# Medicare Inpatient Prospective Payment System

Payment Rule Brief Provided by the Wisconsin Hospital Association
Program Year: FFY 2024

## Overview and Resources

On August 1, 2023, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2024 final rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and marketbasket, the following policies have been adopted in this rule:

- Utilizing FFY 2022 Medicare Provider and Review (MedPAR) and FFY 2021 Hospital Cost Report (HCRIS) data for standard calculations;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies including hospital eligibility for DSH payments in FFY 2024 being based on audited FFY 2018, FFY 2019, and FFY 2020 S-10 data, using the a three-year average of S-10 data to calculate interim payments FFY 2024 and beyond, and the exclusion of capital DSH payments for urban providers who reclassify as rural;
- Graduate Medical Education (GME) policies for Rural Emergency Hospitals (REH);
- Updates to the Value-Based Purchasing (VBP), Readmission Reduction Program (RRP) and Hospital-Acquired Condition (HAC) programs; and
- Updates to the payment penalties for non-compliance with the Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Incentive Programs.

Program changes will be effective for discharges on or after October 1, 2023 unless otherwise noted. CMS estimates the overall impact of this final rule update to be an increase of approximately $2.2 billion (proposed at $2.7 billion) in aggregate payments for acute care hospitals in FFY 2024. This estimate includes increased operating and capital payments and decreases due to changes in new technology add-on payments.

A copy of the final rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page.

An online version of the final rule will be available on August 28, 2023 at https://www.federalregister.gov/d/2023-16252.

***Note:*** Text in italics is extracted Display version of the final rule unless otherwise noted.

## IPPS Payment Rates

***Display pages 38 – 43, 975 – 994, 1,214 – 1,241, and 1,850 – 1,937***

The table below lists the federal operating and capital rates adopted for FFY 2024 compared to the rates currently in effect for FFY 2023. These rates include all marketbasket increases and reductions as well as the application of annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g. penalty for non-compliance under the IQR Program and EHR Meaningful Use Program, quality penalties/payments, DSH, etc.).

| | Final<br>FFY 2023 | Final<br>FFY 2024 | Percent Change |
|---|---|---|---|
| **Federal Operating Rate** | **$6,375.74** | **$6,497.77**<br>(proposed at $6,524.94) | **+1.91%**<br>(proposed at +2.34%) |
| **Federal Capital Rate** | **$483.79** | **$503.83**<br>(proposed at $505.54) | **+4.14%**<br>(proposed at +4.50%) |

The following table provides details for the final annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2024.

<table>
<tr><th></th><th>Federal Operating/Hospital Specific Rate</th><th>Federal Capital Rate</th></tr>
<tr><td>Marketbasket/Capital Input Price Index update</td><td>+3.3%<br>(proposed at +3.0%)</td><td>+2.9%<br>(proposed at +3.5%)</td></tr>
<tr><td>ACA-Mandated Productivity Adjustment</td><td>-0.2 percentage point (PPT)<br>(as proposed)</td><td>—</td></tr>
<tr><td>Forecast Error Adjustment</td><td>—</td><td>+0.9%</td></tr>
<tr><td>Lowest Quartile Wage Index Adjustment</td><td>-0.07%<br>(proposed at -0.08%)</td><td rowspan="2">-0.08%<br>(proposed at -0.38%)</td></tr>
<tr><td>Wage Index Cap Policy</td><td>-0.00%<br>(proposed at -0.31%)</td></tr>
<tr><td>MS-DRG Weight Cap Policy</td><td>-0.01%<br>(as proposed)</td><td>-0.01%<br>(as proposed)</td></tr>
<tr><td>All Other Annual Budget Neutrality Adjustments</td><td>-1.06%<br>(proposed at -0.05%)</td><td>+0.43%<br>(proposed at +1.19%)</td></tr>
<tr><td>Net Rate Update</td><td>+1.91%<br>(proposed at +2.34%)</td><td>+4.14%<br>(proposed at +4.50%)</td></tr>
</table>

- **Effects of the Inpatient Quality Reporting (IQR) and Electronic Health Record Meaningful Use (EHR MU) Incentive Programs** ***(Display pages 989 – 991, 1,851, and 1,917 – 1,918)***: The IQR MB penalty imposes a 25% reduction to the full MB and the EHR MU penalty imposes a 75% reduction to the full MB; hence the entirety of the full MB update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2024 is below:

<table>
<tr><th></th><th>Neither Penalty</th><th>IQR Penalty</th><th>EHR MU Penalty</th><th>Both Penalties</th></tr>
<tr><td>Net Federal Rate Marketbasket Update (3.3% MB less 0.2 PPT productivity adjustment)</td><td colspan="4">+3.1%</td></tr>
<tr><td>Penalty for Failure to Submit IQR Quality Data<br>(25% of the base MB Update of 3.3%)</td><td>—</td><td>-0.825 PPT</td><td>—</td><td>-0.825 PPT</td></tr>
<tr><td>Penalty for Failure to be a Meaningful User of EHR<br>(75% of the base MB Update of 3.3%)</td><td>—</td><td>—</td><td>-2.475 PPT</td><td>-2.475 PPT</td></tr>
<tr><td>Adjusted Net Marketbasket Update<br>(prior to other adjustments)</td><td>+3.1%</td><td>+2.275%</td><td>+0.625%</td><td>-0.2%</td></tr>
</table>

- **Data Sources for IPPS Rate Setting (*Display pages 38 – 43):*** In past years, CMS has utilized the best available data sources for IPPS rate setting, including MedPAR claims data for the fiscal year that is two years prior and hospital cost repot (HCRIS) data beginning three fiscal years prior to the rate setting year (FFYs 2022 and 2021, respectively for FFY 2024). Based on recent data trends, CMS does not believe that there will be a meaningful difference between the numbers of COVID-19 cases treated in 2024 relative to 2022. As such, CMS will utilize FFY 2022 MedPAR claims and the FFY 2021 HCRIS dataset for FFY 2024, with no modifications to account for the impact of COVID-19.

- **Outlier Payments** ***(Display pages 1,874 – 1,908 and 1,924 – 1,925)*****:** CMS continues to believe that using a methodology that incorporates historic cost report outlier reconciliations to develop the outlier threshold is a reasonable approach and would provide a better predictor for the upcoming fiscal year. Therefore, for FFY 2024, CMS will incorporate total outlier reconciliation dollars from the FFY 2018 cost reports into the outlier model using a similar methodology to what was finalized in FFY 2020.

  An analysis done by CMS determined outlier payments at 5.12% of total IPPS payments; CMS is adopting an outlier threshold of $42,750 (proposed at $40,732) for FFY 2024, which includes a charge inflation factor which is calculated using the March 2022 MedPAR file for FFY 2021 charge data and the March 2023 MedPAR file of FFY 2022 charge data. This threshold is 10.0% higher than the current (FFY 2023) outlier threshold of $38,859.

  Additionally, CMS will use the estimated per-discharge IHS/Tribal and Puerto Rico supplemental payments in the calculation of the outlier fixed-loss cost threshold, consistent with the policy of including estimated uncompensated care payments.

- **Stem Cell Acquisition Budget Neutrality Factor** (***Display page 1,853***): CMS will continue to not remove the Stem Cell Acquisition budget neutrality factor and to also not apply a new factor for FFY 2024 as they do not believe that it would satisfy budget neutrality requirements. CMS intends to consider using cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

## Wage Index

***Display pages 747 – 840, 1,865 – 1,873, 1,908 – 1,914, 1,925 – 1,931, and 1,932***

- **Permanent Cap on Wage Index Decreases** ***(Display pages 813 – 815 and 1,872 – 1,873)*****:** In order to reduce large swings in year-to-year wage index changes and increase the predictability of IPPS payments, CMS adopted a policy to apply a 5% cap on any decrease of the FFY 2023 IPPS wage index, and all future IPPS wage indexes, compared with the previous year's final wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IPPS provider's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. If a hospital reclassifies as rural under 42 CFR §412.103 with an effective date after this day, the policy will apply to the reclassified wage index instead. Additionally, a new IPPS will be paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS will not have a wage index in the prior FFY.

  This policy will be implemented in a budget neutral manner with a net budget neutrality factor of 0.99996 (proposed at 0.99687), after backing out the effects of the FFY 2023 adjustment.

- **Rural Floor** ***(Display pages 783 – 804 and 1,868 – 1,870)*****:** In the FFY 2020 IPPS final rule, CMS adopted a policy where hospitals that reclassified from urban to rural had their wage data removed from the rural floor calculation to prevent inappropriate payment increases under the rural floor. This wage data was also removed from the calculation to determine the wage index for rural areas of each state. This rural floor policy and the related budget neutrality adjustment were subject to litigation (*Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*) in which it was determined that the Secretary does not have the authority to establish a rural floor lower than the rural wage index for a state. In the FFY 2023 IPPS final rule, CMS adopted the removal of that policy that had begun in FFY 2020. Upon further review of this case law, prior public comments, and relevant statues, CMS now fully agrees with the court's decisions on this and will treat §412.103 (redesignated rural) hospitals the same as geographically rural hospitals for the rural wage index calculation, including those hospitals with other reclassifications.

  CMS has a longstanding hold harmless policy to prevent the rural wage index of a state from being lowered by hospitals that reclassify to a state rural area. Due to the adopted policy above, the rural wage index will no longer be held harmless from in-state hospitals reclassifying as rural under §412.103. However, for hospitals who have a state-to-state MGCRB reclassification, CMS will continue this hold harmless policy to exclude the

data of hospitals reclassifying into another state's rural area if doing so would reduce that state's rural wage index.

- **Addressing Wage Index Disparities between High and Low Wage Index Hospitals *(Display pages 804 – 813, 1,871 – 1,872, and 1,932)*:** CMS had noted that many comments from the Wage Index Request for Information in the FFY 2019 IPPS proposed rule reflected *"a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals."* As a result, CMS had made a variety of changes in the FFY 2020 final rule to reduce the disparity between high and low wage index hospitals.

  As adopted, this policy will be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years. For FFY 2024, CMS will continue the policy that hospitals with a wage index value in the bottom quartile of the nation will have that wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25$^{th}$ percentile wage index value across all hospitals.

  CMS notes that this policy is subject to pending litigation (*Bridgeport Hospital, et al., v. Becerra)* in which the court found that the Secretary did not have the authority to adopt this low wage index policy and has ordered additional briefing on an appropriate remedy. This court decision involves only FFY 2020, is not final, and is has been appealed by CMS. Given there is only one year of relevant data (FFY 2020) that CMS could use to evaluate any potential impacts of the policy on hospital wages, CMS believes it necessary to wait until usable data from additional fiscal years is available before making a decision to modify or discontinue the policy for additional years.

  CMS will continue to offset these wage index increases in a budget neutral manner by applying a budget neutrality adjustment to the national standardized amount. The value of the 25$^{th}$ percentile wage index for FFY 2024 will be 0.8667 (proposed at 0.8615), and the net budget neutrality adjustment is 0.99925 (proposed at 0.99922) after backing out the effects of the FFY 2023 adjustment.

- **Occupational Mix Adjustment *(Display pages 776 – 782)*:** In the FFY 2022 IPPS final rule, CMS finalized the use of the calendar year (CY) 2019 Occupational Mix Survey for the calculation of the FFY 2024 wage index. The FFY 2024 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS is adopting a FFY 2024 occupational mix adjusted national average hourly wage of $50.34 (proposed at $50.27).

  For FFY 2025, a new occupational mix is required and is based on a new CY 2022 survey, which hospitals were required to submit to their MACs by June 30, 2023. CMS released preliminary, unaudited CY 2022 survey data on July 12, 2023. Providers have until September 1, 2023 to submit corrections of these data to CMS and their MAC. Details on the timeline for the FFY 2025 wage index development can be found here https://www.cms.gov/files/document/fy2025-hospital-wage-index-development-timetable.pdf.

- **Labor-Related Share *(Display pages 837 – 840 and 1,908 – 1,913)*:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2024, CMS will continue to apply a labor-related share of 67.6% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

A complete list of the final wage indexes for payments in FFY 2024 is available on the CMS website at https://www.cms.gov/files/zip/fy2024-ipps-fr-tables-2-3-4.zip.

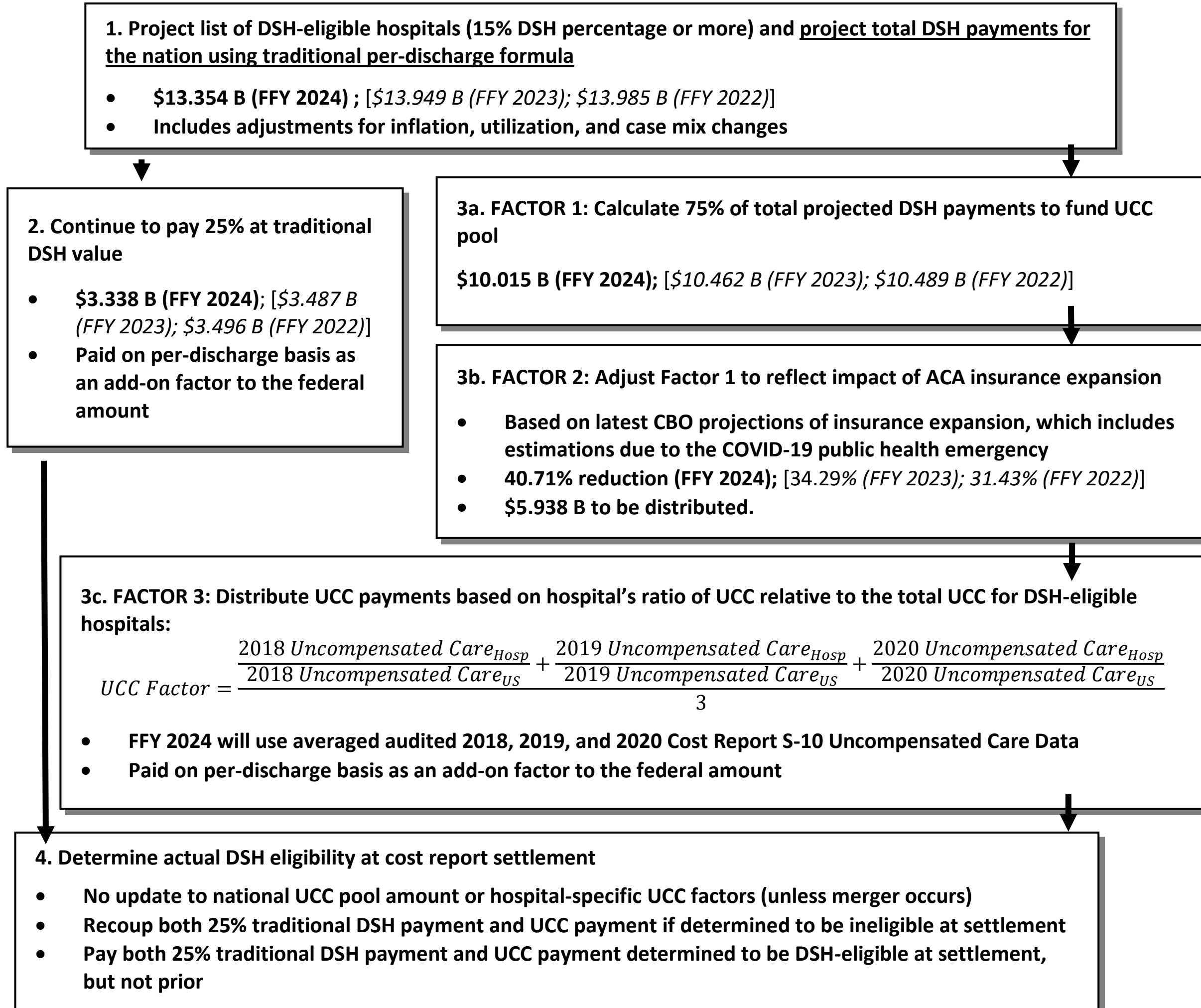
## DSH Payments

***Display pages 841 – 965, 1,224 – 1,226, and 1,860 – 1,861***

The ACA mandates the implementation of Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds, referred to as the Uncompensated Care (UCC) pool, are subject to reduction to reflect the impact of insurance

expansion under the ACA. This UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

- **DSH Payment Methodology for FFY 2024** ***(Display pages 841 – 918)*****:** The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2023 to FFY 2024:




DSH dollars available to hospitals under the ACA's payment formula will decrease by $0.936 billion in FFY 2024 relative to FFY 2023 due to a decrease in the pool from projected DSH payments.

- **Eligibility for FFY 2024 DSH Payments** ***(Display pages 845 – 850)*****:** CMS is projecting that 2,384 (proposed at 2,395) hospitals will be eligible for DSH payments in FFY 2024 based on audited FFY 2018, FFY 2019, and FFY 2020 S-10 data. CMS has made a file available that includes estimated DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file is available at https://www.cms.gov/files/zip/fy-2024-ipps-final-rule-dsh-supplemental-data-file.zip.

- **Adjustment to Factor 3 Determination** ***(Display pages 881 – 918)*****:** In the FFY 2023 IPPS final rule, CMS adopted the use of the most recent three years of audited cost report data in the determination of Factor 3 for FFYs 2024 and onwards. Specifically, for FFY 2024 CMS will use FFY 2018, FFY 2019, and FFY 2020 for this determination. Hospitals that do not have data for all three years will have their Factor 3 determined based on the average of the available data for the appropriate years. In the rare case when CMS would use a cost report that starts in

one FFY and spans the entirety of the subsequent FFY, the same cost report would not be used to determine UCC costs for the earlier FFY. As an alternative for the earlier FFYs, the most recent prior cost report that spans some portion of that FFY will be used. To ensure that total UCC payments for all eligible hospitals are consistent with the total estimated UCC amount made available to hospitals, a scaling factor will be applied to the Factor 3 values for each of these hospitals. For each DSH-eligible hospital, this scaling factor is calculated as:

$$\frac{1}{Actual\ sum\ of\ all\ hospital\ Factor\ 3\ values}.$$

This quotient is then multiplied by the UCC payment determined for each DSH-eligible hospital to obtain a scaled UCC payment amount. This process ensures that the sum of the scaled UCC payments for all hospitals is consistent with the estimate of the total amount available to make UCC payments.

For new hospitals established on or after October 1, 2020 that do not have cost report data for the most recent year of data being used in the Factor 3 calculation, CMS will continue the policy established in FFY 2020 that if the hospital has a preliminary projection of being eligible for DSH it may receive interim DSH payments but would not receive interim UCC payments. Factor 3 for new hospitals will use a denominator based solely on UCC costs from cost reports for the most recent year for which audits have been conducted. The resulting Factor 3 would then have a scaling factor applied to it. This modification will also apply to newly merged hospitals with data based on the surviving hospital's CMS Certification Number (CCN). If the hospital's cost reporting period is less than 12 months, the data from the newly merged hospital's cost report will be annualized.

CMS will continue to use the trimming methodology adopted in the FFY 2021 IPPS final rule and a modification for the use of multiple years of cost report data. If unaudited UCC costs for FFY 2018, FFY 2019, or FFY 2020 are greater than 50% of total operating costs for that FFY, then a ratio of UCC costs to the hospital's total operating costs for the other year would be applied to the total operating costs of the aberrant year. Additionally, for hospitals that have not had their FFY 2018, FFY 2019, and/or FFY 2020 cost reports audited, CMS will continue the policy adopted in FFY 2021 for an alternative trimming methodology using a threshold of three standard deviations from the mean ratio of insured patients' charity care costs to total uncompensated care costs, and a dollar threshold that is the median total uncompensated care cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible, including Indian Health Service (IHS), Tribal, and Puerto Rico hospitals. Specifically, in cases where a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care to total UCC costs is greater than 60%, CMS will exclude the hospital from the prospective Factor 3 calculation. For hospitals subject to this alternate trim, and determined to be DSH-eligible at cost report settlement, CMS will continue to apply its policy where those hospitals' UCC payments will be calculated after their MACs have reviewed the UCC information reported on worksheet S-10, subject to the previously mentioned scaling factor.

CMS will use a hospital's three-year average discharge number to estimate interim uncompensated care payment per discharge for FFY 2024 and subsequent years. As in past years, interim payments made using this value will be reconciled at cost report settlement to equal the uncompensated care pool distribution amount that will be published with accompanying final rule. Due to FFY 2020 discharges being affected by the COVID-19 public health emergency (PHE), CMS will use FFYs 2019, 2021, and 2022 to calculate this average for FFY 2024.

For FFY 2024 and subsequent years, CMS will eliminate the 15 business day time period after the display of the final rule for hospitals to submit issues regarding mergers and/or potential upload discrepancies. CMS believes that the proposed rule comment period allows sufficient time for these errors to be identified.

Instead, for FFY 2024 and subsequent years, CMS finalized that hospitals would have 60 business days from the date of public display of the IPPS proposed rule to review and submit issues related to mergers and/or potential upload discrepancies of Worksheet S-10 data published along with the proposed rule. Comments regarding issues that are specific to data and supplemental data files for the proposed rule can be submitted

to Section3133DSH@cms.hhs.gov. Any changes to distribution amounts will be posted on the CMS website prior to the beginning of the FFY.

- **Treatment of Rural Reclassifications for Capital DSH Payments** ***(Display pages 1,224 – 1,226)*****:** In the FFY 2007 IPPS final rule, CMS codified that urban hospitals that reclassified as rural are also considered rural when determining eligibility for capital DSH payments. On September 30, 2021, in *Toledo Hospital v. Becerra*, it was ruled that this codification did not demonstrate that CMS took relative costs into account when considering the policy. As such, CMS revising this regulation so that, effective for discharges occurring on or after October 1, 2023, hospitals reclassified as rural under §412.103 will no longer be considered rural for purposes of determining eligibility for capital DSH payments.
- **Supplemental Payment for IHS/Tribal and Puerto Rico Hospitals** ***(Display pages 851 – 855 and 1,860 – 1,861):*** In the FFY 2023 final rule, CMS finalized the utilization of Worksheet S-10 for the calculation of Factor 3 for IHS, Tribal, and Puerto Rico hospitals rather than determining Factor 3 amounts for these providers by utilizing the FFY 2013 data for Medicaid days combined with the most recent update of the SSI days. This rule had also established a permanent supplemental payment for these hospitals to mitigate the impact of moving to utilizing Factor 3 for DSH payments.

- **Counting Days Associated with Section 1115 Demonstration Projects in the Medicaid Fraction** ***(Display pages 919 – 965)***: In February 2023, CMS released a proposed rule for the Medicare DSH program which proposed revisions to regulations on counting the days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction of a hospital's disproportionate patient percentage (DPP). This proposed rule can be found here https://www.federalregister.gov/documents/2023/02/28/2023-03770/medicare-program-medicare-disproportionate-share-hospital-dsh-payments-counting-certain-days. Utilizing the comments from this final rule listed on Display pages 937 - 965, as well as comments from proposals related to this policy from the FFY 2022 and FFY 2023 IPPS proposed rules, CMS is adopting the following in this final rule effective October 1, 2023:
  - Days associated with section 1115 demonstrations will counted in the DPP Medicaid fraction numerator only if the patient can be "regarded as" eligible for Medicaid for those days
  - A patient would be "regarded as" eligible for Medicaid if they either receive health insurance authorized by a section 1115 demonstration or buy health insurance with premium assistance provided to them under a section 1115 demonstration.
  - The additional days included in the numerator must only be made up of health insurance that covers inpatient hospital services, or premium assistance that covers 100% of premium costs to the patient which the patient uses to buy health insurance to for inpatient hospital services, provided that the patient is not also entitled to Medicare Part A.
  - Patients whose hospital costs are paid with funds from a hospital's UCC pool authorized by a section 1115 demonstration are not "regarded as" eligible for Medicaid and would not be included in the DPP Medicaid fraction numerator.

## GME Payments

***Display pages 29 – 31 and 1,028 – 1,068***

In the CY 2023 Outpatient Prospective Payment System (OPPS) final rule, CMS finalized payment policies and conditions of participation (CoP) with respect to the new REH provider type established in the Consolidated Appropriations Act (CAA) of 2021. Commenters in the OPPS final rule requested that CMS designate these facilities as GME eligible facilities similar to critical access hospitals (CAH). As such, CMS is adopting that, effective for cost reporting periods on or after October 1, 2023, a hospital may include full time equivalent (FTE) residents training at an REH in its direct GME and Indirect Medical Education (IME) FTE counts as long as it meets the non-provider setting requirements and other regulations that will be applicable to CAHs.

The IME adjustment factor will remain at 1.35 for FFY 2024. Additionally, based on requests from providers, CMS is adopting clarifications to the instructions for cost report Worksheet E, Part A line 20, which can be found on Display page 1,042.

## Updates to the MS-DRGs

***Display pages 44 – 746, 966 – 974, 1,068 – 1,072, 1,823, and 1,862 – 1,865***

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. For IPPS rate-setting, CMS typically uses the MedPAR claims data file that contains claims from discharges 2 years prior to the fiscal year that is the subject of rulemaking. For Hospital Cost Report data, CMS traditionally uses the dataset containing cost reports beginning 3 years prior to the fiscal year under study. As stated earlier, CMS will utilize FFY 2022 IPPS claims data and FFY 2021 HCRIS data, without modifications, to calculate FFY 2024 rates.

There will be 764 payable DRGs for FFY 2024 (compared to 765 for FFY 2023), with 70.0% of DRG weights changing by less than +/- 5%, 21.9% changing at least +/-5% but less than +/- 10%, 6.2% changing more than +/-10%, 4.5% that are affected by the relative weight cap on reductions, and 2.0% being new MS-DRGs. The five MS-DRGs with the greatest year-to-year change in weight, taking into account the relative weight cap, are:

| MS-DRG | Final FFY 2023 Weight | Final FFY 2024 Weight | Percent Change |
|---|---|---|---|
| MS-DRG 017: AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC | 4.3701 | 6.1770 | 41.35% |
| MS-DRG 927: EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITH SKIN GRAFT | 18.9822 | 26.3587 | 38.86% |
| MS-DRG 886: BEHAVIORAL AND DEVELOPMENTAL DISORDERS | 1.365 | 1.6817 | 23.20% |
| MS-DRG 117: INTRAOCULAR PROCEDURES WITHOUT CC/MCC | 0.9928 | 1.1984 | 20.71% |
| MS-DRG 592: SKIN ULCERS WITH MCC | 1.754 | 2.0901 | 17.16% |

When CMS reviews claims data, they apply several criteria to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within an MS-DRG is needed. A subgroup must meet all five criteria in order to warrant creation.

Beginning in FFY 2021, CMS expanded the criteria to also include Non-CC subgroups with the belief that this would better reflect resource stratification and promote stability of MS-DRG relative weights by avoiding low volume counts for the Non-CC level MS-DRGs. CMS found that applying this criteria to all MS-DRGs would cause major changes in the list of MS-DRGs. These updates would have also had an impact on relative weights and payments rates. Due to the PHE and concerns about the impact that implementing major changes to the list of MS-DRG changes at one time, in the FFY 2022 and FFY 2023 final rules CMS adopted delays of the application of the Non-CC subgroup criteria for these MS-DRGs. For FFY 2024, CMS analysis indicated that 135 MS-DRGs (45 base MS-DRGs across 3 severity levels) would potentially be subject to deletion and 86 MS-DRGs would potentially be created when applying the NonCC subgroup criteria. Therefore, CMS will continue to delay the application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FFY 2024.

Beginning with FFY 2024, CMS will only accept MS-DRG classification requests via the Medicare Electronic Application Request Information System™ (MEARIS™) and will not accept requests via email. MEARIS™ can be access at https://mearis.cms.gov/, which contains links and documentation related to the new system.

The full list of the FFY 2024 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2024-ipps-fr-table-5.zip. For

comparison purposes, the final FFY 2023 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2023-ipps-fr-table-5.zip.

- **Cap for Relative Weight Reductions** ***(Display pages 381, 1,862 – 1,865, and 1,872)*****:** In an effort to address concerns from commenters and to mitigate financial impacts due to significant fluctuations, beginning FFY 2023, CMS adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget neutral manner. As such, CMS will apply a budget neutrality adjustment of 0.999928 (proposed at 0.999925) to the operating rate and 0.9999 (as proposed) to the capital rate for all hospitals in FFY 2024. This cap will only apply to a given MS-DRG if it retains its MS-DRG number from the prior year and will not apply to the relative weight for any new or renumbered MS-DRGs for the year. CMS has released a supplemental file along with this final rule showing how MS-DRG weights are calculated, including the weight prior to the application of this cap.

- **Chimeric Antigen Receptor (CAR) T-Cell Therapies** ***(Display pages 373 – 381, 1,068 – 1,072, 1,823, and 1,863 – 1,864)*****:** In the FFY 2021 final rule, CMS assigned cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a new MS-DRG 018 [Chimeric Antigen Receptor (CAR) T-cell Immunotherapy]. As additional procedure codes for CAR-T cell therapies are created, CMS will use its established process to assign these procedure codes to the most appropriate MS-DRG.

  For FFY 2024, CMS is adopting two changes in the methodology for identifying clinical trial claims and expanded access use claims in MS-DRG 018. First, CMS will exclude claims with the presence of condition codes 90 or ZB and claims that contain ICD-10-CM diagnosis code Z00.6 without payer-only code ZC when calculating the average cost. Second, CMS will no longer use the proxy of standardized drug charges of less than $373,000 to identify clinical trial claims and expanded access use cases when calculating the average cost of this MS-DRG.

  As providers do not typically pay for the cost of a drug for clinical trials, CMS is adopting an adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018, similarly to prior years. The adjustment of 0.27 (proposed at 0.28) will be applied to the payment amount for clinical trial cases that would both group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6, contain standardized drug charges of less than $373,000, or when there is expanded access use of immunotherapy. As in the past, CMS will not apply this payment adjustment to cases where a CAR T-cell therapy product is purchased but the case involves a clinical trial of a different product as well as where there is expanded us of immunotherapy.

- **New Technology** ***(Display pages 385 – 746)***: CMS states that numerous new medical services or technologies are eligible for add-on payments outside the PPS. Table II.F.-01 on Display page 407 shows the 11 technologies that will continue to receive add-on payments for FFY 2024 since their 3-year anniversary date will occur on or after April 1, 2024. Table II.F.-02 on Display page 413 shows the 15 technologies that are will longer receive add-on payments for FFY 2024 since their 3-year anniversary date will occur prior to April 1, 2024.

  Beginning in the FFY 2024 new technology add-on payment cycle, CMS will post the application and certain materials received from the applicants online. This includes any information acquired subsequent to the application submission but not cost, volume, any submitted materials that the applicant does not have the right to make public, or any confidential information identified as such by the applicant. All relevant materials are publically posted as of the release of this rule and exclude any applications withdrawn prior to the publication of the proposed rule. To further increase transparency and improve the review process, CMS adopted to move the FDA marketing authorization deadline from July 1 to May 1, beginning in FFY 2025. The applicant must have a complete and active FDA marketing authorization at the time of the new technology add-on payment application submission.

  CMS approved new technology add-on payments for 8 technologies under the traditional pathway and 11 under alternative pathways. CMS is also conditionally approving 1 new technology (taurolidine/heparin) under the alternate pathway.

CMS previously established the New COVID-19 Treatments Add-on Payment (NCTAP) to increase the current IPPS payment amount for drugs and biologicals authorized for emergency use for the treatment of COVID-19 in the inpatient setting. Specifically, beginning for discharges on or after November 2, 2020 through the end of the PHE, hospitals will be paid the lesser of 65% of the operating outlier threshold for the claim or 65% of the amount by which the cost of the case exceed the standard DRG payment, including the relative weight Coronavirus Aid, Relief, and Economic Security Act adjustment.

In the FFY 2022 IPPS final rule, CMS finalized that discharges which qualify for NCTAP shall remain eligible for the add-on for the remainder of the fiscal year following the end of the PHE in order to minimize payment disruption. The extension of NCTAP was also adopted for eligible products that are not otherwise approved for new technology add-on through the end of the fiscal year in which the PHE ends. The PHE ended in May of 2023. As such, discharges involving eligible products will continue being eligible for the NCTAP through September 30, 2023. Further information about NCTAP can be found at https://www.cms.gov/medicare/covid-19/new-covid-19-treatments-add-payment-nctap.

- **Social Determinants of Health (SDOH) Diagnosis Codes** ***(Display pages 293 – 309)*****:** In the FFY 2023 proposed rule, CMS requested information on the following topics that pertain to the 96 diagnosis codes relating to SDOH (Z codes found in categories Z55 – Z65) to gauge whether or not proposing to change severity level designations of these codes in future rulemaking would be appropriate:
  - *"How the reporting of certain Z codes – and if so, which Z codes - may improve our ability to recognize severity of illness, complexity of illness, and utilization of resources under the MS-DRGs?*
  - *Whether CMS should require the reporting of certain Z codes – and if so, which ones – to be reported on hospital inpatient claims to strengthen data analysis?*
  - *The additional provider burden and potential benefits of documenting and reporting of certain Z codes, including potential benefits to beneficiaries.*
  - *Whether codes in category Z59 (Homelessness) have been underreported and if so, why? In particular, we are interested in hearing the perspectives of large urban hospitals, rural hospitals, and other hospital types in regard to their experience. We also seek comments on how factors such as hospital size and type might impact a hospital's ability to develop standardized consistent protocols to better screen, document and report homelessness."*

  CMS continues to welcome feedback and comments regarding these guiding principles.

  Additionally, CMS adopted a change to the severity level for the following diagnosis codes regarding homelessness from NonCC to CC for FFY 2024:
  - Z59.00 - Homelessness, unspecified;
  - Z59.01 - Sheltered homelessness; and
  - Z59.02 - Unsheltered homelessness.

- **MS-DRG Changes** ***(Display pages 47 – 394 and 968 – 974)*****:** Based on the analysis of FFY 2022 MedPAR claims, CMS is making changes to a number of MS-DRGs effective for FFY 2024. Specifically, CMS will :
  - *"Reassign procedures describing thrombolysis when performed for pulmonary embolism from MS-DRGs 166, 167, and 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) to new MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis for Pulmonary Embolism).*
  - *Create new base MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures) for cases reporting an aortic valve repair or replacement procedure and a mitral valve repair or replacement procedure in addition to another concomitant cardiovascular procedure.*
  - *Reassign the procedures involving cardiac defibrillator implants by deleting MSDRGs 222 through 227 (Cardiac Defibrillator Implant, with and without Cardiac Catheterization, with and without AMI/HF/shock, with and without MCC, respectively) and create new MS-DRG 275 (Cardiac Defibrillator Implant with Cardiac Catheterization and MCC) for cases reporting cardiac defibrillator*

*implant with cardiac catheterization with MCC, and new MS-DRGs 276 and 277 (Cardiac Defibrillator Implant with MCC and without MCC, respectively) for cases reporting cardiac defibrillator implant.*

- *Reassign procedures describing thrombolysis performed on peripheral vascular structures from MS-DRGs 252, 253, and 254 (Other Vascular Procedures with MCC, with CC, and without CC/MCC, respectively) to new MS-DRG 278 (Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures with MCC) and new MS-DRG 279 (Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures without MCC).*
- *Create new MS-DRGs 323 and 324 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC and without MCC, respectively) for cases reporting C-IVL with placement of an intraluminal device, create new base MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device) for cases reporting C-IVL without the placement of an intraluminal device, delete MS-DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents), MS-DRG 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent without MCC), MS-DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Arteries or Stents) and MS-DRG 249 (Percutaneous Cardiovascular Procedures with Non-Drug- Eluting Stent without MCC) and create new MS-DRG 321(Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices) and new MS-DRG 322 (Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC).*
- *Delete MS-DRGs 338 through 340 (Appendectomy with Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) and MS-DRGs 341 through 343 (Appendectomy without Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) describing appendectomy with and without a complicated principal diagnosis and create new MS-DRGs 397, 398, and 399 (Appendix Procedures with MCC, with CC, without CC/MCC, respectively).”*

The table on Display page 972 details which of these new or revised MS-DRGs will be subject to the post-acute care transfer policy for FFY 2024. The table on Display page 973 details which of these new or revised MS-DRGs are subject to MS-DRG special payment policy.

## Low-Volume Hospital Adjustment

***Display pages 30 and 1,010 – 1,022***

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The Bipartisan Budget Act of 2018 had extended the relaxed low volume adjustment criteria (>15-road miles/ <1,600 Medicare discharges), through the end of FFY 2018. In addition, the Act included a further extension of the adjustment for FFYs 2019 – 2022 with a change to the discharge criteria by requiring that a hospital have less than 3,800 total discharges (rather than 1,600 Medicare discharges). The CAA of 2023 extended these criteria thought FFY 2024. The current payment adjustment formula for hospitals with between 500 and 3,800 total discharges is:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

CMS will continue to use the discharge and mileage criteria, as well as the above formula, to determine and calculate low-volume payment adjustments for FFY 2024.

In FFY 2025 and subsequent years, the criteria for the low-volume hospital adjustment will return to more restrictive levels. In order to receive a low-volume adjustment subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status for FFY 2024, consistent with historical practice, a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to

establish that the hospital meets the applicable mileage and discharge criteria for FFY 2024. The MAC must receive a written request by September 1, 2023 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2023. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

A hospital that qualified for the low-volume hospital payment adjustment for FFY 2023 may continue to receive the adjustment for FFY 2024 without reapplying if it meets both the adopted discharge and mileage criteria.

## Sole Community Hospitals (SCH) Status

***Display pages 990 – 991 and 995 – 1,003***

CMS is modifying the effective date for SCH status in the case where there is a merger that allows two hospital to operate under a single provider agreement but one hospital was not eligible for SCH classification due to its proximity to a nearby like hospital. For SCH applications received on or after October 1, 2023 where a hospital's SCH approval is dependent on a merger with another nearby hospital and the applying hospital meets other SCH classification requirements, CMS is adopting that the SCH and payment adjustment will be effective as of the approved merger effective date if the MAC receives the complete application within 90 days of CMS' written notification to the hospital of the approval of the merger. If the MAC does not receive this complete application within 90 days, the SCH classification will be effective as of the date the MAC receives the application. Also, the effective date of the rural reclassification of these hospitals will be effective on the same day as the SCH classification.

## Rural Referral Center (RRC) Status

***Display pages 1,004 – 1,009***

Hospitals that meet a minimum case-mix and discharge criteria (as well as one of 3 optional criteria relating to specialty composition of medical staff, source of inpatients, or referral volume) may be classified as RRCs. This special status provides an exemption from the 12% rural cap on traditional DSH payments and exemption from the proximity criteria when applying for geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The FFY 2024 minimum case-mix and discharge values are available on the pages listed above.

## Medicare-Dependent, Small Rural Hospital (MDH) Program

***Display pages 30, 990 – 991, and 1,023 – 1,027***

The MDH program has been extended multiple times since its creation for FFY 2012, with the most recent extension being through FFY 2024 as granted by the CAA of 2023. As a result of these extensions, any provider that was classified as an MDH as of December 23, 2022 was reinstated as a MDH effective December 24, 2022 without the need to reapply. Due to the retroactive nature of these extensions, providers classified as MDHs as of September 30, 2022 will generally be classified as MDHs as of October 1, 2022. CMS is not adopting any other changes in regulations regarding eligibility or payments for the MDH program through FFY 2024. CMS also recommends that any provider that is unsure of their MDH status should contact their MAC.

## Physician Self-Referral Law - Physician-Owned Hospitals

***Display pages 1,681 – 1,750***

CMS is adopting numerous proposals to modify and clarify the process that Physician-Owned Hospitals would need to follow in order to be granted an exception from the prohibition on facility expansion, including a new expansion exception process and related definitions for hospitals eligible to request an expansion. A hospital that meets the criteria for an applicable hospital or a high Medicaid facility can request an exception if:

- *"the hospital has not already been approved by CMS for an expansion exception that would allow the hospital to reach 200 percent of its baseline facility capacity; and*
- *it has been at least 2 calendar years from the date of the most recent decision by CMS approving or denying the hospital's most recent expansion exception."*

Detail and discussion of the finalized policies that would affect the expansion of these providers can be found on Display pages 1,681 – 1,737. Adopted policies related to program integrity restrictions with respect to facilities approved for expansion can be found on Display pages 1,737 – 1,750.

## Special Requirements for Rural Emergency Hospitals (REH)

***Display pages 1,674 – 1,680***

In this final rule, CMS is finalizing and codifying various policies and requirements associated with the new REH payment setting that were introduced in the CAA of 2021, the CY 2023 OPPS final rule, and *Guidance for Rural Emergency Hospital Provisions, Conversion Process and Conditions of Participation* (QSO-23-07-REH). Additionally, CMS is adopting updates to certain definitions in the Medicare survey and certification regulations to address REHs, including:

- Definition of provider of services or provider;
- Addition of the statutory basis for REHs to Statutory Basis section of the regulations under Title 42, section 488;
- Update to the regulations pertaining to documentation of findings that if a State agency receives information that an REH is not in compliance with the Emergency Medical Treatment and Labor Act (EMTALA), that the agency must report its findings to CMS; and
- Enrollment requirements for providers, including:
    - Providers must include an action plan with their application for enrollment which contains:
        - A plan for initiating REH services;
        - A detailed transition plan that lists the specific services that the provider will retain, modify, add, or discontinue as an REH;
        - A detailed description of other outpatient medical and health services that it intends to furnish on an outpatient basis as an REH; and
        - information regarding how the provider intends to use the additional facility payment provided to REHs.
    - REHs will be subject to the same basic requirements that all other Medicare providers must adhere to.

## Request for Comment – Safety-Net Hospitals

***Display pages 1,751 – 1,761***

In the FFY 2024 IPPS proposed rule, CMS sought comment on two potential approaches to identify which hospitals should classify as safety-net, outlined below.

The Safety-Net Index (SNI) developed by MedPAC, measures the degree to which a hospital functions as a safety-net hospital. The SNI is calculated as "*…the sum of-- (1) the share of the hospital's Medicare volume associated with low-income beneficiaries; (2) the share of its revenue spent on uncompensated care; and (3) an indicator of how dependent the hospital is on Medicare."* Specifically, CMS sought comment on how this calculation should address the "*new hospitals… hospital mergers, hospitals with multiple cost reports and/or cost reporting periods that are shorter or longer than 365 days, cost reporting periods that span fiscal years, and potentially aberrant data."* ,CMS also seeks comments on whether the approaches used in the uncompensated care methodology are appropriate.

CMS states that area-level indices could be used as an alternative approach to the SNI and could include the use of the area deprivation index or the Social Deprivation Index, which were recommended as the best existing indices for addressing health related social needs or social determinants of health by the Assistant Secretary for Planning and Evaluation.

Additionally, CMS requested comments on several questions listed on Display pages 1,759 – 1,761. CMS did not respond to comments on this topic in this final rule.

## Quality-Based Payment Adjustments

***Display pages 1,073 – 1,213***

For FFY 2024, IPPS payments to hospitals VBP Program, RRP, and the HAC Reduction Program. Detail on the FFY 2024 programs and payment adjustment factors are below (future program year changes are addressed in the next section of this brief).

In the August 2020 COVID-19 interim final rule with comment period, CMS updated the extraordinary circumstances exception policy in response to the PHE so that no claims data or chart-abstracted data reflecting services provided January 1, 2020 - June 30, 2020 will be used in calculations for the any of the three quality programs.

- **VBP Adjustment** ***(Display pages 1,075 – 1,196)*****:** The FFY 2024 program will include hospital quality data for 20 measures in 4 domains: safety; clinical outcomes; person and community engagement; and efficiency and cost reduction. By law, the VBP Program must be budget neutral and the FFY 2024 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.7 billion). Because the program is budget neutral, hospitals can earn back some, all, or more than their individual 2.0% reduction.

  While the data applicable to the FFY 2024 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the historical baseline and performance periods that would have been used in the FFY 2023 program. Hospitals should use caution in reviewing these factors as they do not reflect updated performance periods/standards, nor changes to hospital eligibility.

  The proxy factors published with the final rule are available in Table 16A on the CMS website at https://www.cms.gov/files/zip/fy2024-ipps-fr-table-16a.zip

  CMS anticipates making actual FFY 2024 VBP adjustment factors available in the fall of 2023. Details and information on the program are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp.

- **RRP** ***(Display pages 1,073 – 1,074)***: The FFY 2024 RRP will evaluate hospitals on 6 conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG).

  The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

  Due to COVID-19 impacts, the FFY 2024 RRP will only use data from July 1, 2019 – December 31, 2019 and July 1, 2020 – June 30, 2022 for calculations.

  Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual eligible patients as a ratio of total Medicare FFS and Medicare Advantage (MA) patients during the same 3-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

  The data applicable to the FFY 2024 RRP program is still being reviewed and corrected by hospitals, and therefore CMS have not yet posted factors for the FFY 2024 program in Table 15. CMS expects to release the final FFY 2024 RRP factors in the fall of 2023.

  Details and information on the RRP currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hrrp.

- **HAC Reduction Program** ***(Display pages 1,197 – 1,213)*****:** The FFY 2024 HAC program will evaluate hospital performance on 6 measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-

resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC Reduction Program is not budget neutral; hospitals with a total HAC score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score.

CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Details and information on the HAC currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hac.

## Quality-Based Payment Policies—FFYs 2025 and Beyond

For FFYs 2025 and beyond, CMS is adopting new policies for its quality-based payment programs.

- **VBP Program** ***(Display pages 1,075 – 1,196)*****:** CMS had already adopted VBP program rules through FFY 2024 and some program policies and rules beyond FFY 2024. CMS is finalizing further program updates through FFY 2028, described below.

  New baseline periods, performance periods, and performance standards are finalized for a subset of measures for the FFYs 2026 through 2029 programs.

  CMS is adopting modifications to the Medicare Spending per Beneficiary (MSPB) measure beginning with FFY 2028 that include:

  - *"An update to allow readmissions to trigger new episodes to account for episodes and costs that are currently not included in the measure but that could be within the hospital's reasonable influence;*
  - *A new indicator variable in the risk adjustment model for whether there was an inpatient stay in the 30 days prior to episode start date; and*
  - *An updated MSPB amount calculation methodology to change one step in the measure calculation from the sum of observed costs divided by the sum of expected costs (ratio of sums) to the mean of observed costs divided by expected costs (mean of ratios)."*

  These same modifications were finalized for the MSPB measure in the IQR program in the FFY 2023 final rule and the updated measure will be posted to Care Compare in January 2024.

  CMS is also adopting modifications to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (THA/TKA complications measure) beginning with the FFY 2030 program. These updates are *"…the inclusion of index admission diagnoses and in-hospital comorbidity data from Medicare Part A claims. Additional comorbidities prior to the index admission are assessed using Part A inpatient, outpatient, and Part B office visit Medicare claims in the 12 months prior to index (initial) admission."* Hospitals would not be required to submit additional data to calculate the updated measure.

  These same modifications were finalized for the THA/TKA complications measure in the IQR program in the FFY 2023 final rule and the updated measure were posted to Care Compare in July 2023.

  Beginning with the FFY 2026 program, CMS is adding the Severe Sepsis and Septic Shock: Management Bundle (CBE #0500) (SEP-1) measure to the Safety domain because it supports the efficient, effective, and timely delivery of high-quality sepsis care and the measure contributes towards CMS' goal of advancing health equity. The baseline period for this measure is January 1, 2022 – December 31, 2022 and the performance period is January 1, 2024 – December 31, 2024. The minimum case count requirement for this sepsis measure is 25 cases.

  In addition, CMS is adopting the following changes to the form and manner of the administration of HCAHPS Survey measures beginning with January 2025 discharges:

  - 3 new web-based modes of survey administration;

- Removing the survey's prohibition on patient proxy respondents;
- Extending the data collection period from 42 to 49 days;
- Limiting the number of supplemental survey items to 12;
- Requiring hospitals to collect language information about a patient while in the hospital and requiring the official Spanish translation for Spanish language-preferring patients; and
- Removing two administration methods that are not used by participating hospitals.

Separately, beginning with the FFY 2026 program, CMS is adopting a change to the VBP scoring methodology to reward hospitals for excellent care in underserved populations. This will be through the addition of Health Equity Adjustment (HEA) bonus points to a hospital's Total Performance Score (TPS), calculated using a methodology that incorporates a hospitals performance across all four domains and the hospital's proportion of dual eligible patients.

Specifically, depending on if a hospital's performance is in the top third, middle third, or bottom third of performance of all hospitals within a domain, the hospital will be awarded 4, 2, or 0 points, respectively. The sum of the points awarded to a hospital for each domain would be the "measure performance scaler", where the maximum points would be 16. For hospitals that only score in 3 domains due to measure case count requirements, the maximum points will be 12.

CMS is defining the "underserved multiplier" as the number of inpatient stays for dual eligible patients out of the total inpatient Medicare stays during the calendar year 2 years prior to the start of the respective program year. For the FFY 2026 program, this will be FFY 2024 data. Similar to the RRP program, dual eligible patients will be identified using the State Medicare Modernization Act file of dual eligible beneficiaries. CMS will use a logistic exchange function to calculate the underserved multiplier so that there would be a lower rate of increase at the beginning and the end of the curve.

The logistic exchange function is finalized to be:

$$\frac{1}{1+e^{-(-5+10*\frac{Dual\ Rank}{Max\ Dual\ Rank})}}$$

HEA bonus points will be calculated as the product of the measure performance scaler and the underserved multiplier (formula shown below), and would be capped at 10. These points are added to the hospital's TPS, and a hospital could earn no more than 110 maximum as a final TPS, including the HEA bonus points.

*Health Equity Adjustment (HEA) bonus points = measure performance scaler × underserved multiplier*

<u>CMS states that with the HEA adjustment, the VBP program will remain budget neutral as the HEA bonus points are added before the TPS is calculated and the linear exchange function slope would not be changed. According to CMS *"this would only result in a change to the hospital's relative position to other hospitals as opposed to the distribution of bonuses and penalties."* However, it is impossible for the slope to remain unchanged and the program to still remain budget neutral. Clarification has been requested from CMS on this matter.</u>

Lastly, in the proposed rule CMS requested information on potential additional changes to the program to address health equity with specific questions and comments back to CMS listed on Display pages 1,189 – 1,193.

- **RRP** ***(Display pages 1,073 – 1,074)*****:** CMS did not adopt any changes to the RRP program, but did receive comments about health equity opportunities and will take these comments into consideration in future rulemaking.
- **HAC Reduction Program** ***(Display pages 1,197 – 1,213)***: Beginning with FFY 2025, CMS is adopting its proposal to establish a validation reconsideration process for hospitals who fail data validation. This will affect CY 2022 discharges. Specifically, hospitals that fail the confidence interval calculation validation can request reconsideration of their results before use in the HAC scoring calculations. This will be conducted once per program year after the validation of hospital acquired infections for all four quarters of data and after the confidence interval has been calculated.

Similar to the IQR reconsideration process, hospitals that fail the validation requirements will be notified by CMS with instructions of how to submit a request for reconsideration using a reconsideration request form. This must be done within 30 days from the date stated on the notification letter. This form can be found on the QualityNet website along with a detailed description of the reconsideration process. CMS will email hospitals an acknowledgment after receiving the form using the contact information provided on the request. CMS will also provide written notification of the final decision in approximately 90 days.

The scope of reconsideration reviews will be limited to information already submitted by the hospital during the initial validation process.

In addition, CMS is adopting a modification to the validation targeting criteria for extraordinary circumstances exceptions (ECE) beginning FFY 2027 and impacting CY 2024 discharges. As a new criterion, in addition to the five established targeting criteria used to select the up to 200 additional hospitals, CMS will include any hospital with an estimated reliability upper bound of the two-tailed confidence interval that is less than 75 percent and received an ECE for one or more quarters. These hospitals will be targeted for validation in the subsequent validation year and will not fail data validation in the program.

Lastly, CMS solicited feedback on measures for future use in the HAC program to address patient safety and health equity. Specific questions for comment as well as comments are on Display pages 1,203 – 1,204.

## Updates to the IQR Program and Electronic Reporting Under the Program

***Display pages 1,295 – 1,473***

CMS is adopting three measures for the IQR program beginning with the CY 2025 reporting period/FFY 2027 payment determination:

- Hospital Harm – Pressure Injury eCQM;
- Hospital Harm – Acute Kidney eCQM; and
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) In Adults (Hospital Level-Inpatient eCQM).

Beginning with the FFY 2025 IQR, CMS is adopting its proposal to modify the "COVID-19 Vaccination Coverage among Healthcare Personnel" measure to replace the term "complete vaccination course" with the term "up to date" in the healthcare personnel vaccination definition. CMS will also update the numerator to specify the time frames within which a healthcare personnel is considered up to date with recommended COVID-19 vaccines.

Separately, CMS is finalizing modification to the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure and the Hybrid Hospital-Wide All-Cause Readmission (HWR) measure beginning with the FFY 2017 IQR program. For both measures, CMS is expanding the cohort from only Medicare FFS to both FFS and MA patients 65 and older (up to 94 years old for the HWM measure) since MA beneficiary enrollment has been rapidly increasing as a share of overall beneficiaries.

CMS is also adopting its proposal to remove three measures from the IQR program:

- Hospital-Level RSCR Following Elective Primary THA/TKA measure beginning with the April 1, 2025 through March 31, 2028 reporting period/FY 2030 payment determination;
- MSPB—Hospital measure beginning with the CY 2026 reporting period/FFY 2028 payment determination; and
- Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC–01) measure beginning with the CY 2024 reporting period/FFY 2026 payment determination.

In addition, CMS sought public feedback on the future inclusion of two measures:

- Geriatric Hospital structural measure (discussed on Display pages 1,431 – 1,434); and
- Geriatric Surgical structural measure (discussed on Display pages 1,434 – 1,436).

With this, CMS is considering a geriatric care hospital designation to be publically reported on a CMS website, initially be based on data from hospitals reporting on both Geriatric Hospital and Geriatric Surgical structural measures, and in the future develop a scoring methodology for granting this designation. Specific areas for comment, and comments already received, are listed on Displays page 1,437 – 1,439.

CMS is adopting the same changes to the form and manner of the administration of HCAHPS Survey measures as the VBP program, which are detailed in that section.

Lastly, CMS is modifying the validation targeting criteria for ECE beginning FFY 2027 and impacting CY 2024 discharges. As a new criterion in addition to the five established targeting criteria used to select the up to 200 additional hospitals, CMS will include any hospital with a two-tailed confidence interval that is less than 75 percent and submitted less than four quarters of data due to receiving an ECE for one or more quarters. These hospitals will be targeted for validation in the subsequent validation year and will not fail data validation in the program.

Tables in the final rule on Display pages 1,416 – 1,424 outline the previously adopted and newly adopted Hospital IQR Program measure set for the FFYs 2025 – 2028 payment determination and subsequent years.

### Request for Information on Potential Addition of Patients with a Primary Psychiatric Diagnosis to the HCAHPS Survey Measure

*Display pages 1,463 – 1,465*

CMS requested comment on the inclusion of patients with a primary psychiatric diagnosis in the HCAHPS survey. Specifically, CMS asked for comment on *"…whether all patients in the psychiatric service line (that is, MS-DRG codes of 876, 880-887, 894-897) or particular sub-groups thereof should be included in the HCAHPS Survey; whether the current content of the HCAHPS Survey is appropriate for these patients; and whether the current HCAHPS Survey measure implementation procedures might face legal barriers or pose legal risks when applied to patients with primary psychiatric diagnoses."* Comments can be found on Display pages 1,464 – 1,465.

## Promoting Interoperability Program

***Display pages 1,630 – 1,673***

The Medicare Promoting Interoperability program provides incentive payments and payment reductions for the adoption and meaningful use of certified EHR technology.

CMS is finalizing that the EHR reporting period in CY 2025 will be a minimum of any continuous 180-day period within CY 2025. For CY 2026, CMS is considering increasing the length of the EHR reporting period to encourage hospitals and CAHs to prepare to produce more comprehensive and reliable data.

Beginning with the CY 2025 reporting period/FFY 2027 payment determination, CMS is adopting that hospitals that have not successfully demonstrated they are a meaningful EHR user in the prior year will no longer be differentiated for the purposes of a payment adjustment from those who did successfully demonstrate they are meaningful EHR users in a prior year. Those hospitals that have not demonstrated they are meaningful EHR users in a prior year will not have to attest to meaningful use no later than October 1, 2025 (or October 1 for future years). Those that wish to attest by October 1, 2023 or October 1, 2024 will need to email CMS through the QualityNet helpdesk (QnetSupport@cms.hhs.gov) due to technological modifications made by CMS to the data submission process.

The Safety Assurance Factors for EHR Resilience (SAFER) Guides measure was adopted beginning with CY 2022 reporting into the Protect Patient Health Information Objective in the FFY 2022 IPPS final rule. Beginning in CY 2022, the attestation of this measure was required, but eligible hospitals and CAHs were not scored, and an attestation of "yes" or "no" were both acceptable answers without penalty. In this rule, beginning CY 2024, CMS is adopting its proposal to require hospitals and CAHs to conduct the SAFER Guides self-assessments and attest "yes" to accounting for completion of all nine guides.

CMS is not adopting any changes to the scoring of the objectives and measures for the CY 2024 EHR reporting period, outlined below:

| Performance-Based Scoring Methodology Beginning with the CY 2024 EHR Reporting Period |
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| Objectives | Measures | 2023: Maximum Points | Redistribution if Exclusion Claimed |
|---|---|---|---|
| Electronic Prescribing | e-Prescribing | 10 points | 10 points to Health Information Exchange (HIE) Objective |
| | Query of Prescription Drug Monitoring Program | 10 points | 10 points to e-Prescribing measure |
| HIE | Support Electronic Referral Loops by Sending Health Information | 15 points | No exclusion |
| | Support Electronic Referral Loops by Receiving and Reconciling Heath Information | 15 points | No exclusion |
| | **OR** | | |
| | HIE Bi-Directional Exchange measure | 30 points | No exclusion |
| | **OR** | | |
| | Enabling Exchange under TEFCA | 30 points | No exclusion |
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information | 25 points | |
| Public Health and Clinical Data Exchange | Required with yes/no response<br>• Syndromic Surveillance Reporting<br>• Immunization Registry Reporting<br>• Electronic Case Reporting<br>• Electronic Reportable Laboratory Result Reporting<br>• AUR Surveillance Reporting | 25 points | If an exclusion is claimed for all 5 measures, 25 points redistributed to Provide Patients Electronic Access to their Health Information |
| | Optional to report one of the following<br>• Public Health Registry Reporting<br>• Clinical Data Registry Reporting | 5 points (bonus) | |

Consistent with the Hospital IQR program, CMS will add 3 additional eCQMs from the Hospital IQR programs measure set beginning with the CY 2025 reporting period. The measures are listed in the IQR section of this brief.

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