary diagnosis codes:

- 1) MCC—Major Complication/Comorbidity reflects the highest level of severity
- 2) CC—Complication/Comorbidity is the next level of severity
- 3) Non-CC—Non-Complication/Comorbidity does not significantly affect severity of illness and resource use

Payment Rates

The IPPS per-discharge payment is based on two national base payment rates or standardized amounts: one that provides for operating expenses and another for capital expenses. These payment rates are adjusted to account for:

- ❖ The costs associated with the patient's clinical condition and related treatment relative to the costs of the average Medicare case (the DRG relative weight, as described in the How Payment Rates Are Set section)
- ❖ Market conditions in the hospital's location relative to national conditions (the wage index, as described in the How Payment Rates Are Set section)

In addition to these adjusted per discharge base payment rates, you can qualify for outlier payments for cases that are extremely costly. Hospitals that train residents in approved Graduate Medical Education (GME) programs also receive a payment separate from the IPPS for the direct costs of training residents. The operating and capital payment rates for these teaching hospitals are increased to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals or indirect costs of graduate medical education (Indirect Medical Education [IME]).

Operating and capital payment rates are increased for hospitals that treat a disproportionate share of low-income patients, and they receive additional payments for uncompensated care. You may be paid an additional amount for treating patients with certain approved technologies that are new and costly and offer a substantial clinical improvement over existing treatments available to Medicare patients. Finally, in some cases, payment is reduced when a patient has a short length of stay (LOS) and is transferred to another acute care hospital or, in certain circumstances, to a post-acute care setting.

Beginning with discharges occurring on and after October 1, 2012, IPPS payments also reflect any applicable adjustments under the Hospital VBP and Hospital Readmissions Reduction Program (HRRP). Under the Hospital VBP Program, a portion of operating IPPS payments to acute inpatient hospitals' eligible for the program are reduced to fund value-based incentive payments to those eligible hospitals, based on their overall performance on a set of quality measures. Under the HRRP, a portion of eligible hospitals' operating IPPS payments are reduced for those hospitals with excess readmissions. Under the Hospital-Acquired Conditions (HACs) Reduction Program, which began in fiscal year (FY) 2015, overall payments are reduced by 1 percent for applicable hospitals in the worst-performing quartile of risk-adjusted quality measures for reasonable preventable HACs.

The steps for determining an IPPS payment are:

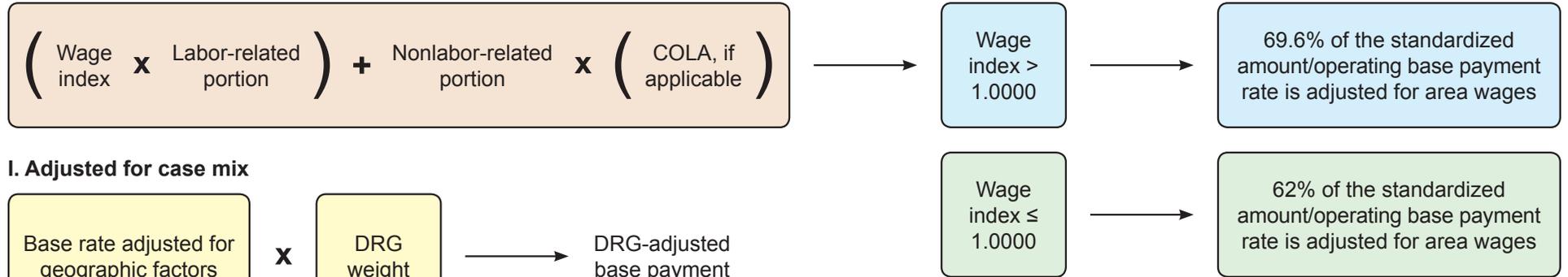
- 1) The hospital submits a bill to the Medicare Administrative Contractor (MAC) for each Medicare patient it treats. Based on the information on the bill, the MAC categorizes the case into a DRG.
- 2) The base payment rate, or standardized amount (a dollar figure), includes a labor-related and nonlabor-related share. The labor-related share is adjusted by a wage index to reflect area differences in the cost of labor. If the area wage index is greater than 1.0000, the labor share equals 69.6 percent. The law requires the labor share to equal 62 percent if the area wage index is less than or equal to 1.0000. The nonlabor-related share is adjusted by a cost-of-living adjustment (COLA) factor, which equals 1.0000 for all States except Alaska and Hawaii.
- 3) The wage-adjusted standardized amount is multiplied by a relative weight for the DRG. The relative weight is specific to each of 757 DRGs (for FY 2017), and each DRG weight represents the average resources required to care for cases in that particular DRG, relative to the average resources to treat cases in all DRGs.
- 4) If applicable, these additional amounts will be added to the IPPS payment:
 - The hospital engages in teaching medical residents to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals
 - The hospital treats a disproportionate share of low-income patients (which includes incurring costs of uncompensated care)
 - Cases that involve certain approved new technologies
 - High-cost outlier cases
- 5) If applicable, adjustments are made to the IPPS payment under the Hospital VBP Program, HRRP, and HAC Reduction Program.

The Operating Base Payment Rate and Capital Base Payment Rate charts show the formulas for calculating the Acute Care Hospital IPPS operating base payment rate and the capital base payment rate.



Acute Care Hospital Inpatient Prospective Payment System: Operating Base Payment Rate

Adjusted for geographic factors

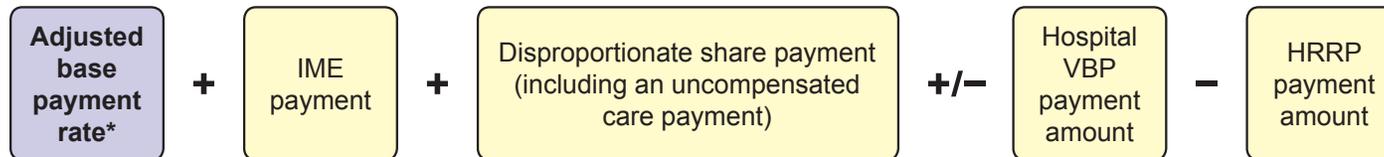


I. Adjusted for case mix

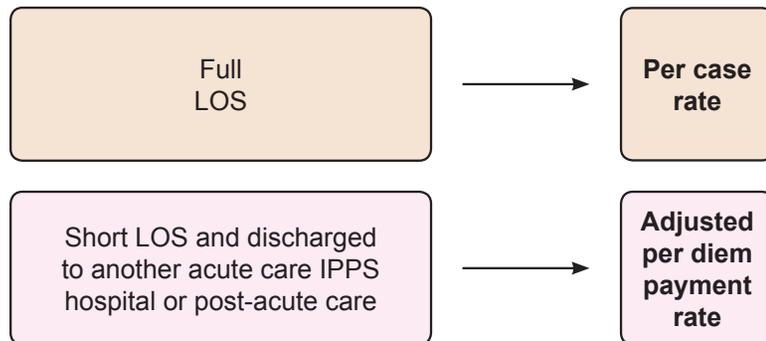


Policy adjustments for qualifying hospitals:

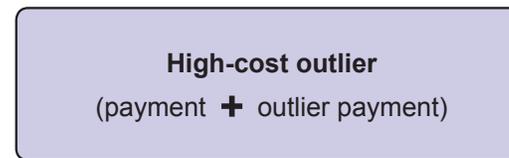
I. Additional operating amounts



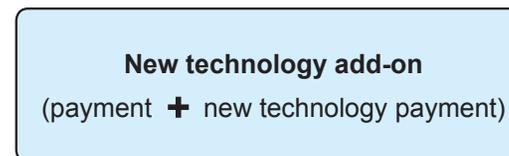
II. Adjustments for transfers



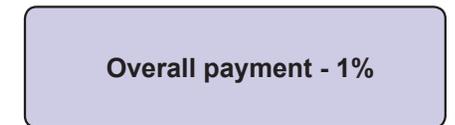
III. If case is extraordinarily costly



IV. If case qualifies for new technology add-on

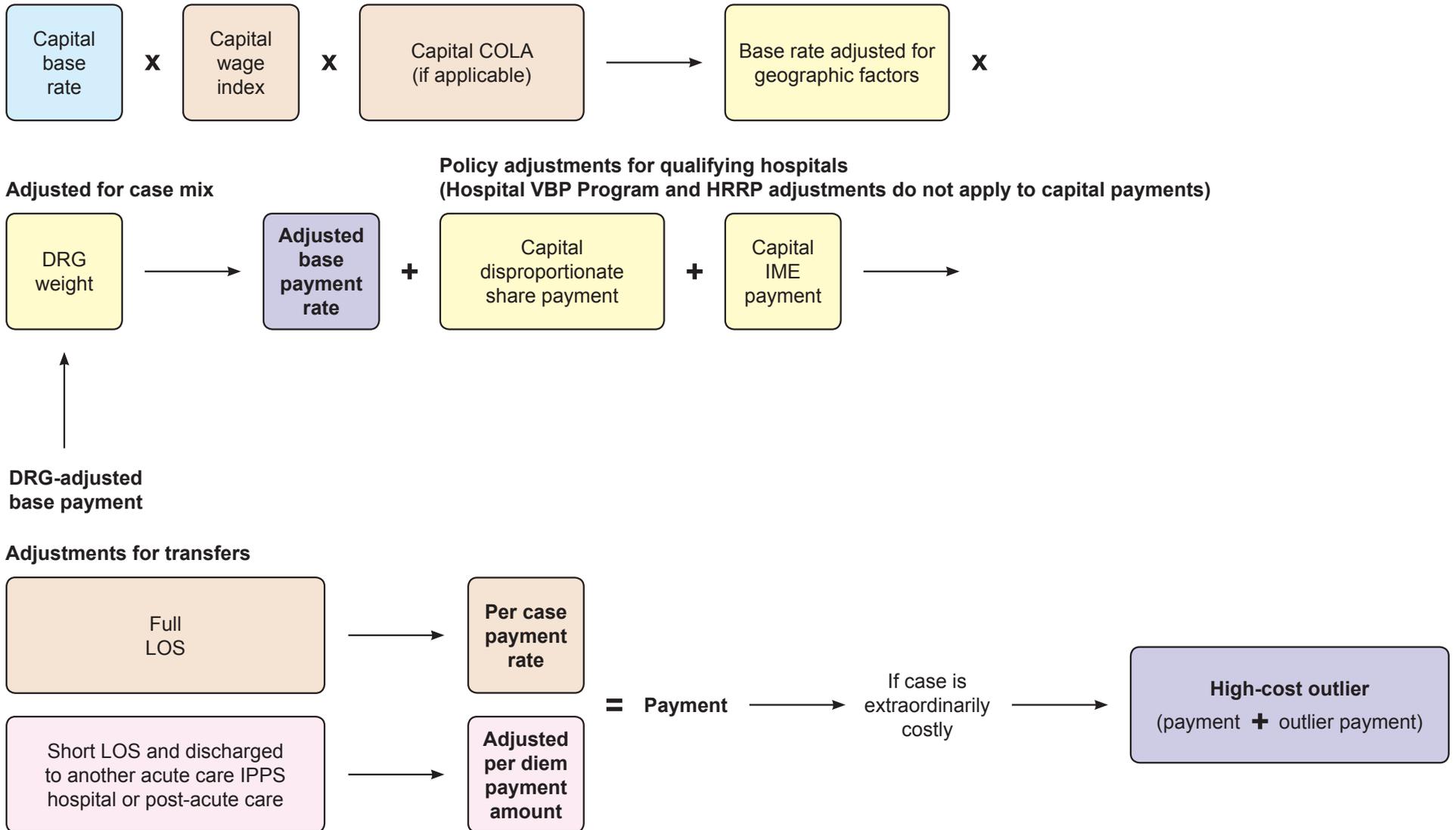


V. If hospital ranks in lowest performing quartile for HACs



* Reflects the applicable Hospital IQR and EHR Meaningful User Incentive Programs payment adjustments.

Acute Care Hospital Inpatient Prospective Payment System: Capital Base Payment Rate



How Payment Rates Are Set

IPPS payments are derived through a series of adjustments applied to separate operating and capital base payment rates. The base rates are updated annually and unless there are other policy changes, the update raises all payment rates proportionately.

Base Payment Amounts

Discharge base rates, also known as standardized payment amounts, for operating payments and the Federal rate for capital payments are set for the operating and capital costs that efficient facilities are expected to incur in furnishing covered inpatient services. Some costs (for example, direct costs of operating GME Programs and organ acquisition costs) are excluded from the IPPS and paid separately. Capital payments cover costs for depreciation, interest, rent, and property-related insurance and taxes. Hospitals in Puerto Rico receive 100 percent of the Federal base payment amount for operating payments as of January 1, 2016, and 100 percent of the capital Federal base payment beginning October 1, 2016. Prior to that, operating payments and capital payments, respectively, were based on a blend of 75 percent of the Federal base payment amount and 25 percent of a Puerto Rico-specific rate.



DRG Relative Weights

A weight is assigned to each MS-DRG that reflects the average relative costliness of cases in that group compared with the costliness for the average Medicare case. The same MS-DRG weights are used for operating and capital payment rates. The MS-DRG weights are recalibrated annually, without affecting overall payments, based on standardized charges and costs for all IPPS cases in each MS-DRG. Hospitals' billed charges are standardized to improve comparability, which involves:

- ❖ Adjusting charges to remove differences associated with hospital wage rates across labor markets
- ❖ The size and intensity of the hospital's resident training activities
- ❖ The number of low-income patients the hospital treats

The charges are reduced to costs by using national average ratios of hospital costs to charges for 19 different hospital departments.

Adjustment for Market Conditions

Base operating and capital rates are adjusted by an area wage index to reflect the expected differences in local market prices for labor, which is intended to measure differences in hospital wage rates among labor markets by comparing the average hourly wage (AHW) for hospital workers in each urban or statewide rural area to the nationwide average. CMS uses the Office of Management and Budget's Core-Based Statistical Area definitions (with some modifications) to define each labor market area. The wage index is revised each year based on wage data reported by IPPS hospitals. A hospital may request geographic reclassification if it believes it competes for labor with a different area than the one in which it is located. For more information about hospital reclassifications, visit the [Medicare Geographic Classification Review Board](#) webpage.

The wage index is applied to the labor-related portion or labor share of the operating base rate, which reflects an estimated portion of costs affected by local wage rates and fringe benefits. The current estimate of the national operating labor share is 69.6 percent, which is applied to hospitals with a wage index greater than 1.0000. The national operating labor share is 62 percent for areas with a wage index less than or equal to 1.0000. Alternative labor shares are applicable to hospitals located in Puerto Rico. Additionally, the wage index is applied to the whole capital base rate. The wage index applied to the capital base rate is raised to a fractional power, which narrows the geographic variation in wage index values among market areas. A COLA, which reflects the higher costs of supplies and other nonlabor resources, is also applied to the base operating and capital rates of IPPS hospitals in Hawaii and Alaska. The COLA is applied to the nonlabor-related portion of the operating base rate and to the whole capital base rate.

Bad Debts

For beneficiaries in a hospital setting, bad debt is reimbursed at 65 percent. Bad debts are attributable to nonpayment of coinsurance and deductible amounts after you make a reasonable collection effort.

Policy Adjustments

This section provides information on payments made in addition to the operating and capital amounts.



Direct Graduate Medical Education (DGME)

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs receive DGME payments that reflect the direct costs of operating approved residency training programs. These payments are made separately from the IPPS. DGME payments are generally based on the product of:

- ❖ Updated hospital-specific costs per resident in a historical base year
- ❖ The number of residents a hospital trains
- ❖ The hospital's Medicare patient load (the proportion of Medicare inpatient days to total inpatient days)

Indirect Costs of Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs also receive IME adjustments to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. The size of the IME adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by the hospital's number of residents trained per inpatient bed (that is, the resident-to-bed ratio).

Medicare Disproportionate Share Hospitals (DSHs)

Hospitals that treat a disproportionate share of low-income patients receive additional operating and capital payments. Effective for discharges occurring in FY 2014 and beyond, hospitals receive 25 percent of the amount they previously would have received under the current statutory formula for Medicare DSH operating payments. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH operating payments, will become available for an uncompensated care payment after the amount is reduced for changes in the percentage of individuals who are uninsured. Currently, each Medicare DSH hospital will receive an uncompensated care payment based on its share of insured low income days (that is, the sum of Medicaid days and Medicare Supplemental Security Income days) reported by Medicare DSH hospitals.

Sole Community Hospitals (SCHs)

SCHs can receive operating payments based on the higher of their hospital-specific payment rate or the Federal rate, while their capital payments are solely based on the capital base rate (like all other IPPS hospitals). Medicare makes SCH payments based on which of these yields the greatest aggregate payment for the cost reporting period:

- ❖ The IPPS Federal rate applicable to the hospital
- ❖ The updated hospital-specific rate based on FY 1982 costs per discharge
- ❖ The updated hospital-specific rate based on FY 1987 costs per discharge
- ❖ The updated hospital-specific rate based on FY 1996 costs per discharge
- ❖ The updated hospital-specific rate based on FY 2006 costs per discharge

SCHs may also qualify for a payment adjustment if they experience a significant volume decrease. For more information about the volume decrease payment adjustment, refer to the Code of Federal Regulations (CFR) at [42 CFR 412.92\(e\)](#).

A hospital paid under the Medicare IPPS is eligible for classification as a SCH if it meets **one** of these criteria:

- 1) The hospital is located at least 35 miles from other like hospitals
- 2) The hospital is rural, located between 25 and 35 miles from other like hospitals, **and** meets **one** of these criteria:
 - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area

- The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital
- 3) The hospital is rural and located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years
 - 4) The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes

A like hospital:

- ❖ Furnishes short-term, acute care
- ❖ Is paid under the Medicare Acute Care Hospital IPPS
- ❖ Is not a Critical Access Hospital

A hospital's service area is the area from which it draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a SCH.

Certain hospitals formerly designated as Essential Access Community Hospitals (EACHs) are also treated as SCHs for payment purposes under the IPPS. For more information about EACHs, refer to [42 CFR 412.109](#).

Medicare Dependent Hospitals (MDHs)

MDHs can receive operating payments based on the higher of the Federal rate or a blended rate based, in part, on each of these rates: the Federal rate and their hospital-specific payment rate. Their capital payments are solely based on the capital base rate. MDHs may also qualify for a payment adjustment if they experience a significant volume decrease.

Rural Referral Center (RRC) Program

The RRC Program was established to support high-volume rural hospitals. [42 CFR 412.96](#) contains a full description of the criteria for RRCs. In general, a Medicare participating acute care hospital is classified as a RRC if it is located in a rural area and it meets **one** of these criteria:

- 1) It has 275 or more beds available for use during its most recently completed cost reporting period. If the hospital's bed count has changed, written documentation may be submitted with the application on one or more of these reasons for the change:
 - The merger of two or more hospitals.
 - Acute care beds that previously were closed for renovation are reopened.
 - Acute care beds that previously were classified as part of an excluded unit are transferred to the IPPS.
 - The hospital expands the number of acute care beds for use, and these beds are permanently maintained for inpatients. This expansion does not include beds in corridors or other temporary beds.
- 2) It shows one of these elements:
 - At least 50 percent of the hospital's Medicare patients are referred from other hospitals or from physicians who are not on the staff of the hospital.
 - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital.
 - At least 60 percent of all services the hospital furnishes to Medicare patients are furnished to patients who live more than 25 miles from the hospital.
- 3) If the criteria in 1) or 2) cannot be met, a hospital is classified as a RRC if it is located in a rural area and meets the criteria specified in a. and b. **and** at least **one** of the criteria specified in c., d., or e.:
 - a. For discharges during the most recent Federal FY ending at least 1 year prior to the beginning of the cost reporting period for which the hospital is seeking RRC status, its Case-Mix Index (CMI) equals at least one of these:
 - The lower of the median CMI value for all urban hospitals nationally.
 - The median CMI value for urban hospitals located in its region, excluding those hospitals receiving indirect medical education payments as provided in [42 CFR 412.105](#).
 - b. Its number of discharges is at least one of these:
 - Five thousand or 3,000 for an osteopathic hospital.
 - The median number of discharges for urban hospitals in the census region in which it is located, set by CMS yearly in Acute Care Hospital IPPS rulemaking, in accordance with [42 CFR 412.96\(c\)\(2\)](#).
 - c. Medical staff: More than 50 percent of its active medical staff are specialists who meet the conditions specified at [42 CFR 412.96\(c\)\(3\)](#).
 - d. Source of inpatients: At least 60 percent of all discharges are for inpatients who reside more than 25 miles from the hospital.
 - e. Volume of referrals: At least 40 percent of all inpatients treated are referred from other hospitals or from physicians who are not on the hospital's staff.

Section 4202(b) of the Balanced Budget Act of 1997 states that any hospitals designated as RRCs in FY 1991 are grandfathered as such for FY 1998 and each subsequent year.

A hospital that currently has RRC status or once had RRC status has certain advantages:

- 1) Proximity:
 - Any hospital that is currently a RRC does not have to demonstrate a close proximity to the area to which it seeks reclassification
 - The hospital can apply for reclassification to the closest urban or rural area
- 2) AHW Data Comparison:
 - Any hospital that was ever a RRC is exempt from the 106/108 percent AHW comparison test
 - Any hospital that was ever a RRC is only required to meet the 82 percent AHW comparison regardless of its location in an urban or rural area
- 3) DSH Cap: Any hospital that is currently a RRC is exempt from the 12 percent cap on DSH payments applicable to other rural hospitals

Low-Volume Hospitals

Add-on payments are made to qualifying low-volume hospitals more than 15 road miles from the nearest subsection (d) hospital and have fewer than 1,600 Medicare discharges based on the latest available Medicare Provider Analysis and Review data:

- ❖ Those with 200 or fewer Medicare discharges receive an adjustment of an additional 25 percent for each discharge.
- ❖ Those with more than 200 and fewer than 1,600 Medicare discharges receive an adjustment of an additional percentage for each discharge. This adjustment is calculated using the formula $[(4/14) - (\text{number of Medicare discharges}/5600)]$.

Outlier Payments

To promote access to high quality inpatient care for seriously ill patients, additional payments are made for outlier or extremely costly cases. These cases are identified by comparing their estimated operating and capital costs to a fixed-loss threshold. The fixed-loss threshold is set each year, which is adjusted to reflect labor costs in the hospital's local market. You are paid 80 percent of your costs above your fixed-loss thresholds and 90 percent of costs above the outlier threshold for burn cases. Outliers are financed by offsetting reductions in the operating and capital base rates (there is a reduction to the rates paid to all cases so that the amount paid as outliers does not increase or decrease estimated aggregate Medicare spending). The national fixed-loss threshold is established at the level that will result in estimated outlier payments equaling 5.1 percent of total payments for the FY. For more information about outlier payments, refer to the outlier calculation example at [CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/outlier_example_fy07.zip](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/outlier_example_fy07.zip).

Transfer Policy

DRG payments are reduced when:

- ❖ The patient's LOS is at least 1 day less than the geometric mean LOS for the DRG
- ❖ The patient is transferred to another hospital covered by the Acute Care Hospital IPPS or, for certain MS-DRGs, discharged to a post-acute setting
- ❖ The patient is transferred to a hospital that does not have an agreement to participate in the Medicare Program (effective October 1, 2010)
- ❖ The patient is transferred to a CAH (effective October 1, 2010)

These post-acute care settings are included in the transfer policy:

- ❖ Long-term care hospitals
- ❖ Rehabilitation facilities
- ❖ Psychiatric facilities
- ❖ SNFs
- ❖ Home health care when the patient receives clinically-related care that begins within 3 days after the hospital stay
- ❖ Rehabilitation distinct part (DP) units located in an acute care hospital or a CAH
- ❖ Psychiatric DP units located in an acute care hospital or a CAH
- ❖ Cancer hospitals
- ❖ Children's hospitals

Readmissions Adjustment

Under the HRRP, for discharges beginning on or after October 1, 2012, an adjustment is made to the base operating DRG payment to account for excess readmissions. A hospital's excess readmission ratio is a measure of its readmission performance compared to the national average for its set of patients for each of these three conditions in FYs 2013 and 2014:

- ❖ Acute myocardial infarction
- ❖ Heart failure
- ❖ Pneumonia

In FY 2015, these conditions were included in the HRRP:

- ❖ Hip and knee surgery
- ❖ Chronic obstructive pulmonary disease

In FY 2017, coronary artery bypass graft surgery is included in the HRRP.

A readmission generally refers to an admission to an acute care hospital paid under the IPPS within 30 days of a discharge from the same or another acute care hospital.

Hospital VBP Adjustment

Under the Hospital VBP Program, effective for discharges beginning on or after October 1, 2012, a participating hospital's base operating DRG payments are reduced to fund value-based incentive payments to those hospitals based on their overall performance on a set of quality measures. Hospitals may earn back more than, all of, or less than the applicable percent reduction for a given year. The Hospital VBP program generally applies to all acute IPPS hospitals with certain exceptions.

Incentive payments are awarded under the Hospital VBP Program to participating hospitals that meet or exceed performance standards and/or improve performance during the applicable performance period. Incentive adjustments are paid on a claim-by-claim basis for all discharges occurring in the FY associated with a given performance period. Each participating hospital's value-based incentive payment adjustment factor is based on the hospital's Total Performance Score for the specified performance period.

By law, the applicable percent reduction to base operating DRG payment amounts will increase to 2 percent beginning in FY 2017, increasing the total estimated amount available for value-based incentive payments. This is equal to the estimated total amount of payment reductions for all participating hospitals for the FY. For FY 2017, the estimated available funding pool, equal to 2 percent of the estimated annual base operating DRG payment amounts for all acute inpatient hospitals eligible for the Hospital VBP Program, is \$1.8 billion. For 2017, the measure set includes measures of clinical process of care, patient experience of care, outcome, and efficiency.

HAC Reduction Program Adjustment

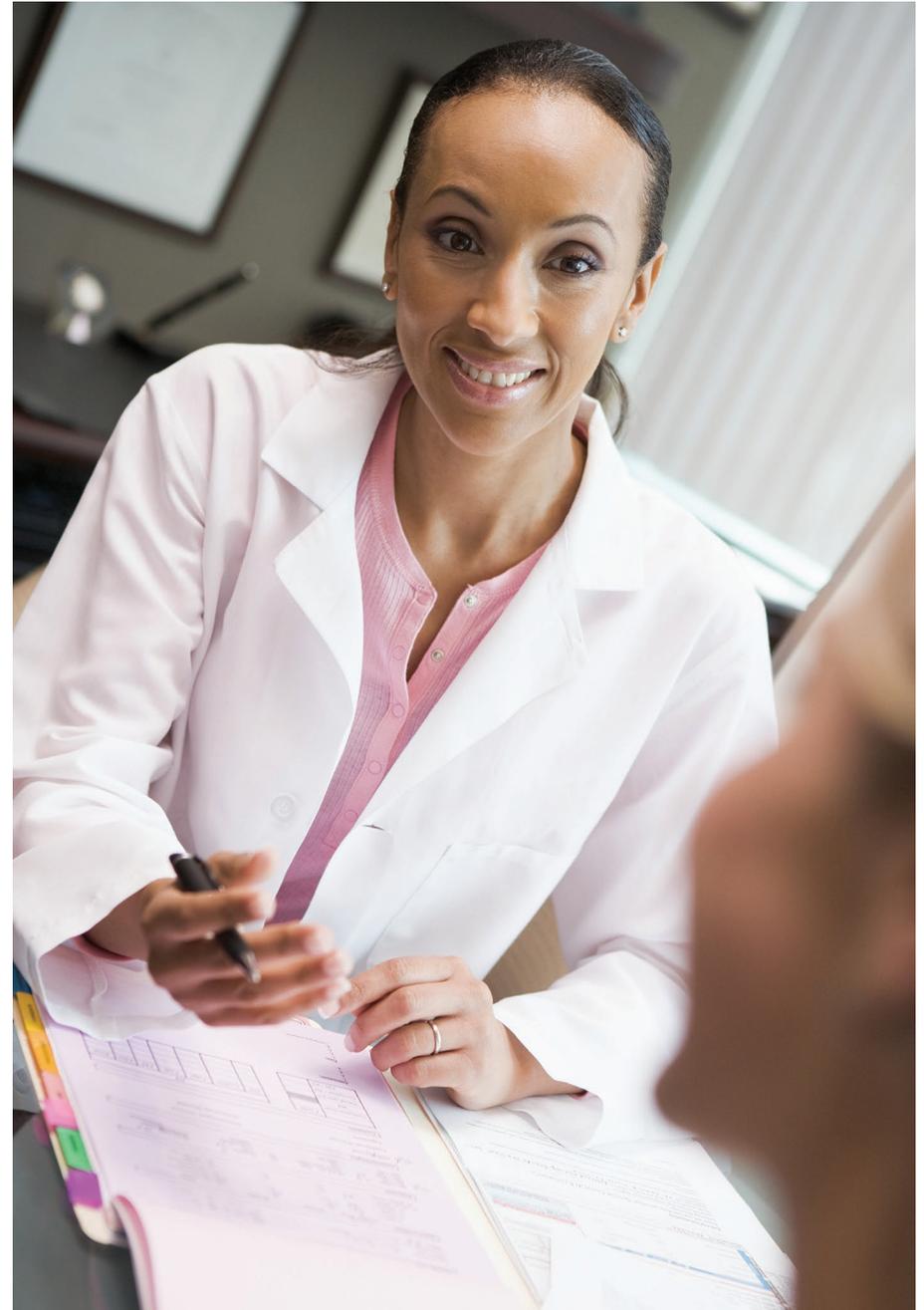
For discharges beginning on or after October 1, 2015, hospitals that rank in the lowest performing quartile of all subsection (d) hospitals with respect to the occurrence of HACs will receive payments equal to 99 percent of what would otherwise have been paid under the Acute Care Hospital IPPS. HACs are conditions acquired during hospitalization (the condition was not present on admission).

Payment Updates

The operating and capital payment rates are updated annually. The operating update is set by Congress, considering the projected increase in the market basket index. The market basket index measures the price increases of goods and services hospitals buy to produce patient care. For more information about Acute Care Hospital IPPS payment updates, refer to [Hospital Inpatient Prospective Payment System \(IPPS\) and Long Term Acute Care Hospital \(LTCH\) Final Rule Policy and Payment Changes for Fiscal Year \(FY\) 2017](#) and [FY 2017 Acute Care Hospital IPPS Final Rule](#).

Hospital IQR and EHR Meaningful User Incentive Programs

For FY 2017, hospitals that report specific quality data to the Department of Health & Human Services (HHS), meet all other requirements of the Hospital IQR Program, and are meaningful Medicare EHR users will receive the full operating update set by Congress of 1.65 percent. Hospitals that do not report specific quality data to HHS and are not meaningful Medicare EHR users will receive a reduction of one-quarter of the applicable percentage increase to the market basket update. Hospitals that are not meaningful EHR users will receive a reduction of three-fourths of the applicable increase to the market basket update.



Resources

This chart provides Acute Care Hospital IPPS resource information.

Acute Care Hospital Inpatient Prospective Payment System Resources

For More Information About...	Resource
Acute Care Hospital IPPS	CMS.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS Medicare Benefit Policy Manual (Publication 100-02) Medicare Claims Processing Manual (Publication 100-04)
Medicare DSHs	Chapter 3 of the Medicare Claims Processing Manual (Publication 100-04) Medicare Disproportionate Share Hospital
SCHs	Chapter 3 of the Medicare Claims Processing Manual (Publication 100-04) Chapter 28, Section 2810, of the Provider Reimbursement Manual – Part 1 (Publication 15-1)
MDHs	Chapter 3 of the Medicare Claims Processing Manual (Publication 100-04)
CFR	GPO.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR
Hospital VBP Program	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing
Hospital Readmissions Reduction Program	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html
HAC Reduction Program	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html QualityNet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774189166
All Available Medicare Learning Network® Products	MLN Catalog
Provider-Specific Medicare Information	MLN Guided Pathways: Provider Specific Medicare Resources
Medicare Information for Patients	Medicare.gov

Hyperlink Table

Embedded Hyperlink	Complete URL
Medicare Geographic Classification Review Board	https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB
42 CFR 412.92(e)	http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_192
42 CFR 412.109	http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_1109
42 CFR 412.96	http://www.ecfr.gov/cgi-bin/text-idx?SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&node=se42.2.412_196
42 CFR 412.105	http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_1105
42 CFR 412.96(c)(2) 42 CFR 412.96(c)(3)	http://www.ecfr.gov/cgi-bin/text-idx?SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&node=se42.2.412_196
Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Final Rule Policy and Payment Changes for Fiscal Year (FY) 2017	https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-02.html
FY 2017 Acute Care Hospital IPPS Final Rule	https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-18476.pdf
Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html
Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
Chapter 3 of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
Medicare Disproportionate Share Hospital	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Disproportionate_Share_Hospital.pdf
Provider Reimbursement Manual – Part 1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
MLN Catalog	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
MLN Guided Pathways: Provider Specific Medicare Resources	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf



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