



ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM

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Learn about these Acute Care Hospital Inpatient Prospective Payment System (IPPS) topics:

- Background
- IPPS payment basis
- Payment rates
- Setting payment rates
- Payment updates
- Hospital Inpatient Quality Reporting (IQR) Program and Promoting Interoperability (PI) Program (formerly the Electronic Health Record [EHR] Incentive Programs)
- Resources

Background

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

The inpatient hospital benefit covers 90 days of care per episode of illness with an additional 60-day lifetime reserve. Patient illness episodes begin on admission and end after 60 days post-hospitalization or after Skilled Nursing Facility (SNF) discharge.

IPPS Payment Basis

Generally, Medicare pays acute care hospitals an IPPS payment on a per inpatient case or per inpatient discharge basis. The claim for the inpatient stay **must** include all outpatient diagnostic services and admission-related outpatient non-diagnostic services the admitting hospital, or an entity wholly owned or operated by the admitting hospital, furnished to the patient during the 3 days preceding the date of the patient's hospital admission. Acute care hospitals **cannot** separately bill these services to Medicare Part B.

The Centers for Medicare & Medicaid Services (CMS) assigns discharges to diagnosis-related groups (DRGs). A DRG is a grouping of similar clinical conditions (diagnoses) and the service procedures furnished during the inpatient hospital stay. The patient's principal diagnosis and up to 24 secondary diagnoses, including any comorbidities or complications, determine the DRG assignment. Up to 25 procedures furnished during the stay can affect the DRG. Other factors influencing DRG assignment include a patient's gender, age, or discharge status disposition.

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

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

1. **MCC:** Major Complication/Comorbidity, the highest level of severity
2. **CC:** Complication/Comorbidity, the next level of severity
3. **Non-CC:** Non-Complication/Comorbidity, this level does not significantly affect severity of illness and resource use

CMS applies a recoupment adjustment to acute care hospital payments to account for changes in MS-DRG documentation and coding that do not reflect real changes in case-mix. In Fiscal Year (FY) 2020, a **0.5 percentage point** adjustment is applied to the standardized amount.

Payment Rates

CMS bases the IPPS per-discharge payment on two national base payment rates (standardized amounts): one for operating costs and the other for capital-related costs. CMS adjusts these payment rates for:

- The costs associated with the patient's clinical condition and related treatment compared to the costs of the average Medicare case (the DRG relative weight, described in the [Setting Payment Rates](#) section)
- Market conditions in the hospital's location compared to national conditions (the wage index, described in the [Setting Payment Rates](#) section)

Other IPPS Hospital Payments

Acute care hospitals can qualify for outlier payments for extremely costly cases.

Hospitals that train residents in approved Graduate Medical Education (GME) programs get a separate payment for the direct cost of training residents, referred to as direct GME. Medicare increases the operating and capital payment rates of hospitals paid under the IPPS to reflect the teaching hospitals' higher indirect patient care costs compared to non-teaching hospitals, referred to as indirect medical education (IME).

Effective with portions of cost reporting periods beginning October 1, 2019, a hospital may include FTE residents training at a Critical Access Hospital (CAH) in its Full-Time Equivalent (FTE) count as long as it meets the non-provider setting requirements in [42 Code of Federal Regulations \(CFR\) § 412.105\(f\)\(1\)\(ii\)\(E\)](#) and [§ 413.78\(g\)](#). If a hospital is at some point in its 5-year cap building period as of October 1, 2019, and as of that date is sending residents in a new program to train at a CAH, the time spent by FTE residents training at the CAH on or after October 1, 2019 will be included in the hospital's facility response team (FRT) cap calculation.

Medicare increases operating and capital payment rates to hospitals treating a disproportionate share of low-income patients, and they get additional payments for uncompensated care. For fiscal year (FY) 2020, CMS revised the definition of [uncompensated care](#) (health care of services provided by hospitals or health care providers that do not get reimbursed) and the method for calculating it.

Medicare may also pay acute care hospitals for treating patients with certain newly approved, costly technologies that offer a substantial clinical improvement over existing treatments.

Finally, Medicare reduces payment in some cases 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. This transfer policy applies to patients assigned to one of the MS-DRGs subject to this policy who transfer to a Skilled Nursing Facility, Long Term Care Hospital, Inpatient Rehabilitation Facility, Inpatient Psychiatric Facility, Cancer Hospital, Children's Hospital or to get home health care from a Home Health Agency or hospice care by a hospice program.

IPPS discharge payments reflect applicable adjustments under the Hospital Value-Based Purchasing (VBP) and Hospital Readmissions Reduction Program (HRRP). Medicare adjusts a portion of operating IPPS payments to acute inpatient hospitals upward or downward for hospitals eligible for value-based incentive payments, based on their performance on a set of quality measures. Medicare reduces a portion of eligible hospitals' operating IPPS payments for excess readmissions.

The Hospital-Acquired Condition (HAC) Reduction Program reduces overall payments by 1 percent for applicable hospitals with the worst-performing quartile of risk-adjusted quality measures for reasonably preventable HACs.

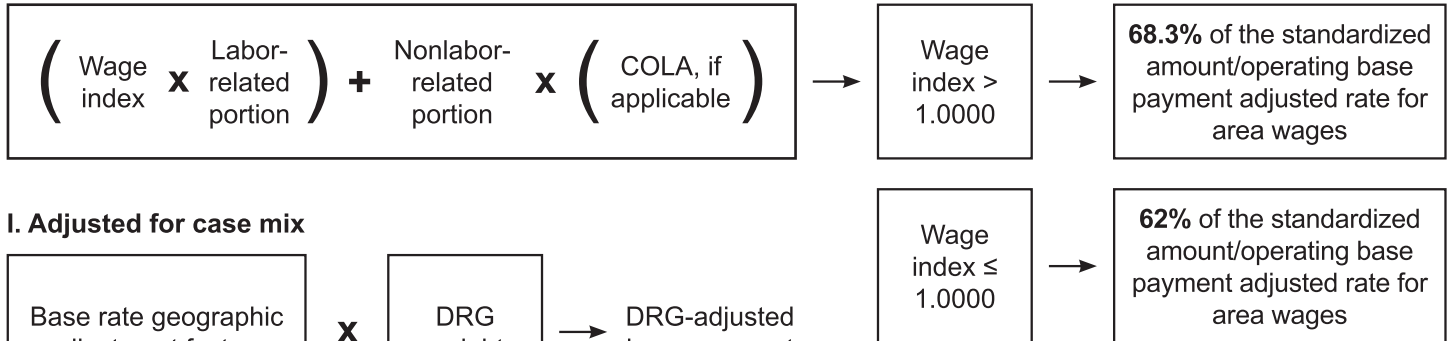
To determine an IPPS payment:

1. The hospital submits a bill to their Medicare Administrative Contractor (MAC) for each Medicare patient treated. Based on the billing information, 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. CMS adjusts the labor-related share by a wage index to reflect area differences in labor costs. If the area wage index is greater than 1.0000, the labor share equals **68.3 percent**. The law requires the labor share to equal **62 percent** if the area wage index is less than or equal to 1.0. The nonlabor-related share is adjusted by a cost-of-living adjustment (COLA) factor equal to 1.0 for all States except hospitals located in Alaska or Hawaii.
3. CMS multiplies the wage-adjusted standardized amount by a DRG weighting factor. The weight is specific to each DRG (761 DRGs for FY 2020). Each DRG relative weight represents the average resources to care for those DRG cases compared to the average resources to treat cases in all DRGs.
4. If applicable, CMS adds these amounts to the IPPS payment:
 - The hospital engages in teaching medical residents to reflect the higher indirect teaching hospital patient care costs compared to non-teaching hospitals
 - The hospital treats a disproportionate share of low-income patients including incurred, uncompensated care costs
 - Certain newly-approved technology cases
 - High-cost outlier cases
5. The Hospital VBP Program, HRRP, and HAC Reduction Programs adjust the IPPS payment.

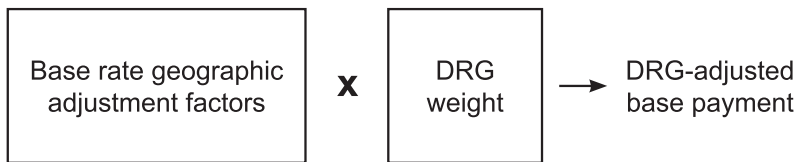
See the [Acute Care Hospital: IPPS Operating Base Payment Rate](#) and [Acute Care Hospital: IPPS Capital Base Payment Rate](#) formulas to understand how CMS calculates them.

Acute Care Hospital IPPS: Operating Base Payment Rate

Adjusted for geographic factors

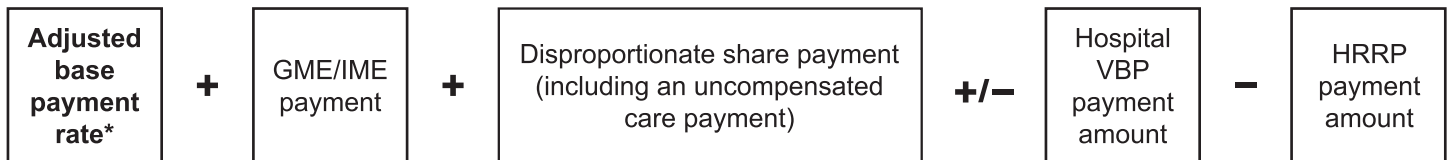


I. Adjusted for case mix

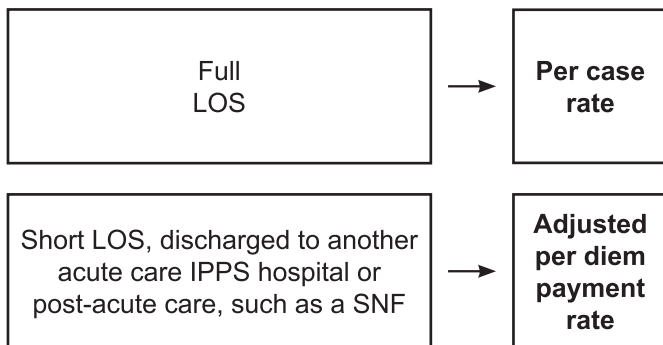


Qualifying hospitals' policy adjustments:

I. Additional operating amounts



II. Transfer adjustments



III. If extraordinarily costly case



IV. If case qualifies for new technology add-on

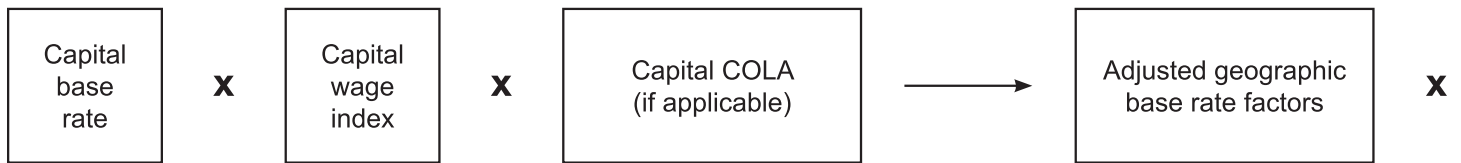


V. If hospital ranks in lowest performing HACs quartile

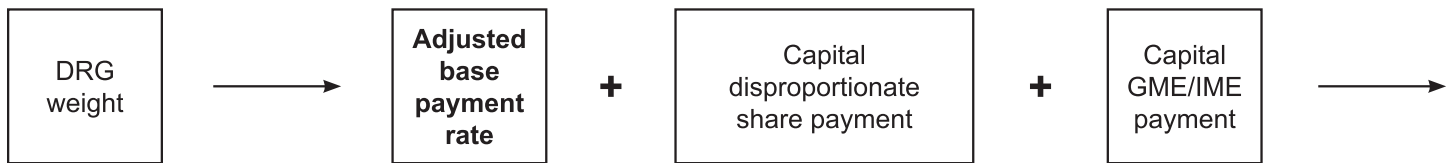
(overall payment is -1%)

* Reflects the applicable Hospital IQR and Promoting Interoperability Programs payment adjustments.

Acute Care Hospital IPPS: Capital Base Payment Rate

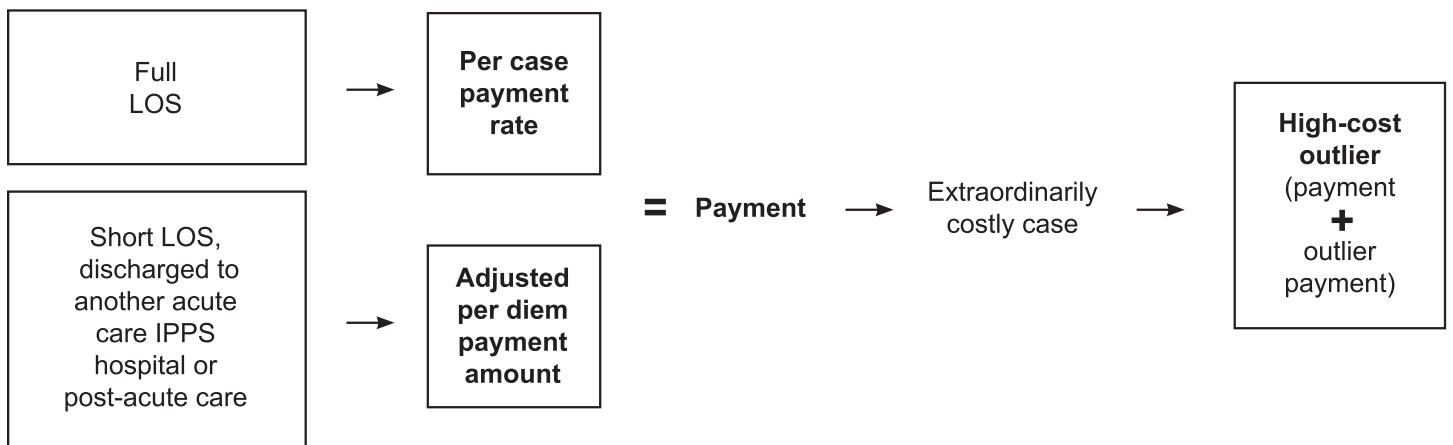


Case mix adjustment



DRG-adjusted base payment

Transfer adjustments



Setting Payment Rates

CMS determines IPPS payments through a series of adjustments to separate operating and capital base payment rates. CMS annually updates the base rates, and unless CMS makes additional policy changes, the update raises all payment rates proportionally.

Base Payment Amounts

CMS sets discharge base rates (the standardized payment amount) for the operating and capital costs they expect efficient hospitals to incur while furnishing inpatient services. Medicare excludes some costs, such as direct GME program operating costs and organ acquisition costs, from IPPS rates and pays them separately. Capital payments cover depreciation, interest, rent, and property-related insurance and tax costs.

DRG Relative Weights

CMS assigns a weight to each MS-DRG that reflects the average case cost in that group compared to the average Medicare case cost and uses the same MS-DRG weights for operating and capital payment rates. CMS annually adjusts the MS-DRG weights without affecting overall payments, based on standardized charges and all IPPS case costs in each MS-DRG. CMS standardizes hospitals' billed charges to improve comparability by:

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

NOTE: CMS reduces charges to costs using national average hospital cost ratios to charges for 19 different hospital departments.

Market Condition Adjustments

CMS adjusts rates based on operating and capital rates by an area wage index to reflect the differences in local labor market prices. CMS measures 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, and annually revises the wage index based on IPPS hospital wage data. If a hospital believes it competes for labor in a different area than the one where located, it may request geographic reclassification. For more information about requesting reclassification, refer to the [Medicare Geographic Classification Review Board](#) webpage.

CMS applies the wage index to the whole capital base rate, and raises it to a fractional power, narrowing the geographic variation in wage index values among market areas. CMS applies a COLA, which reflects the higher costs of supplies and other nonlabor resources, to the base operating and capital rates of IPPS hospitals in Hawaii and Alaska. CMS also applies the COLA to the nonlabor-related portion of the operating base rate and to the whole capital base rate.

Bad Debts

Hospitals get patient bad debt reimbursement at 65 percent. CMS attributes bad debts to coinsurance and deductible nonpayment amounts after the hospital makes a reasonable collection effort. Providers claiming Medicare bad debt reimbursement must submit a detailed bad debt listing that corresponds to the bad debt amounts claimed in the cost report. CMS will reject a cost report they get without the detailed bad debt listing for lack of supporting documentation.

Payment Adjustments

Direct Graduate Medical Education

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs get direct graduate medical education (DGME) payments. These payments reflect the approved residency training programs' direct operating costs. CMS makes these payments separately from the IPPS and generally bases the DGME payments on:

- 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 Graduate Medical Education Costs

Teaching hospitals or hospitals that train residents in approved medical allopathic, osteopathic, dental, or podiatry residency programs also get IME adjustments to reflect the higher indirect patient care costs of teaching hospitals compared to non-teaching hospitals. CMS calculates the IME adjustment factor using a hospital's residents-to-beds ratio.

Medicare Disproportionate Share Hospitals

Hospitals that treat a disproportionate share of low-income patients get additional operating and capital payments. Hospitals get 25 percent of the amount they previously got under the "traditional" Medicare Disproportionate Share Hospital (DSH) operating payments statutory formula. The remainder, equal to 75 percent of what Medicare otherwise would have paid as Medicare DSH operating payments, goes toward an uncompensated care payment after reducing the amount for the percentage change of uninsured individuals.

Each hospital eligible for DSH payments gets an uncompensated care payment based on its share of uncompensated care costs relative to all Medicare DSH-eligible hospitals. CMS annually updates the factor estimates used to determine each eligible hospital's uncompensated care payments.

CMS audited data from Worksheet S-10 of the FY 2015 cost report and used it to calculate uncompensated care costs for FY 2020.

NOTE: CMS continues to use data regarding low-income days (Medicaid days for FY 2013 and Supplemental Security Income (SSI) days for FY 2017) to determine the amount of uncompensated care payments for Puerto Rico hospitals, Indian Health Service and Tribal hospitals.

Sole Community Hospitals

Sole Community Hospitals (SCHs) can get operating payments based on the higher of their hospital-specific payment rate or the Federal rate, while capital payments are solely based on the capital base rate (like all other IPPS hospitals). Medicare makes operating payments to SCHs based on which of the following yield the greatest cost reporting period aggregate payment:

- The applicable hospital IPPS Federal rate
- 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 get a payment adjustment if they experience a significant volume decrease. For more information about the volume decrease payment adjustment, refer to [42 CFR § 412.92\(e\)](#).

A Medicare IPPS hospital is eligible for SCH classification if it meets **one** of these criteria:

1. The hospital is 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 hospitalized inpatient residents, or no more than 25 percent of hospitalized inpatient Medicare patients in the hospital's service area, are admitted to other like hospitals 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 except some patients get specialized care unavailable in the hospital service area
3. The hospital is rural and between 15 and 25 miles from other like hospitals but inaccessible because of local topography or periods of prolonged severe weather conditions 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, 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 the Medicare Acute Care Hospital IPPS
- Is not a CAH

A hospital's service area is the area 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 an SCH.

CMS treats certain hospitals formerly designated as Essential Access Community Hospitals (EACHs) as SCHs for IPPS payment purposes. For more information about EACHs, refer to [42 CFR § 412.109](#).

Medicare Dependent Hospitals

Medicare Dependent Hospitals (MDHs) can get operating payments based on the higher of the Federal rate or the Federal rate plus 75 percent of the difference between the Federal rate and the hospital-specific rate. The hospital-specific rate is based on FY 1982, FY 1987, or FY 2002 costs per discharge (whichever yields the greatest aggregate payment).

An MDH's capital payments are solely based on the capital base rate. MDHs may also qualify for a payment adjustment if the hospital experiences a significant volume decrease. For more information about the volume decrease payment adjustment, refer to [42 CFR § 412.108\(d\)](#).

Rural Referral Center Program

CMS established the Rural Referral Center (RRC) Program to support high-volume rural hospitals. [42 CFR § 412.96](#) describes the criteria for RRCs. In general, CMS classifies a Medicare participating acute care hospital as an RRC if it is in a rural area and it meets one of these criteria:

1. It has 275 or more usable beds available during its most recently completed cost reporting period. If the hospital's bed count changed, the hospital may submit written documentation with the application on one or more of these reasons for the change:
 - The merger of two or more hospitals
 - Acute care beds previously closed for renovation reopen
 - The hospital transfers acute care beds to the IPPS that were previously classified as part of an excluded unit
 - The hospital expands the number of acute care beds for use and permanently maintains them for inpatients. The expansion does not include beds in corridors or other temporary beds.
2. It shows one of these elements:
 - Non-staff physicians or other hospitals refer at least 50 percent of the hospital's Medicare patients
 - At least 60 percent of the hospital's Medicare patients live more than 25 miles from the hospital
 - The hospital furnishes at least 60 percent of all services to Medicare patients living more than 25 miles from the hospital
3. If a hospital does not meet the criteria in numbers 1 or 2, it is classified as an RRC if located in a rural area, meets the criteria specified in a and b below, and meets at least one of the criteria specified in c or d below:
 - a. Discharges during the most recent Federal FY ended at least 1 year prior to the beginning of the cost reporting period the hospital is seeking RRC status, and its Case-Mix Index (CMI) equals one of these:
 - The lower of the median CMI value for all urban hospitals nationally
 - The median CMI urban hospital's value for urban hospitals in its region, excluding those hospitals getting indirect medical education payments specified in [42 § CFR 412.105](#)

- b. Its number of discharges is at least one of these:
 - 5,000 (3,000 for an osteopathic hospital)
 - The median urban hospital's number of discharges in the census region it is located, set annually by CMS in Acute Care Hospital IPPS rulemaking, according to [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 inpatient discharges reside more than 25 miles from the hospital
- e. Volume of referrals: Other hospitals or non-staff physicians refer at least 40 percent of all inpatients treated

In FY 1998 CMS grandfathered hospitals designated RRCs in FY 1991 and each subsequent year.

Current hospitals, or those that once had RRC status, get certain advantages:

1. Proximity:

- A hospital currently designated an RRC need not demonstrate a proximity to the area where it seeks reclassification
- The hospital can apply for reclassification to the closest urban or rural area

2. AHW Data Comparison:

- Any hospital ever designated an RRC is exempt from the 106/108 percent AHW comparison test
- Any hospital ever designated an RRC must meet the 82 percent AHW comparison regardless of its location in an urban or rural area

3. DSH Cap:

- Any hospital designated an RRC is exempt from the 12 percent cap on DSH payments applicable to other rural hospitals

Low-Volume Hospitals

Currently, Medicare makes add-on payments to qualifying low-volume hospitals more than 15 road miles from the nearest subsection (d) hospital if the hospital discharges fewer than 3,800 total patients based on the hospital's most recently submitted cost report. Qualifying hospitals get an adjustment of up to an additional 25 percent for each patient discharge. Medicare bases a qualifying hospital's low-volume payment adjustment on the following:

- For low-volume hospitals with 500 or fewer total discharges during the FY, the low-volume hospital payment adjustment is an additional 25 percent for each Medicare discharge
- For low-volume hospitals with total discharges during the FY of more than 500 and fewer than 3,800, the adjustment for each Medicare discharge is an additional percentage calculated using the formula $[(95/330) \text{ minus } (\text{number of total discharges}/13,200)]$

Outlier Payments

To promote seriously ill patients' access to high quality inpatient care, CMS makes additional payments for extremely costly outlier cases. CMS identifies these cases by comparing their estimated operating and capital costs to a fixed-loss threshold. CMS annually sets the fixed-loss threshold and adjusts it to reflect labor costs in the hospital's local market.

CMS pays outliers by offsetting reductions in the operating and capital base rates (reducing the payment rates to all cases so the amount paid as outliers does not increase or decrease estimated aggregate Medicare spending). CMS established the national fixed-loss threshold at **5.1 percent** of total FY payments.

Transfer Policy

Medicare reduces DRG payments when:

- The patient's LOS is at least 1 day less than the geometric mean DRG LOS
- The hospital transfers the patient to another IPPS-covered acute care hospital, or for certain MS-DRG patients, a post-acute setting
- The hospital transfers the patient to a hospital not participating in the Medicare Program
- The hospital transfers the patient to a CAH

CMS' transfer policy includes these post-acute care settings:

- Long-term care hospitals
- Rehabilitation facilities
- Psychiatric facilities
- SNFs
- Home health care, when the patient gets clinically related care that begins within 3 days after a hospital stay
- Rehabilitation distinct part units located in an acute care hospital or a CAH
- Psychiatric distinct part units located in an acute care hospital or a CAH
- Cancer hospitals
- Children's hospitals
- Hospice care, effective October 1, 2018

Hospital Readmissions Reduction Program

The HRRP allows an adjustment for discharges to the base operating DRG payment to account for excess readmissions. CMS bases the reduction on a hospital's risk-adjusted readmission rate during a 3-year period for:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Chronic obstructive pulmonary disease
- Total hip/knee arthroplasty
- Coronary artery bypass graft surgery

A readmission generally means an acute care hospital admission within 30 days of discharge from the same or another Medicare-IPPS acute care hospital.

Hospital Value-Based Purchasing Program

The Hospital VBP Program provides upward, downward, or neutral adjustments to participating hospitals' base operating DRG payments, based on their performance on a set of quality measures. CMS funds value-based incentive payments by reducing hospitals' base operating DRG payment amounts. Hospitals may earn back more than, all, or less than the applicable reduced percent each year. The Hospital VBP Program generally applies to all acute IPPS hospitals, with certain exceptions. The applicable reduction to base operating DRG payment amounts is 2.00 percent.

Hospital-Acquired Condition Reduction Program

An HAC is a condition a patient gets during hospitalization (the condition was not present on admission). The HAC Reduction Program reduces overall payments by 1 percent for applicable hospitals with the worst-performing quartile of risk-adjusted quality measures for reasonably preventable HACs.

Payment Updates

CMS annually updates the operating and capital payment rates. Congress sets the operating update by 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 payment updates, refer to the [FY 2020 Acute Care Hospital IPPS Final Rule](#).

Inpatient Quality Reporting and Promoting Interoperability Programs

For FY 2020, the increase in operating payment rates for general acute care hospitals that report specific quality data, meet all other requirements of the Hospital IQR Program, and promote interoperability is approximately 3.0 percent.

Hospitals that do not report specific quality data but promote interoperability get a reduction of one-quarter of the applicable percentage increase to the market basket update. Hospitals that report specific quality data but do not promote interoperability get a reduction of three-fourths of the applicable increase to the market basket update.

Resources

Table 1. IPPS Resources

For More Information About...	Resource
Acute Care Hospital IPPS	CMS.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
HAC Reduction Program	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-ReductionProgram Qualitynet.org/inpatient/hac
Hospital Readmissions Reduction Program	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program
Hospital VBP Program	CMS.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing
Sole Community Hospitals	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929 (Chapter 28, Section 2810)
Medicare Dependent Hospitals	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
§ 413.78(g)	https://www.ecfr.gov/cgi-bin/text-idx?SID=d0a5e77ce27fc0e37df65d0454ac3000&mc=true&node=pt42.2.413&rgn=div5#se42.2.413_178
42 Code of Federal Regulations (CFR) § 412.105(f)(1)(ii)(E)	https://www.ecfr.gov/cgi-bin/text-idx?SID=d0a5e77ce27fc0e37df65d0454ac3000&mc=true&node=se42.2.412_1105&rgn=div8
42 § CFR 412.105	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_1105
42 CFR § 412.109	https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&r=SECTION&n=se42.2.412_1109
42 CFR § 412.108(d)	https://www.ecfr.gov/cgi-bin/text-idx?SID=abd5fd6f7e59fd8b4ef6aa70eed53&mc=true&node=se42.2.412_1108&rgn=div8
42 CFR § 412.96 42 CFR § 412.96(c)(2) 42 CFR § 412.96(c)(3)	https://www.ecfr.gov/cgi-bin/text-idx?SID=133edc1b2d24b2d18d4e21ea10e5a806&mc=true&node=se42.2.412_196
FY 2020 Acute Care Hospital IPPS Final Rule	https://www.federalregister.gov/d/2019-16762
Medicare Geographic Classification Review Board	https://www.cms.gov/Regulations-and-Guidance/Review-Boards/MGCRB

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