Inpatient Prospective Payment System (IPPS) 101

Educational Briefing for Providers and Suppliers

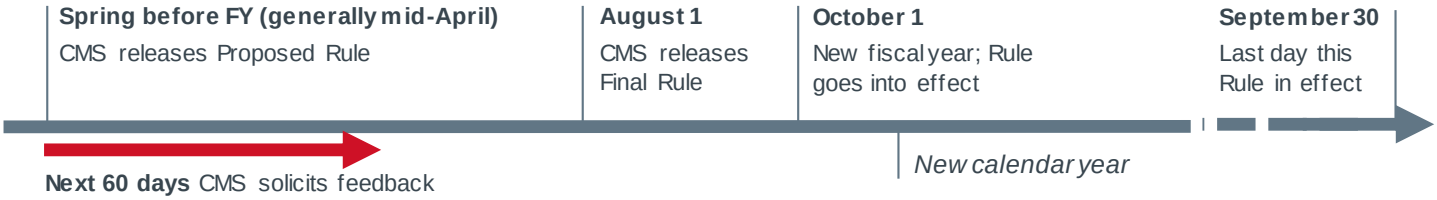
What is the IPPS?

The Inpatient Prospective Payment System (IPPS) is the payment system through which the Centers for Medicare and Medicaid Services (CMS) reimburses short-term acute care hospitals (STACHs) for inpatient services delivered under Medicare Part A to Medicare Fee-for-Service patients.

How often is the IPPS updated, and which elements are subject to change?

CMS updates the IPPS each federal fiscal year (FY) and sets payment rates which take effect from October 1 through September 30 of the following year. For example, the FY 2017 IPPS rates were in effect from October 1, 2016 through September 30, 2017.

The Department of Health and Human Services (HHS) updates the IPPS through federal rulemaking. First, a Proposed Rule is released the spring before the changes will take effect. The Proposed Rule details proposed changes to inpatient payment rates, and also contains updates to critical inpatient adjustments and initiatives, such as inpatient quality reporting requirements. For 60 days after the Proposed Rule's release, CMS solicits comment on the Proposed Rule from health care stakeholders and then releases a Final Rule by August 1. The changes in the Final Rule take effect on October 1, when the new federal fiscal year begins.



Which hospitals are reimbursed by Medicare under the IPPS?

Medicare-certified STACHS, with a few exceptions, such as:

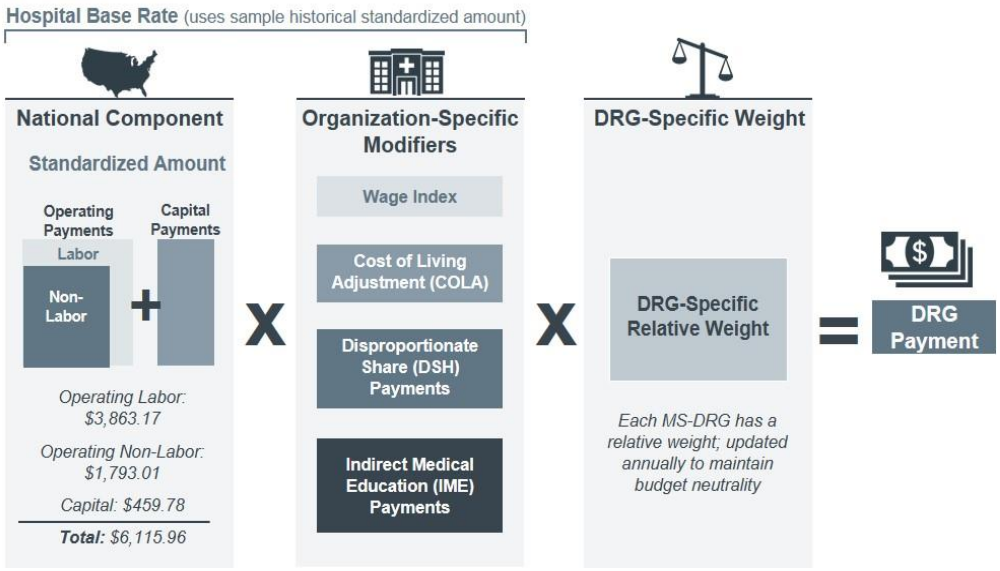
- Critical access hospitals (CAHs)
- PPS-exempt cancer hospitals
- Children's hospitals
- Maryland hospitals

How are IPPS-reimbursed hospitals paid for inpatient services?

Each inpatient stay is categorized into a Medicare severity-adjusted diagnosis-related group (**MS-DRG**), based upon the ICD-10 procedure and diagnosis codes present on that patient's claim (as well as other factors like patient age, sex, and discharge disposition). An MS-DRG payment covers all of the inpatient services rendered for that inpatient stay.

How do MS-DRGs turn into payments?

Each MS-DRG has an associated payment weight, based on how resource-intensive it is to treat patients in that category. A given hospital's MS-DRG payment is based upon that relative weight, adjusted by various geographic and hospital-specific factors:



- More clinically-intensive cases are assigned MS-DRGs with higher relative weights, so hospitals receive higher payment for those cases than for cases assigned lower-severity MS-DRGs.
- Hospitals may receive higher or lower hospital base rates, depending upon factors like teaching status, location, or proportion of low-income inpatient stays.
- Hospitals' payment rates may be reduced if they receive a penalty under one of three mandatory inpatient Pay-for-Performance programs, or if they fail to report mandatory inpatient quality measures.

Source: CMS; Advisory Board interview and analysis.