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Special Bulletin

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CMS Releases Hospital Inpatient PPS Final Rule for Fiscal Year 2024

The Centers for Medicare & Medicaid Services (CMS) August 1 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS final rule for fiscal year (FY) 2024. This Special Bulletin reviews highlights of the inpatient PPS provisions in the rule, while the LTCH PPS provisions are covered in a separate Special Bulletin.

The rule will increase inpatient PPS payment rates by a net of 3.1% in FY 2024. This 3.1% payment update reflects a hospital market basket increase of 3.3% as well as a productivity cut of 0.2%. Overall, CMS estimates that hospital payments will increase by $2.2 billion in FY 2024 as compared to FY 2023, which also includes a $957 million decrease in disproportionate share hospital payments (due to a decrease in the estimate of the uninsured) and a $364 million decrease in new technology add-on payments.

KEY HIGHLIGHTS

CMS' final policies will:

- Increase inpatient PPS payment rates by a net 3.1% in FY 2024.
- Continue the low wage index hospital policy for FY 2024 and treat rural reclassified hospitals as geographically rural for the purposes of calculating the wage index.
- Allow hospitals to count training time in Rural Emergency Hospitals for the purposes of Medicare graduate medical education payments.
- Reinstate program integrity restrictions for physician-owned hospitals approved as "high Medicaid facilities."
- Add fifteen new MS-DRGs and delete sixteen MS-DRGs.
- Add a new health equity adjustment and a sepsis bundle measure to the Hospital Value-based Purchasing Program.
- Permit the use of web-based surveys for Hospital Consumer Assessment of Healthcare Providers and Systems.
- Require reporting of "up to date" vaccination status for the Inpatient Quality Reporting health care personnel COVID-19 vaccination measure.
- Extend the "EHR reporting period for a payment adjustment year" from 90 days to 180 days and adjust the attestation requirement for meaningful EHR use.

AHA TAKE

We remain deeply concerned that CMS continues to finalize payment rate increases that are not commensurate with the near decades-high inflation and increased costs for labor, equipment, drugs and supplies that hospitals across the country are experiencing. A market basket update of 3.3% continues to be inadequate given these circumstances. In addition, CMS finalized a cut in disproportionate share hospital payments of almost $1 billion. This staggering amount is based on CMS' Office of the Actuary's (OACT) estimate that the rate of uninsured will decline from 9.2% in FY 2023 to 8.3% in FY 2024. This is an inexplicable assumption given that the Department of Health and Human Services itself estimates that 15 million individuals will leave Medicaid once the continuous enrollment provision comes to an end, only one-third of whom will be eligible for Marketplace subsidies. Medicare's chronic underpayments and payment cuts to hospitals that care for a large proportion of the underserved and historically marginalized threaten their ability to continue providing essential services for their communities. **See AHA's full statement that was shared with the media.**

Highlights of the inpatient PPS rule follow.

Inpatient PPS Payment Update

The proposed rule will increase inpatient PPS rates by a net of 3.1% in FY 2024, compared to FY 2023, after accounting for inflation and other adjustments required by law. Specifically, CMS finalized an initial market-basket update of 3.3%, less 0.2 percentage points for productivity, as required by the Affordable Care Act (ACA). Table 1 below details the impact of proposed policies.

Table 1: Impacts of FY 2024 CMS Final Policies

Policy	Average Impact on Payments
Market-basket update	+ 3.3%
Productivity cut mandated by the ACA	- 0.2%
Total	**+ 3.1%**

Additionally, hospitals not submitting quality data would be subject to a one-quarter reduction of the initial market basket and, thus, would receive an update of 2.28%. Hospitals that were not meaningful users of electronic health records in FY 2020 would be subject to a three-quarter reduction of the initial market basket and, thus, would receive an update of 0.63%. Hospitals that fail to meet both requirements would be subject to a payment decrease of 0.2%.

For rate-setting purposes, CMS will use FY 2022 MedPAR claims and FY 2021 cost report data, as it ordinarily would have done. Unlike the previous two years, CMS will not make any modifications to its usual rate-setting methodologies to account for the impact of COVID-19.

Disproportionate Share Hospital (DSH) Payment Changes
Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75% flows into a separate funding pool for DSH hospitals. This pool is updated as the percentage of uninsured individuals changes and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

For FY 2024, CMS estimates the empirically justified DSH payments to be $3.34 billion. It estimates the 75% pool to be approximately $10.02 billion. After adjusting this pool for the percent of individuals without insurance, CMS estimates that it will total approximately $5.94 billion. This results in a decrease in DSH and uncompensated care payments of $957 million, due to the OACT's estimate that the uninsured rate will decrease from 9.2% in FY 2023 to 8.3% in FY 2024. **The AHA strongly disagrees with this estimate. As we commented previously, it is expected that health coverage for millions of people will end as the Medicaid continuous coverage requirements are now unwinding. As such, we expect to see a large *increase*, not decrease, in the number of the uninsured in FY 2024.**

To distribute the 75% pool, the agency will continue to use cost report data on uncompensated care. Specifically, it will use a three-year average of the three most recent fiscal years for which audited cost report data are available. For FY 2024, this is the 2018, 2019 and 2020 audited cost reports.

Finally, CMS had previously proposed in separate rulemaking to revise its regulations on calculation of the Medicaid fraction of the Medicare DSH calculation. Specifically, it proposed to define "regarded as eligible" for Medicaid to include only patients who receive health insurance authorized by a section 1115 demonstration or patients who pay for all or substantially all the cost of such health insurance with premium assistance authorized by a section 1115 demonstration where state expenditures are matched with federal Medicaid funds. In this rule, CMS finalized these policies.

Area Wage Index
CMS finalized several proposals for the area wage index, which adjusts payments to reflect differences in labor costs across geographic areas.

First, the agency finalized its proposal to continue its low-wage-index hospital policy as first established in the FY 2020 final rule. Under this policy, for hospitals with a wage index value below the 25th percentile, the agency will continue to increase the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. As it has done previously, the agency will reduce the FY 2024 standardized amount for all hospitals to make this policy budget neutral.

Second, CMS had previously made policy changes in reaction to numerous courts' decisions related to the rural wage index and rural floor. In this year's rule, CMS stated that it has taken the opportunity to revisit the case law, public comments and statutory language. The agency finalized, as proposed, that it would treat hospitals that reclassified from urban to rural as geographically rural in the calculation of the rural wage index. Specifically, hospitals with §412.103 reclassifications, along with geographically rural hospitals, will be included in all rural wage index calculations. "Dual-reclass" hospitals (hospitals with simultaneous §412.103 and Medicare Geographic Classification Review Board reclassifications) implicated by the wage index hold harmless provision will be excluded.[1]

Medicare Graduate Medical Education (GME)

To increase access to physicians in rural areas, CMS finalized its policy to allow Rural Emergency Hospitals (REHs) to be designated as GME-eligible facilities, similar to the GME designation for critical access hospitals. Specifically, beginning on or after Oct. 1, 2023, a hospital may include full-time equivalent (FTE) residents training at REHs in its direct GME and indirect medical education FTE counts for Medicare payment purposes.

Additionally, CMS finalized its proposed modifications to payments for nursing and allied health (NAH) education programs. Medicare pays providers for Medicare's share of the costs that providers incur in connection with approved education activities, including NAH programs. The total spending for these programs is capped at $60 million for any calendar year (CY). However, Section 4143 of the Consolidated Appropriations Act (CAA) 2023 stipulated that this limit would not apply for CY 2010-2019 to correct for the agency's mistaken application of the cap in previous years. CMS will now implement Section 4143 of the CAA and correct payments made to providers in the relevant years, such that amounts previously recouped will be returned to hospitals and recoupments that would have otherwise occurred will not occur.

COVID-19 Treatments Add-on Payment (NCTAP)

CMS restated that because the public health emergency ended May 2023, discharges involving eligible products will continue to be eligible for the NCTAP through Sept. 30, 2023 (that is, through the end of FY 2023). However, beginning in FY 2024 (that is, for discharges on or after Oct. 1, 2023), no NCTAPs will be made.

MS-DRG Classification Changes Analysis

CMS finalized the creation of fifteen new MS-DRGs and the deletion of sixteen MS-DRGs, many of which are in MDC 05 (Diseases and Disorders of the Circulatory System).

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[1] This provision provides that if an MGCRB decision reduces the wage index for that rural area, the secretary shall calculate and apply such wage index under this subsection as if the hospitals so treated had not been excluded from calculation of the wage index for that rural area.

Complication/Comorbidity (CC) and Major Complication/Comorbidity (MCC) Analysis

CMS continues to solicit feedback regarding the nine guiding principles that, when applied, could assist in determining whether the presence of the specified secondary diagnosis would lead to increased hospital resource use in most instances. Additionally, CMS continues to encourage feedback related to other possible ways to incorporate meaningful indicators of clinical severity for future rule making consideration. That said, CMS finalized the severity level changes related to three Social Determinants of Health ICD-10-CM homelessness codes for FY 2024:

- Z59.00 (Homelessness, unspecified)
- Z59.01 (Sheltered homelessness)
- Z59.02 (Unsheltered homelessness)

CMS also finalized the addition of four unspecified diagnosis codes related to pressure ulcers that were inadvertently omitted from the Medicare Code Editor (MCE) edit implemented April 1, 2022.

- L89.103 Pressure ulcer of unspecified part of back, stage 3
- L89.104 Pressure ulcer of unspecified part of back, stage 4
- L89.93 Pressure ulcer of unspecified site, stage 3
- L89.94 Pressure ulcer of unspecified site, stage 4

Application of the Non-CC Subgroup Criteria and Detailed Data Analysis

In the FY 2021 rule, CMS finalized the expansion of existing criteria to create a new CC or MCC subgroup within a base MS-DRG, which included the expansion of the criteria to encompass the non-CC subgroup for a three-way severity level split. Consistent with FY 2022 and 2023 proposals, CMS finalized the delay in application of the non-CC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2024. CMS continues to have interest in comments for consideration in the FY 2025 proposed rule.

Physician Self-referral Law: Physician-owned Hospitals

CMS finalized its proposal to codify that it has the discretion to approve or deny requests for expansion exceptions for physician-owned hospitals. The final rule clarifies that CMS will only consider expansion exception requests from eligible hospitals, specifies the data and information that must be included in requests, and identifies the process/factors for requests.

In addition, the final rule reinstates program integrity restrictions for physician-owned hospitals approved as “high Medicaid facilities” (which had been removed in the CY 2021 outpatient PPS final rule). Specifically, CMS reinstated:

- Restrictions to expansion that would result in a hospital’s facility capacity exceeding 200% of its baseline facility capacity, including consideration of any prior expansion exception approvals when determining maximum facility capacity;

- Limitation of requests for expansion exceptions to once every two years; and
- Restrictions on the location where expansion could occur to only the hospital's main campus.

Hospital Quality Reporting and Value Programs
CMS finalized nearly all the changes it proposed for its hospital quality reporting and value programs.

Hospital Value-based Purchasing (HVBP) Program. Beginning with the FY 2026 program year, CMS will adopt a health equity adjustment (HEA) that adds up to 10 bonus points to a hospital's HVBP Total Performance Score. CMS believes the HEA will reward high quality performance for hospitals caring for underserved patient populations. The HEA is the product of two factors — a "measure performance scaler" and "an underserved multiplier." The measure performance scaler assigns hospitals points based on whether they score in the top, middle or bottom third of performance on each HVBP measure domain. The underserved multiplier is based on the proportion of a hospital's inpatient stays for patients that are dually eligible for Medicare and Medicaid.

CMS also finalized its proposals to:
- Add one new measure to the HVBP — severe sepsis and septic shock management bundle — beginning with the FY 2026 HVBP program;
- Modify the Medicare Spending per Beneficiary (MSPB) measure by allowing readmissions to trigger new episodes starting with the FY 2028 program year;
- Include new conditions in the total knee arthroplasty/total hip arthroplasty (THA/TKA) complication measure beginning with the FY 2030 program year; and
- Update the administration process for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey starting with the CY 2025 reporting/FY 2027 payment year. This includes permitting the use of web-based surveys, allowing a patient's proxy to respond to surveys and requiring hospitals to administer the Spanish translation of the HCAHPS to patients who prefer it.

Inpatient Quality Reporting (IQR). CMS will add three new electronic clinical quality measures (eCQMs) measures to the IQR program beginning with the CY 2025 reporting/FY 2027 payment year. The three measures below will be added to the menu of available eCQMs from which hospitals may self-select to fulfill eCQM reporting requirements for both the IQR and the Hospital Promoting Interoperability program:
- Hospital harm — pressure injury eCQM
- Hospital harm — acute kidney injury eCQM
- Excessive radiation dose or inadequate image quality for diagnosis computed tomography (CT) in adults eCQM

Beginning with Q4 2023 reporting, CMS also will update its Healthcare Personnel (HCP) COVID-19 vaccination measure to require hospitals to report on the cumulative number of HCP that meet the Centers for Disease Control and Prevention's definition of "up to date" on their COVID-19 vaccinations. CMS also will include Medicare Advantage patients in calculating performance on its hybrid hospital-wide all-cause mortality and readmission measures. CMS also finalized the same modifications to the HCAHPS survey administration process that it adopted for the HVBP.

Lastly, CMS will remove three measures from the IQR:

- THA/TKA complications and MSPB because updated versions of these measures will now be used in the HVBP program; and
- Elective delivery prior to 39 weeks gestation (PC-01), because measure performance is topped out.

Promoting Interoperability Program for Hospitals

Reporting Period. As proposed, CMS finalized the definition of "EHR reporting period for a payment adjustment year" in two areas:

- Minimum reporting period duration — For participating eligible hospitals and critical access hospitals (CAHs) to define the EHR reporting period in CY 2025 as a minimum of any continuous 180-day period within CY 2025.
- Attestation requirements — If an eligible hospital has not demonstrated meaningful EHR use in a prior year, the hospital is not required to attest for the next payment adjustment year, starting with CY 2025.

SAFER Guidelines. CMS modified the attestation of the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure. All eligible hospitals and CAHs must attest "yes" to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs, beginning with the EHR reporting period in CY 2024.

Clinical Quality Measurement. CMS formally adopted three new eCQMs eligible hospitals and CAHs can self-select that count toward their IQR requirements. See the IQR section of this advisory for further details.

FURTHER QUESTIONS

The final rule will be published in the August 28 Federal Register and provisions will generally take effect October 1. Watch for a more detailed analysis of the final rule in the coming weeks.

If you have further questions, contact Shannon Wu, AHA's senior associate director of policy, at 202-626-2963 or swu@aha.org.