Fiscal Year (FY) 2024 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule (CMS-1785-F)

W.L. GORE and Associates

INTRODUCTORY SUMMARY AND BACKGROUND

On August 1, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2024.

With a few exceptions as defined by law, CMS reimburses acute care hospitals under IPPS. Under this payment system, CMS sets prospective base payment rates for inpatient admissions on the diagnoses and procedures performed. The facility receives a single payment for each case based on the reimbursement classification determined at discharge. IPPS cases are paid by Medicare Severity Diagnosis-Related Groups (MS-DRGs).

Certain hospitals and hospital units are excluded from IPPS:

- Inpatient rehabilitation facility (IRF) hospitals and units
- Long-term care hospitals (LTCHs)
- Psychiatric hospitals and units
- Children's hospitals
- Cancer hospitals
- Extended neoplastic disease care hospitals
- Hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa)
- Religious nonmedical health care institutions (RNHCIs)
- Critical Access Hospitals (CAHs)

The formula used to calculate the base payment rate for a specific case multiplies an individual hospital's payment rate per case by the weight of the MS-DRG to which the case is assigned. Each MS-DRG weight represents the average resources required to care for beneficiary cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

To specify further, the base payment rate is comprised of a standardized amount which is divided into labor-related and nonlabor related shares. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. The base rate is multiplied by the DRG relative weight.

Section 1886(d)(4)(C) of the Act requires the Secretary to adjust the MS-DRG classifications and relative weights at least annually to account for changes in use of resources. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. This is known as the "market basket" for the hospital.

The finalized policies will apply to acute care hospitals under IPPS for discharges occurring on or after October 1, 2023.

IPPS FINAL RULE

The FY 2024 final rule is located in its entirety at the following link:
https://public-inspection.federalregister.gov/2023-16252.pdf.

This document in PDF form is 2,144 pages in length. The format of the information is intended to summarize the finalized changes so readers are encouraged to view the document in its entirety for further details.

Changes to IPPS Payment Rates

The finalized increase in payment rates for acute care hospitals under IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) and demonstrate meaningful use of Electronic Health Record (EHR) program is approximately 3.1 percent. This reflects the projected hospital market basket update of 3.3 percent, reduced by a 0.2 percent productivity adjustment. The following table reflects the finalized FY 2024 applicable percentage increases for IPPS:

FY 2024	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	3.3	3.3	3.3	3.3
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.825	-0.825
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.475	0.0	-2.475
Productivity Adjustment Under Section 1886(b)(3)(B)(xi) of the Act	-0.2	-0.2	-0.2	-0.2
Applicable Percentage Increase Applied to Standardized Amount	**3.1**	**0.625**	**2.275**	**-0.2**

CMS projects the operating payment rate increase with the other finalized changes to IPPS payment polices will be approximately $2.2 billion, primarily led by an increase in (1) FY 2024 operating payments and capital payments, as well as changes in Disproportionate Share Hospital (DSH) and uncompensated care payments; and (2) a decrease resulting from estimated changes in new technology add-on payments, as projected for this final rule.

Individual hospitals may be subject to other payment adjustments including:

- Penalties for excess admissions under the Hospital Readmissions Reduction Program (HRRP);
- Penalties for worst performing under the Hospital Acquired Condition (HAC) reduction program;
- Adjustments under the Hospital Value-Based Purchasing (VBP) program;
- Add-on payments under the disproportionate share hospital (DSH) adjustment;

- Add-on payments under the Indirect Medical Education (IME) adjustment;
- Add-on payments under the Graduate Medical Education (GME) adjustment;
- Add-on payments for approved new technologies/medical services; and
- Add-on payments for outlier cases.

When calculating the payment rates for FY 2024, CMS proposes to return to their historical practice of using the most recent data available, including FY 2022 MedPAR claims and FY 2021 cost report data. CMS observed that some shifts in inpatient utilization and costs that occurred in FY 2020 have continued through FY 2022, mainly admissions associated with COVID-19. However, based on current information available, CMS believes there will not be a significant difference in the number of COVID-19 hospitalizations in FY 2024 compared to FY 2022. Therefore, CMS is finalizing their proposal to use FY 2022 claims file and FY 2021 cost report data for ratesetting as the most recent and best available data without modifications.

Changes to Specific MS-DRG Classifications

Beginning with FY 2024, CMS revised the deadline to request MS-DRG classifications changes to October 20 each year to allow more time to evaluate MS-DRG change requests. In addition, CMS also explained the new process for submitting requests, questions and feedback using the new electronic intake system, Medicare Electronic Application Request Information System™ (MEARIS™): https://mearis.cms.gov/public/home. CMS stated it would only accept requests submitted through MEARIS™, and no longer through email.

CMS is finalizing changes for the MS-DRGs classifications, including addition, deletion and restructuring of multiple MS-DRGs for FY 2024. Changes include new MS-DRGs for surgical ablation, coronary intravascular lithotripsy, among others.

For FY 2024, CMS is providing a version of the ICD-10 MS-DRG Grouper Software Version 41, which includes new diagnosis and procedure codes (Tables 6A and 6B); invalid diagnosis codes (Table 6C); the version of the ICD-10 MS-DRG Definitions Manual Version 41; and the supplement diagnosis code mapping file from version 40 to version 41. This information is available through the CMS website at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#Tables.

The latest version of the GROUPER Software, the latest version of the Definitions Manual Version 41 and supplemental mapping files can be found at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/ms-drg-classifications-and-software.

O.R. vs Non-O.R. Procedures

Currently, each ICD-10-PCS procedure code has designations that determine whether and if so, in what way the presence of that procedure on a claim impacts the MS-DRG assignment:

- Each ICD-10-PCS procedure code is either designated as an O.R. procedure for purposes of MS-DRG assignment ("O.R. procedures") or is not designated as an O.R. procedure for purposes of MS-DRG assignment ("Non-O.R. procedures").
    - For each procedure that is designated as an O.R. procedure, that O.R. procedure is further classified as either extensive or non-extensive.
    - For each procedure that is designated as a non-O.R. procedure, that non-O.R. procedure is further classified as either affecting the MS-DRG assignment or not affecting the MS-DRG assignment.

- For new procedure codes that have been finalized and are proposed to be classified as O.R. procedures or non-O.R. procedures affecting the MS-DRG, MS-DRG assignment is then selected and subject to public comment.

In this FY 2024 final rule, based on the comments provided, CMS has finalized their proposal to continue evaluating alternatives on how to restructure the current O.R. and non-O.R. designations for procedures, by utilizing the detail that is currently available in the ICD-10 claims data. In addition, in response to requests to change the designation of specific ICD-10-PCS procedure codes from non-O.R. to O.R., CMS finalized to not change the designation of any of these codes, due to their plan to conduct a "comprehensive, systematic review of the ICD-10-PCS procedure codes." CMS is seeking additional comments regarding factors for refinement in this area, and will provide more detail in future rulemaking.

Changes to the ICD-10-CM and ICD-10-PCS Coding Systems

CMS has identified new, revised and deleted diagnosis and procedure codes for FY 2024. These code titles are adopted as a part of the ICD-10 Coordination and Maintenance Committee meeting process. Therefore, they are not subject to comment in the proposed or final rules. Based on code updates, effective October 1, 2023, there is a total of 74,044 ICD-10-CM diagnosis codes; and 78,603 ICD-10-PCS procedure codes for FY 2024 as shown in the following table:

FY 2023 ICD-10-CM	73,674 total codes	FY 2023 ICD-10-PCS	78,530 total codes
FY 2024 ICD-10-CM	395 additions	FY 2024 ICD-10-PCS	78 additions
FY 2024 ICD-10-CM	25 deletions	FY 2024 ICD-10-PCS	5 deletions
FY 2024 ICD-10-CM	**74,044 total codes**	**FY 2024 ICD-10-PCS**	**78,603 total codes**

These codes can be found on Tables 6A-6E at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#Tables.

Changes to Code Severity (MCCs, CCs or non-CCs)

In the FY 2021 IPPS final rule, CMS finalized their proposal to expand the existing criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG. This expansion of the criteria included a NonCC subgroup for a three-way severity level split, recognizing this application may result in modifications to certain MS-DRGs which are currently split into three severity levels. This process involves the analysis of claims data and the application of nine guiding principles, as well as the plan to present findings and proposals in future rulemaking. The guiding nine principles include:

1) Represents end of life/near death or has reached an advanced stage associated with systemic physiologic decompensation and debility.
2) Denotes organ system instability or failure.
3) Involves a chronic illness with systemic physiologic decompensation and debility.
4) Serves as a marker for advanced disease states across multiple different comorbid conditions.
5) Reflects systemic impact.
6) Post-operative/post-procedure condition/complication impacting recovery.
7) Typically requires higher level of care (that is, intensive monitoring, greater number of caregivers, additional testing, intensive care unit care, extended length of stay).
8) Impedes patient cooperation or management of care or both.

9) Recent (last 10 years) change in best practice, or in practice guidelines and review of the extent to which these changes have led to concomitant changes in expected resource use.

For FY 2024, after consideration of public comments received, CMS is finalizing their proposal to continue to delay application of the NonCC subgroup criteria to the 45 existing MS-DRGs with a three-way severity level split for until FY 2025 or later; and finalizing their proposal to maintain the current structure of the 45 MS-DRGs that currently have a three-way severity level split.

In addition, CMS is finalizing their proposal to change the several level designation for social determinants of health (SDOH) diagnosis codes identifying homelessness from non-complication or comorbidity (NonCC) to complication or comorbidity (CC). This comes as a result of CMS' recognition of homelessness being an indicator of increased resource utilization in the acute inpatient hospital setting.

The finalized additions and deletions to the diagnosis code MCC and CC severity levels for FY 2024 can be found on Tables 6I-6J.2 at:
https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#Tables.

Replaced Devices Offered without Cost or with a Credit

In FY 2008, CMS implemented a policy to reduce a hospital's IPPS payment for certain MS-DRGs in which the implantation of a device that failed or was recalled determined the base MS-DRG assignment. This is based on a credit for a replaced device equal to 50 percent or more of the cost of the device. For FY 2024, CMS is finalizing their proposal to include the existing MS-DRGs currently under the policy as listed in the table below:

MDC	MS-DRG	MS-DRG Title
05	216	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC
05	217	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC
05	218	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization without CC/MCC
05	219	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC
05	220	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with CC
05	221	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization without CC/MCC
05	268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
05	269	Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC
05	270	Other Major Cardiovascular Procedures with MCC
05	271	Other Major Cardiovascular Procedures with CC
05	272	Other Major Cardiovascular Procedures without CC/MCC

The final list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit will be included in the FY 2024 IPPS final rule and also will be issued to providers in the form of a Change Request (CR).

MS-DRG Relative Weights

CMS calculates MS-DRG relative weights based on 19 national cost to charge ratios (CCRs), claims data from the MedPAR (Medicare Provider Analysis and Review) file and Medicare cost reports. After adjustments are made to determine Medicare-specific charges, the total specific Medicare costs (for all hospitals) are divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs. CMS calculated the FY 2024 relative weights based on 19 CCRs just like FY 2023. The methodology CMS is finalizing to use to calculate the FY 2024 MS-DRG cost-based relative weights is based on claims data in the FY 2022 MedPAR file and data from the FY 2021 Medicare cost reports. The finalized 19 national average CCRs for FY 2024 are listed in the following table:

Group	CCR
Routine Days	0.417
Intensive Days	0.351
Drugs	0.18
Supplies & Equipment	0.303
Implantable Devices	0.269
Inhalation Therapy	0.153
Therapy Services	0.268
Anesthesia	0.072
Labor & Delivery	0.416
Operating Room	0.16
Cardiology	0.086
Cardiac Catheterization	0.102
Laboratory	0.102
Radiology	0.128
MRIs	0.067
CT Scans	0.033
Emergency Room	0.153
Blood and Blood Products	0.245
Other Services	0.34

When the MS-DRG weights were recalibrated for previous years, CMS sets a threshold of 10 cases as the minimum number required to compute a reasonable weight. CMS is finalizing to use the same case threshold in recalibrating the proposed MS-DRG relative weights for FY 2024. For MS-DRGs that contain fewer than 10 cases to meet the threshold, CMS is finalizing their proposal to calculate relative weights for low-volume MS-DRGs by adjusting their final FY 2023 relative weights by the percentage change in the average weight of the in other MS-DRGs from FY 2023 to FY 2024.

In light of the concerns regarding the fluctuations in relative weights from year to year and financial impacts of those fluctuations, CMS finalized their proposal in FY 2023 to recalibrate the MS-DRG relative weights, including a 10 percent cap on decreases in an MS-DRG relative weight from one fiscal year to the next; and application of a budget neutrality adjustment to the standardized amount for all hospitals to ensure this cap does not result in an increase or decrease of estimated cumulative payments. For FY 2024, CMS is finalizing to continue the 10 percent cap.

Add-on Payments for New Services and Technologies (NTAP)

Each year CMS reviews applications received per the deadline for a new medical service or technology requesting an add-on payment to the DRG (NTAP). There are specific criteria which must be met in order to qualify for the additional payment:

1) the medical service or technology must be new;
2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and
3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies.

Newness Criterion

Under the newness criterion, technology is no longer considered "new" for the purposes of the add-on payment if it is substantially similar to one or more existing technologies, even if it has recently received FDA approval or clearance. In addition, if it has been on the market for more than 2 to 3 years, it is no longer considered "new".

In FY 2010, CMS established criteria to evaluate if a new technology is "substantially similar" to an existing technology. If all the following criteria is met, the technology is considered substantially similar to an existing technology, and therefore would not be considered "new" for an add-on payment:

1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome;
2) whether a product is assigned to the same or a different MS–DRG; and
3) whether the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population.

Cost Criterion

Under the cost criterion, CMS will evaluate whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges); or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the MS-DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant MS-DRGs if the new medical service or technology occurs in many different MS-DRGs). CMS does provide access to the data files utilized for this analysis.

Applicants are expected to submit a significant sample of data to demonstrate the technology meets the high-cost threshold. The sample size is expected to be significant to allow for CMS to be able to do an initial validation and analysis of the data.

Substantial Clinical Improvement Criterion

The third and final criterion is the technology must represent an advancement that significantly improves the diagnosis or treatment relative to already existing technologies. Some of the criteria which may support the clinical improvement include:

- The new medical service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments;
- The new medical service or technology offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable, or offers the ability to diagnose a medical condition earlier in a patient population than allowed by currently available methods, and

there must also be evidence that use of the new medical service or technology to make a diagnosis affects the management of the patient;

- The use of the new medical service or technology significantly improves clinical outcomes relative to services or technologies previously available as demonstrated by one or more of the following:
    - A reduction in at least one clinically significant adverse event, including a reduction in mortality or a clinically significant complication;
    - A decreased rate of at least one subsequent diagnostic or therapeutic intervention;
    - A decreased number of future hospitalizations or physician visits;
    - A more rapid beneficial resolution of the disease process treatment including, but not limited to, a reduced length of stay or recovery time;
    - An improvement in one or more activities of daily living; an improved quality of life; or a demonstrated greater medication adherence or compliance; or
    - The totality of the circumstances otherwise demonstrates that the new medical service or technology substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.
- Evidence from published or unpublished sources with the United States or elsewhere may be sufficient to establish the improvement.
- The medical condition diagnosed or treated by the new medical service or technology may have a low prevalence among Medicare beneficiaries.
- The new medical service or technology may represent an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of a subpopulation of patients with the medical condition diagnosed or treated by the new medical service or technology.

CMS received 27 applications for new technology add-on payments for FY 2024 under the traditional new technology add-on pathway. Of these, 12 applicants withdrew their applications, and 2 applications did not meet the July 1, 2023 deadline for FDA approval. Of the remaining 13 applications, 10 were approved, with 4 of the applications considered as 2 technologies due to their substantial similarity. Therefore, CMS approved 8 new applications for new technology add-on payments for FY 2024 under the traditional pathway.

Alternative Inpatient New Technology Add-on Payment Pathway

In addition, certain transformative new devices may qualify under an alternative inpatient new technology add-on pathway. A medical device that is a part of the FDA's Breakthrough Devices Program may qualify for the new technology add-on payment under an alternative pathway beginning in FY 2021.

CMS received 27 applications for new technology add-on payments for FY 2024 under the traditional new technology add-on payment alternative pathway. Of these, 14 applicants withdrew their applications, and 1 application did not meet the July 1, 2023, deadline for FDA approval. Of the remaining 12 applications, 11 were approved, and 1 was conditionally approved for the new technology add-on payments for FY 2024 under the alternative pathway.

New Technology Liaisons

CMS has established a team of new technology liaisons that can serve as an initial resource for interested parties (including device/biologic/drug developers or manufacturers, industry consultants and others) to assist with:

- Providing information and resources regarding process, requirements, and timelines.
- Coordinating and providing opportunities for interested parties to engage with various CMS components.

- Being a primary point of contact for interested parties and providing updates on developments where possible or appropriate.

The new technology liaison resources are available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/newtech, including an email to directly contact the team.

Continuation of NTAPs

Based on CMS policy, a medical service or technology may continue to be considered "new" for the purposes of NTAPs. Based on the newness criterion, CMS is proposing to continue to approve 11 technologies as "new" technologies and thus, continue the NTAP because the three-year anniversary for each of these technologies will occur on or after April 1, 2024.

Of interest is the GORE® TAG® Thoracic Branch Endoprosthesis (TBE) device that was approved for FY 2023 NTAP. The table below shows the technology and the information pertaining to its NTAP status:

Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Maximum NTAP for FY 2024	Coding Used to Identify Cases Eligible for NTAP
GORE® TAG® Thoracic Branch Endoprosthesis	05/13/2022	10/1/2022	05/13/2025	87 FR 48966 through 48969	$27,807.00	02VW3DZ in combination with 02VX3EZ

New Technology Liaisons

CMS has established a team of new technology liaisons that can serve as an initial resource for interested parties (including device/biologic/drug developers or manufacturers, industry consultants and others) to assist with:

- Providing information and resources regarding process, requirements, and timelines.
- Coordinating and providing opportunities for interested parties to engage with various CMS components.
- Being a primary point of contact for interested parties and providing updates on developments where possible or appropriate.

The new technology liaison resources are available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/newtech, including an email to directly contact the team.

Reporting New Services and Technologies in ICD-10-PCS

In the FY 2016 IPPS final rule, ICD-10-PCS included a new section containing the "X" codes, which began being reported for discharges on and after October 1, 2015. CMS established the use of section "X" New Technology codes within ICD-10-PCS classification to more specifically identify new technologies or procedures that have not been captured through ICD-10-CM codes; or to more accurately describe information on a specific procedure or technology not found in the other sections of ICD-10-PCS. Proposals to create, delete or revise

Section "X" codes for new services and technologies will be under the ICD-10 Coordination and Maintenance Committee. Coding guidelines for these "X" codes can be found on the CMS website at: https://www.cms.gov/files/document/2024-official-icd-10-pcs-coding-guidelines.pdf.

Hospital Wage Index

The Medicare wage index is one of the factors that determines a hospital's overall payment from CMS. Its sole purpose is to maintain a consistent payment structure across IPPS hospitals and recognize the difference in labor market costs across the country. Beginning in FY 2022, CMS moved the base year cost structure for IPPS from 2014 to 2018 and revised the data sources used in the price index in the IPPS market basket to reflect a 2018 base year using major cost categories:

- Salaries and hours from short-term, acute care hospitals;
- Home office costs and hours;
- Certain contract labor costs and hours; and
- Wage-related costs, including pensions.

For FY 2024, CMS is using data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2020. Based on a multi-step methodology, CMS is finalizing the unadjusted national average hourly wage at $50.39 for FY 2024. This includes adjustment of the labor-related share for discharges occurring on or after October 1, 2024, of 67.6 percent. CMS is finalizing their proposal not to make any further changes to the labor-related share, and therefore continuing to use 67.6 percent for the national standardized amounts for all IPPS hospitals (including those in Puerto Rico) that have a wage index value greater than 1.0000. The labor-related share is used to determine the part of the national IPPS base payment rate to which the area wage index is applied.

Core-based Statistical Areas (CBSAs)

For FY 2024, CMS is continuing to use the core-based statistical areas (CBSAs) established by the Office of Management and Budget (OMB) and adopted in FY 2015. CMS recognized use of these delineations resulted in the wage index values being more representative of actual labor costs in a given area. However, they also recognized some hospitals would see decreases in wage index values, while others would see higher wage index values.

Permanent Cap of Wage Index Decreases

For FY 2023, CMS finalized their proposal to apply a 5 percent cap on any decrease to a hospital's wage index from the prior FY's wage index, regardless of the decline origin. Meaning, a hospital's wage index would not be less than 95 percent of its final wage index from the prior FY. In addition, CMS finalized to apply this wage index cap policy in a budget neutral manner through a national adjustment to the standardized amount. For FY 2024, CMS finalized their proposal to continue applying this wage index cap and associated budget neutrality adjustment, noting the budget neutrality adjustment would be updated as appropriate based on the final rule data.

Rural Floor

According to the Balanced Budget Act of 1997, the area wage index of a hospital located in an urban area of a state may not be less than the area wage index of a hospital located in a rural area in that state. This is called the "rural floor". Implementing the rural floor must be done in conjunction with a related budget neutrality adjustment. For FY 2023 and subsequent years, the finalized policy includes the wage data of hospitals that have been reclassified from urban to rural under the Act to calculate "the wage index for rural areas in the State in

which the county is located", as it is referred to in the Act. Thus, the rural floor is the same as the rural wage index. CMS is finalizing their proposal to apply a uniform national budget neutrality adjustment to the FY 2024 wage index for the rural floor of 0.978183, which would reduce wage indexes by 2.2 percent, as compared to the rural floor provision not being in effect. Based on the FY 2024 finalized wage index and calculation of the rural floor, including the wage data of hospitals that have been reclassified as rural, CMS estimates 646 hospitals would see an increase in their FY 2024 wage index due to the application of the rural floor.

Frontier Floor Policy

By law, hospitals in frontier states (Montana, North Dakota, South Dakota and Wyoming) cannot be assigned a wage index of less than 1.0000. This is referred to as the "frontier floor" policy, and it has been in place since FY 2011. This ensures the lower population states are not penalized for reimbursement due to the low number of people per square mile when compared to other states. In this final rule, 42 hospitals within the frontier states would receive the frontier floor value of 1.0000 for their FY 2024 wage index. CMS noted while Nevada met the definition of a frontier state, all hospitals within that state currently receive a wage index value greater than 1.000. For FY 2024, CMS is finalizing no further changes to the frontier floor policy.

Low Wage Index Hospital Policy

In the FY 2020 IPPS final rule, CMS adopted a policy to help offset the wage index differences between high wage and low wage hospitals. This policy was thought to provide an opportunity for certain low wage index hospitals to increase employee compensation by increasing the wage index values for certain hospitals with low wage index values (known as the low wage index hospital policy). This policy was adopted in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. CMS indicated this policy would be effective for at least 4 years, beginning in FY 2020, in order to allow sufficient time for employee compensation increases implemented by these hospitals to be reflected in the wage index calculation. At the time of this final rule, CMS only has one year of relevant data to evaluate any potential impacts of this policy. Because of this, CMS believes it needs data from additional fiscal years for analysis before making any decision to modify or discontinue the policy. Therefore, for FY 2024, CMS is finalizing to continue the low wage index hospital policy and budget neutrality adjustment.

Changes to the Hospital Readmissions Reduction Program

Under the Hospital Readmissions Reduction Program, Medicare payments under IPPS for discharges may be reduced for certain excess readmissions. Beginning in FY 2017 and for subsequent years, the reduction is based on a hospital's risk adjusted readmission rates for a 3-year period for the following: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG) surgery. For FY 2024, CMS is finalizing to not make any changes, and refers readers to the FY 2023 finalized changes to this program.

Changes for the Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program was created to provide value-based incentive payments in a fiscal year to hospitals based on their performance on measures established in a performance period for such fiscal year. For FY 2024, CMS is finalizing the following proposals:

- Updates to the Medicare Spending Per Beneficiary (MSPB) Hospital Measure beginning in FY 2028;
- Updates to the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning in FY 2030;

- Adoption of the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning in FY 2026;
- Adoption of a health equity scoring change for rewarding excellent care in underserved populations beginning in FY 2026;
- Technical updates to the administration of the HCAHPS Survey measure under the Hospital VBP Program beginning in FY 2027; and
- Modification of the Total Performance Score (TPS) maximum to be at 110, such that the TPS numeric score range would be 0 to 110 in order to allow top-performing hospitals the opportunity to receive the additional health equity bonus points under the finalized health equity scoring change.

In the FY 2019 final rule, CMS finalized eight measure removal factors for the Hospital VBP program. For FY 2024, CMS is finalizing to codify these eight measure removal factors with minor technical modifications, as well as the policies for updating measure specifications and retaining measures.

CMS requested feedback on potential additional future changes to the Hospital VBP Program scoring methodology that would address health equity. CMS defines health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes." Many commenters supported the measures finalized for the program, as they aligned with CMS' goals to achieve health equity, address health disparities and close the performance gap on the quality of care.

Hospital-Acquired Condition (HAC) Reduction Program

Section 1186 of the Act establishes an incentive to reduce the number of hospital-acquired conditions (HACs) by a 1 percent payment reduction to applicable hospitals, effective October 1, 2014. This adjustment applies to hospitals which rank in the worst performing 25 percent of all applicable hospitals (compared to the national average) of acquired conditions during the specified period and all hospital discharges for the specified year. The HAC reduction program is based on six measures and scoring methodology in which hospitals are ranked:

- One claims-based composite measure of patient safety:
  - Patient Safety and Adverse Events Composite (CMS PSI 90)
- Five chart-abstracted measures of healthcare-associated infections (HAIs) submitted to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN):
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) for abdominal hysterectomy and colon procedures
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)

For FY 2024, CMS is finalizing not to add or remove any measures, and any measure removal and retention policy changes from the HAC Reduction Program. CMS is also finalizing their proposal to establish a validation reconsideration process for hospitals who fail data validation beginning in FY 2025. In addition, CMS is finalizing their proposal to modify the HAC Reduction Program data targeting criteria for extraordinary circumstances exceptions (ECEs) beginning in FY 2027.

Hospitals Excluded from IPPS

Hospitals excluded from the prospective payment system (PPS) receive payment for inpatient hospital services on the basis of reasonable costs, subject to a rate of increase ceiling. A discharge limit is set for each hospital

based on its own cost experience in its base year and updated annually by a rate-of-increase percentage. CMS proposed the FY 2024 operating market basket rate-of-increase percentage of 3.0, which will be applied to the FY 2023 target amounts to calculate the FY 2024 target amounts. As specified in the proposed rule, more recent data was available for review in order to calculate the final IPPS operating market basket update for FY 2024; and therefore, CMS finalized the FY 2024 operating market basket rate-of-increase percentage of 3.3.