Policy Update

CMS Releases FY 2024 IPPS Final Rule

Summary

On August 1, 2023, the Centers for Medicare & Medicaid Services (CMS) released the fiscal year (FY) 2024 Inpatient Prospective Payment System (IPPS) final rule. The rule updates Medicare payment policies and quality reporting programs for inpatient hospital services, and builds on key agency priorities, including advancing health equity and improving the safety and quality of care.

The final rule is available here.
A CMS fact sheet on the final rule is available here.
The final rule is scheduled to be published in the *Federal Register* on August 28, 2023, and the majority of the rule's provisions will be effective October 1, 2023.

Key Takeaways

- The FY 2024 standardized amount for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and that are meaningful electronic health record (EHR) users will be $6,497.77, representing a payment update of 3.1% over FY 2023.
- CMS will distribute roughly $5.94 billion in uncompensated care payment (UCP) to eligible disproportionate share hospitals (DSH) for FY 2024, a decrease of approximately $940 million from FY 2023.
- CMS also finalized the Medicare Disproportionate Share Hospital Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction proposed rule, which was separately proposed in February 2023. This rule changes how Medicare DSH payments are calculated with respect to counting days associated with Section 1115 demonstrations in the Medicaid fraction of the DSH calculation. This change may have negative financial implications for hospitals in states that utilize uncompensated care pools and premium assistance programs through 1115 waivers, and may impact 340B eligibility.
- Relenting to years of challenges to its implementation of urban-to-rural reclassification rules, CMS will treat hospitals with § 412.103 reclassification as rural when calculating the wage index. This change will cause disturbances in the wage index that will affect all hospitals.
- With respect to quality reporting programs, CMS finalized its proposals to make health equity adjustments in the Hospital Value-Based Purchasing Program by providing incentives to hospitals to perform well on existing measures and to those that care for high proportions of underserved individuals, as defined by dual eligibility status. CMS plans to use comments received on how to further address geriatric care in its quality reporting programs in future rulemaking. CMS also finalized a proposal to modify the COVID-19 Vaccination Coverage measure by replacing the term "complete vaccination course" with "up to date."
- CMS finalized its proposal to return to its pre-pandemic practice of using the most recent available data to calculate Medicare Severity Diagnosis-Related Group (MS-DRG) relative weights. CMS finalized its proposal to continue delay of the non-complication or comorbidity (NonCC) subgroup criteria to existing MS-DRGs with a three-way severity split until FY 2025 or later.
- Consistent with the Administration's goals of advancing health equity, CMS will increase the severity

of the designation of homelessness from NonCC to complication or comorbidity as an indicator of increased resource utilization.
- CMS finalized its proposal to treat rural emergency hospitals (REHs) similarly to critical access hospitals (CAHs) for purposes of determining graduate medical education (GME) payments.
- CMS restored the Medicare-Dependent Hospital (MDH) program and Low-Volume Hospital Payment Adjustment pursuant to legislation enacted in late 2022. The agency also made a small but beneficial change concerning the effective date of sole community hospital (SCH) status related to mergers.
- CMS finalized as proposed two revisions to the criteria that applicants must meet in order to apply for new technology add-on payments (NTAP).

Standardized Amount

Key Takeaway: CMS finalized a 3.1% payment update for hospitals that successfully participate in CMS reporting programs.

The standardized amount is a dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital market basket index, then applies various other statutorily mandated or inspired adjustments. The 3.1% increase to the standardized amount reflects a 3.3% market basket update, less a 0.2% productivity adjustment.

Hospitals that fail to submit quality data are subject to a -0.825 percentage point adjustment, and hospitals that fail to be meaningful EHR users are subject to a -2.475 percentage point adjustment. The final FY 2024 standardized amount for hospitals that successfully participate in both programs is $6,497.77. This represents an increase of 1.9% over the FY 2023 standardized amount ($6,375.74).

The final FY 2024 standardized amounts, shown in the table below, are the sum of the labor-related and non-labor-related shares without adjustment for geographic factors. The labor-related share reflects the proportion of the federal base payment that is adjusted by a hospital's wage index.

	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
FY 2024 Final Standardized Amount	$6,497.77	$6,341.79	$6,445.77	$6,289.79
FY 2023 Final Standardized Amount	$6,375.74	$6,186.86	$6,312.78	$6,123.91
Percent Change	1.9%	2.5%	2.1%	2.7%

Medicare Severity Diagnosis-Related Group Updates

New Deadline and Intake System for MS-DRG Change Requests

Key Takeaway: Beginning with FY 2024, all MS-DRG classification change requests must be submitted via a new electronic application intake system by October 20 each year.

CMS is required by statute to adjust the DRG classifications and relative weights at least annually to reflect changes in treatment patterns, technology and any other factors that may change the relative use of hospital resources. Providers and other stakeholders can submit MS-DRG change requests for CMS to consider in the annual rate setting process.

As discussed in the FY 2023 IPPS/Long-Term Care Hospital (LTCH) proposed and final rules, CMS has updated the deadline and process for requesting MS-DRG changes. Beginning with FY 2024, CMS's deadline to request changes to MS-DRGs is October 20 each year. CMS also changed the process for submitting requested changes. Beginning with FY 2024, MS-DRG classification change requests must be submitted via a new electronic application intake system, the Medicare Electronic Application Request Information System™ (MEARIS™). Requests sent via email will no longer be considered.

Data and Methodology Change for Rate Setting

Key Takeaway: CMS will use the most recent available data to calculate MS-DRG relative weights.

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS relies on claims data captured in the Medicare Provider Analysis and Review (MedPAR) file and cost report data captured in the Healthcare Cost Report Information System file. CMS uses the most recent data available at the time of rulemaking, which normally captures claims from discharges that occurred in the FY two years prior to the FY addressed in the rulemaking. In recent years, CMS has veered from normal practice to account for effects of the COVID-19 public health emergency (PHE). For example, for FY 2022, CMS used FY 2019 MedPAR data rather than FY 2020 MedPAR data. For FY 2023, CMS returned to its historical practice of using the most recent available data, including FY 2021 MedPAR claims, but calculated relative weights based on an average of two sets of relative weights, one including and one excluding COVID-19 claims.

For FY 2024, CMS will return to its historical practice of using the most recent available data, including the FY 2022 MedPAR claims and the FY 2021 cost reports, to calculate MS-DRG relative weights.

Refinement of MS-DRG Classification

Key Takeaway: CMS will continue to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way split until FY 2025 or later.

Current MS-DRGs provide up to three levels of severity for a particular condition based on the presence of a complication or comorbidity or a major complication or comorbidity. In FY 2021, CMS finalized a proposal to apply expanded three-way severity split criteria. CMS believes that applying these criteria better reflects resource stratification and avoids low volume counts for the NonCC-level MS-DRGs. In FY 2022 and 2023, CMS delayed implementing this proposal because of the COVID-19 PHE.

For FY 2024, CMS will again delay using the NonCC subgroup criteria for existing MS-DRGs with a three-way severity level split.

Consistent with the Administration's goal of advancing health equity, CMS finalized a change to the severity designation of the three ICD-10-CM diagnosis codes describing homelessness (unspecified, sheltered and unsheltered) from NonCC to CC, based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes.

New Technology Add-On Payments

NTAP Policy Changes for FY 2024

Key Takeaway: CMS finalized as proposed revisions to the criteria that applicants must meet to apply for NTAP status.

Historically, CMS has required that in order to qualify for NTAP, an applicant must have approval or clearance from the US Food and Drug Administration (FDA) by July 1 of the year prior to the beginning of the FY for which the application is being considered (*i.e.*, FDA approval or clearance by July 1, 2023, for FY 2024 NTAP applications). In recent FYs, CMS has seen a substantial increase in the number of NTAP applications: 17 in FY 2020, 24 in FY 2021, 38 in FY 2022, 37 in FY 2023 and 54 in FY 2024. CMS noted that a significant number of these applicants submitted NTAP applications that "lack critical information that is needed to evaluate whether the technology meets the eligibility criteria." This absence of critical information is attributed in part to applicants not yet having submitted evaluation requests to FDA.

To address this concern, CMS proposed two changes:

- Applicants whose technology has not yet received FDA approval or clearance must have completed submission to the FDA, and the application must be in active status. Applicants must submit documentation to demonstrate the completed submission as part of their application.
- Devices or drugs under consideration for NTAP must receive FDA approval or clearance by May 1 prior to the start of the FY for which the applicant is applying. This proposal would change the deadline from July 1 to May 1, shortening the timeframe by two months for applicants.

The second policy proposal would not apply to drugs that apply through the alternative pathway for qualified infectious disease products. Such drugs would still be eligible for conditional approval provided that they receive FDA approval or clearance by July 1 in the FY for which they are applying for NTAP.

Many stakeholders have expressed concern, particularly regarding the change in the FDA marketing authorization deadline and its impact on technologies qualifying for NTAP and on Medicare beneficiaries' access to technologies. Nonetheless, CMS finalized the requirement that the applicant have a complete FDA application prior to submission of an NTAP application and FDA marketing authorization by May 1 prior to the FY in which for which the applicant seeks approval. CMS noted that this decision was driven by the substantial increase in the number of applications for NTAP in the last few years, and by the complexity of technologies pursuing NTAP, including devices with artificial intelligence algorithms.

No Extension for Technologies with Expiring NTAP Period

Key Takeaway: CMS did not extend the NTAP period for designations scheduled to expire at the end of FY 2023, and finalized its proposal to end new COVID-19 technology add-on payments (NCTAP) at the end of FY 2023.

NTAP designation normally endures for the first two to three years that a product is on the market, after which CMS reasons that the costs of the new technology are captured in the MS-DRG weights. CMS evaluates the eligibility of new technologies for this additional payment annually based on their newness date (typically defined as the date of market entry). Under current policy, CMS only extends add-on payments for an additional year if the three-year anniversary of the newness date occurs in the latter half of the upcoming FY.

As previously noted, CMS used FY 2022 MedPAR data for the FY 2024 rate setting process for IPPS.

In the FY 2023 rulemaking cycle, CMS finalized a policy to end NCTAP at the end of the FY following the conclusion of the COVID-19 PHE. In this rule, CMS finalized its plan to end NCTAP September 30, 2023,

given the expiration of the PHE on May 11, 2023.

NTAP Applications for FY 2024

Key Takeaway: CMS reviewed an increased number of NTAP applications in this rule and published applications online.

In the final rule, CMS reviewed 25 NTAP applications. Excluding the applications withdrawn prior to the publication of the proposed and final rules, as well as technologies that did not receive FDA market authorization by July 1, 2023, 13 devices and drugs applied through the traditional pathway (10 of which were approved) and 12 went through the alternative pathways. Of the latter, nine devices had breakthrough or pending breakthrough status, and three products were designated as qualified infectious disease products (all of which were approved including one conditional approval). The number of FY 2024 NTAP applications reviewed represents a 50% increase over applications reviewed for FY 2023, even with the 26 withdrawn applications.

Consistent with its efforts to increase transparency, in the FY 2023 rulemaking cycle CMS finalized a policy to publicly post NTAP applications online starting with the FY 2024 cycle. CMS accordingly posted the applications and supporting documentation for this cycle online. These postings exclude certain cost information, selected volume information, and any information that the applicant noted as confidential or proprietary. The agency did not post any applications withdrawn prior to the publication of the FY 2024 proposed rule.

CMS estimates that the total NTAP (both for new technologies approved and existing technologies continuing under NTAP) for FY 2024 will be $495.5 million. This represents a drop of more than 36% in payments, driven primarily by the drop in payments for existing drugs and technologies maintaining NTAP eligibility for FY 2024.

Cost Criterion for NTAP

Key Takeaway: CMS will use FY 2022 MedPAR data to propose FY 2025 threshold values.

One criterion that CMS uses to assess whether a new technology qualifies for NTAP is whether the charges for the technology meet or exceed certain threshold amounts. Historically, CMS has evaluated this cost criterion using threshold amounts established in the prior year's final rule. In this final rule, as finalized in the FY 2021 IPPS final rule and consistent with the FY 2023 IPPS final rule, CMS finalized its policy to use the threshold amounts for the upcoming FY for any new MS-DRGs to evaluate whether the technology meets the cost criterion.

CMS made no changes to the other criteria it considers when evaluating a new technology's eligibility for the add-on payments (*i.e.*, newness and substantial clinical improvement).

Quality Data Reporting Requirements

Hospital Quality Reporting Program Changes

Key Takeaway: CMS finalized proposals to make health equity adjustments and modified the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure across the Hospital IQR Program, and LTCH Quality Reporting Program (QRP).

CMS monitors, rewards and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospital IQR Program, Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, Hospital Acquired Condition (HAC) Reduction Program, and Medicare and Medicaid Promoting Interoperability Programs. These programs feature a mix of performance-based financial rewards and penalties as well as the public release of

quality data.

In this final rule, CMS finalized a proposal to make health equity adjustments in the HVBP by providing incentives to hospitals that care for high proportions of underserved individuals, as defined by dual Medicare-Medicaid eligibility status. The following chart outlines specific finalized updates to each of the quality programs in more detail.

Hospital IQR Program

Hospitals are required to report data on measures to receive the full annual percentage increase for IPPS services that would otherwise apply.

Updates

- CMS finalized its proposal to adopt three new quality measures (pressure injury, acute kidney injury, excessive radiation dose/inadequate image quality for diagnostic computed tomography), remove three existing quality measures (risk-standardized complication rate total hip/knee arthroplasty, Medicare spending per beneficiary, elective delivery) and modify three current quality measures (hybrid hospital wide all cause readmission/risk standardized mortality measures, COVID-19 Vaccination Among HCP (see below)).
- CMS modified the COVID-19 Vaccination Coverage Among HCP measure beginning with the fourth quarter calendar year (CY) 2023 reporting period/FY 2025 payment determination.
    - The measure previously was defined as the percentage of HCP who receive a complete COVID-19 vaccination course.
    - Numerator:
        - The final rule states that the numerator will be the cumulative number of HCP in the denominator population who are considered up to date with Centers for Disease Control and Prevention (CDC) recommended COVID-19 vaccines.
    - Denominator:
        - The denominator is the number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC.
    - This final rule finalizes CMS's proposal to replace the term "complete vaccination course" with the term "up to date" for recommended COVID-19 vaccines.
        - "Up to date" would be defined by the CDC guidance as of the first day of the applicable reporting quarter, which can be found here.
        - This measure includes at least one week of data collection a month for each of the three months in a quarter.
        - This finalized policy also applies to the LTCH QRP and the PCHQR Program. The final rule does not address the separate condition of participation related to COVID-19 vaccines.

Requested Comment

- In the proposed rule, the agency requested comment on the potential future inclusion of geriatric measures and a potential public-facing geriatric hospital designation. This designation could be similar to the Birthing-Friendly designation that was finalized in the FY 2023 IPPS/LTCH PPS final rule but using geriatric structural measures. Some commenters did not support the implementation of these measures because of increased burden. Others supported a combined geriatric measure that would consolidate the attestation domains of the geriatric hospital and geriatric surgical measures. CMS did not finalize any changes in this rulemaking.

Hospital Readmissions Reduction Program
HRRP reduces payments to hospitals with excess readmissions of selected applicable conditions.

Updates

- There were no proposed changes to this program.
- All previously finalized policies under this program continue to apply.

Hospital Value-Based Purchasing Program
The HVBP Program withholds participating hospitals' Medicare payments by 2% and uses these reductions to fund incentive payments based on a hospital's performance on a set of outcome measures.

Updates

- CMS will make substantive modifications to two existing measures as proposed:
  - Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (CBE #1550) beginning with the FY 2030 program year.
  - Medicare spending per beneficiary (CBE #2158) beginning with the FY 2028 program year. The changes include allowing readmissions to trigger new episodes. With these changes, CMS finalized its proposal to remove this measure from the Hospital IQR program for FY 2028 payment determination.
- CMS added technical changes to the administration of the Hospital Consumer Assessment of Healthcare Providers and Systems Survey as proposed. These changes will begin with the FY 2027 program year in alignment with the Hospital IQR Program.
  - CMS will change the scoring policy to include a health equity scoring adjustment and will modify the Total Performance Score maximum to be 110, resulting in a numeric score range of 0 to 110.
- CMS adopted the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning with the FY 2026 program year as proposed.
- CMS adopted a health equity scoring change for rewarding excellent care in underserved populations as proposed beginning with the FY 2026 program year.
- CMS codified the eight measure removal factors as well as the policies for updating measure specifications and retaining measures with minor technical modifications to regulation text.

Requested Comment

- In the proposed rule, CMS requested feedback on additional health equity changes to the HVBP Program scoring methodology for future consideration. CMS noted that it plans to continue to refine health equity scoring methodology, as appropriate, in the future.

Hospital Acquired Condition Reduction Program
Hospitals report on a set of measures on HACs. Hospitals with scores in the worst performing quartile are subject to a 1% payment reduction.

Updates

- CMS finalized its proposal to establish a validation reconsideration process for hospitals that fail to meet data validation requirements. This process will begin with the FY 2025 program year and affect CY 2022 discharges.
  - CMS intends for the HAC Reduction Program's reconsideration processes to be similar to the reconsideration processes of the Hospital IQR Program.
- CMS finalized its proposal to modify the targeting criteria for data validation to include hospitals that received an extraordinary circumstances exception during the data periods validated beginning with the FY 2027 program year, affecting the CY 2024 discharges.

Requested Comment

- In the proposed rule, CMS requested comment on potential future measures that would advance patient safety and reduce health disparities. CMS also requested comment on the potential adoption of several patient-safety-related electronic clinical quality measures (eCQMs) that are currently used in the Hospital IQR Program. Any proposal to implement a new measure or program modification will be announced through future notice-and-comment rulemaking.

Medicare Promoting Interoperability Program
The Medicare and Medicaid EHR Incentive Programs are now known as the Promoting Interoperability Program.

Updates

CMS finalized its proposals to do the following:

- Adopt three new eCQMs beginning with the CY 2025 reporting period (pressure injury, acute kidney injury, excessive radiation dose/inadequate image quality for diagnostic computed tomography).
- Maintain for an additional year the definition of "EHR reporting period" as a minimum of any continuous 180-day period.

Long-Term Care Hospital Quality Reporting Program Changes

Key Takeaway: CMS will increase the current 80% data threshold to 85% instead of the proposed 90%.

The LTCH QRP is a pay-for-reporting program. LTCHs that do not meet reporting requirements are subject to a 2 percentage point reduction in their annual payment update. Beginning with the FY 2026 quality reporting period, CMS will increase the data completion threshold so that LTCHs must report 100% of the required quality measure data and standardized patient assessment data collected on at least 85% of the assessments they submit through the CMS designated submission system, an increase from the current 80% requirement. While CMS originally proposed a 90% threshold, the agency finalized an 85% threshold in response to comments detailing the burden of workforce challenges and patient complexity. CMS stated its intent to raise this threshold further in future notice-and-comment rulemaking to align data completion thresholds across the post-acute care (PAC) settings. CMS also adopted the COVID-19 Vaccine Percent of Patients/Residents Who Are Up to Date (Patient/Resident Level COVID-19 Vaccine) measure and updated the COVID-19 Vaccination Coverage Among HCP measure, in alignment with the Hospital IQR and PCHQR Programs.

Beginning with the FY 2025 LTCH QRP, CMS will adopt the Functional Discharge (DC Function) measure. This assessment-based outcome measure assesses functional status by assessing the percentage of LTCH patients who meet or exceed an expected discharge function score, and uses mobility and self-care items already collected on the assessment tool. The adoption of this measure would replace the topped-out process measure, Application of Functional Assessment and Care Plan.

Wage Index

Key Takeaway: CMS will relent to years of challenges to its implementation of urban-to-rural reclassification rules and will treat hospitals with § 412.103 reclassification as rural when calculating the wage index. This change will cause disturbances in the wage index that will affect all hospitals.

Medicare payments to hospitals (and various other provider types) are adjusted by a wage index intended to account for geographic differences across labor markets (*e.g.*, the cost of labor is higher in New York City than in rural Oklahoma). CMS updates the wage index annually based on hospital cost report data and other inputs and policies.

Urban-to-Rural Reclassifications

In 1999, Congress created an opportunity for hospitals physically located in urban areas to be treated for Medicare payment purposes as if they were located in rural areas. Many urban hospitals have taken advantage of this opportunity to qualify for certain payment programs and enhancements available only to rural hospitals, or to improve their applicable wage index. From the very beginning, CMS took steps to limit and occasionally discourage use of this reclassification opportunity. Over the years, several hospitals have successfully sued CMS for allegedly arbitrarily restricting access. In light of these many years of litigation, CMS now will treat hospitals undergoing urban-to-rural reclassification (under 42 C.F.R. § 412.103) the same as geographically rural hospitals for the wage index calculation. This change will substantially alter how CMS calculates and applies the wage index in ways that will affect all hospitals, not just those that seek urban-to-rural reclassification. Many more hospitals—CMS estimates "nearly half"—will receive the same wage index assigned to rural areas of their state. Consequently, wage index variation within states will decrease substantially. For example, hospitals in Los Angeles, California; Tampa, Florida; and Rochester, New York, will receive the same wage index as hospitals in rural areas within those states. Simultaneously, wage index variation among states will increase. And because the wage index is applied in a budget-neutral manner, payments to all hospitals will be adjusted downward to accommodate higher than normal wage index values.

Because of the effect of these policy changes, and because many Medicare Advantage plans may not be able to fully implement these changes in current payment years, commenters asked CMS to delay or phase in the changes. CMS declined to do so. These policy changes are effective fully for FY 2024.

Elsewhere in the final rule, CMS conceded to another adverse litigation outcome (*Toledo Hospital v. Becerra*) and announced 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. This decision may seem contrary to the new policy decisions that more consistently treat § 412.103 reclassified hospitals as rural, but it aligns with differences in statutory interpretation as found by the court in *Toledo Hospital*.

Low Wage Index Hospital Policy

In FY 2020, CMS finalized a policy that boosts the wage index for hospitals with a wage index value below the 25th percentile and stated that it intended this policy to be effective for at least four years. Affected hospitals had their wage index value increased by half the difference between the otherwise applicable

wage index value for a given hospital and the 25th percentile wage index value across all hospitals. CMS achieved budget neutrality for this change by adjusting (*i.e.*, reducing) the standardized amount applied across all IPPS hospitals.

This FY 2020 low wage index hospital policy and the related budget neutrality adjustment have been challenged in federal court. In *Bridgeport Hospital, et al. v. Becerra*, the court found that CMS lacked the authority to adopt the low wage index hospital policy. The US Department of Health and Human Services (HHS) has appealed the *Bridgeport* case. For FY 2024, CMS decided to continue the low wage index policy pending resolution of the ongoing judicial proceedings. CMS likely will have to revisit this policy soon if HHS is unable to reverse the lower court decision on appeal.

Disproportionate Share Hospital Payment and Uncompensated Care Payment

Counting Section 1115 Demonstration Days in Medicare DSH Payments

Key Takeaway: In the FY 2024 IPPS final rule, CMS finalized a separately proposed rule that changes how Medicare DSH payments are calculated with respect to counting the days associated with Section 1115 demonstrations in the Medicaid fraction of the DSH calculation. These changes may have negative financial implications for hospitals and impact 340B eligibility.

On February 28, 2023, CMS released the proposed rule Medicare Disproportionate Share Hospital Payments: Counting Certain Days Associated with Section 1115 Demonstrations in the Medicaid Fraction. This rule changes how Medicare DSH payments are calculated with respect to the counting of days associated with Section 1115 demonstrations in the Medicaid fraction of the DSH calculation. This rule was a follow-up to the FY 2022 and FY 2023 IPPS proposed rules, which initially included similar proposed revisions to the treatment of certain Section 1115 waiver days for purposes of the Medicare DSH adjustment.

CMS used the FY 2024 IPPS rulemaking to finalize its definition of patients who are "regarded as eligible" for Medicaid to include only certain patients who receive health insurance or premium assistance that meets certain additional requirements under a Section 1115 waiver. For purposes of the Medicare DSH calculations, CMS finalized its proposal to include in the fraction only those patients who receive health insurance or buy health insurance with premium assistance provided under a Section 1115 demonstration where states receive matching funds for such programs. CMS also finalized its definition of patient days to be included in the Medicaid fraction numerator. The new definition includes only patient days associated with patients covered under a Section 1115 demonstration who receive health insurance that covers inpatient hospital services or who receive premium assistance that covers 100% of the patient's premium cost that includes coverage for inpatient services.

CMS also finalized its proposal to clarify its interpretation that patient days associated with care funded through a Section 1115 demonstration uncompensated care pool are not viewed as patient days for patients who are "regarded as" Medicaid-eligible. Therefore, hospitals in Arizona, California, Florida, Kansas, Massachusetts, New Mexico, Tennessee and Texas will no longer be permitted to report patient days in the DSH calculation associated with payments from these states' Section 1115 demonstration projects for uncompensated or undercompensated care pools.

This change likely will negatively impact hospitals in states that utilize uncompensated care pools and premium assistance programs through 1115 waivers. In addition to decreasing the amounts paid by Medicare to these hospitals, the change in counting patient days could cause hospitals that participate in the 340B Program to lose their program eligibility because of the decreased DSH adjustment percentage. Some hospitals in affected states also will face a decrease in DSH adjustments, which likely will have

negative financial implications for these facilities.

Uncompensated Care Payment

Key Takeaway: CMS will distribute roughly $5.94 billion in UCP for FY 2024, a decrease of about $940 million from FY 2023.

CMS distributes a prospective amount of UCP to Medicare DSH hospitals based on their relative share of uncompensated care nationally. As required by statute, the UCP pool amount is equal to 75% of total estimated Medicare DSH payments, adjusted for the change in the rate of uninsured individuals. For FY 2024, CMS will distribute approximately $5.94 billion in UCP. This is a decrease of about $940 million compared to the UCP amount available for distribution for FY 2023. This amount is also substantially lower than the amount in the proposed rule, which was $6.71 billion.

For FY 2024, CMS finalized its update and its estimates of the three factors used to determine UCP. CMS finalized its proposal to continue to use uninsured estimates produced by the Office of the Actuary as part of the development of the National Health Expenditure Accounts in conjunction with more recently available data in the calculation of Factor 2. CMS will use the three most recent years of audited data on uncompensated care costs from Worksheet S-10 of the FY 2018, FY 2019 and FY 2020 cost reports to calculate Factor 3 in the UCP methodology for all eligible hospitals.

As finalized in the FY 2023 final rule, CMS continues to discontinue the use of low-income insured days as a proxy for uncompensated care in determining UCP for Indian Health Service and Tribal hospitals, and hospitals located in Puerto Rico. To mitigate the significant financial disruption for these hospitals, CMS uses a separate supplemental payment for Indian Health Service and Tribal hospitals and hospitals located in Puerto Rico.

Graduate Medical Education

Key Takeaway: CMS will treat REHs similarly to CAHs for purposes of determining GME payments.

CMS finalized a clarification of the process for calculating the indirect medical education resident-to-bed ratio in circumstances where there is a change in a hospital's full-time equivalent (FTE) residents due to participation in a GME affiliation agreement under which the hospital shares FTE cap slots with another hospital. CMS finalized a clarification to the specific Medicare cost report data used in the calculation. CMS believes that there will be no financial impact associated with this clarification.

CMS finalized its proposal to treat REHs in a manner similar to CAHs for purposes of determining GME payments. REHs will have the option either to be treated as "non-provider" sites, such that another hospital can report the FTEs of residents training at the REH for Medicare payment purposes, or to incur the costs of the resident training and be reimbursed by Medicare at 100% of reasonable costs. This change will likely be favorable to rural communities and REHs, as it will provide for continued training of residents in rural areas for converting CAHs and will offer the opportunity for additional rural training of residents that might not otherwise be viable without this policy.

Special Rural Designations

Key Takeaway: CMS restored the MDH program and Low-Volume Hospital Payment Adjustment pursuant to legislation enacted in late 2022 and made a small but beneficial change concerning the effective date of sole community hospital (SCH) status related to mergers.

Medicare-Dependent Hospital and Low Volume Adjustment Programs

The MDH designation is available to hospitals that have a disproportionately high Medicare patient mix. Qualifying hospitals are eligible for higher IPPS payments. The low-volume adjustment is available to rural hospitals with very low inpatient volumes. Qualifying hospitals receive enhanced payments that increase as volumes decrease. Both programs expired at the end of FY 2022, but legislation enacted in late 2022 restored both programs retroactive to October 1, 2022. In this final rule, CMS restored all applicable regulations for both programs.

Hospitals that were classified as MDHs as of September 30, 2022, generally continue to be classified as MDHs as of October 1, 2022, with no need to reapply for MDH classification. Hospitals that qualified for the low-volume hospital payment adjustment for FY 2023 may continue to receive a low-volume hospital payment adjustment for FY 2024 without reapplying if they continue to meet both the discharge and mileage criteria. A hospital's request for low-volume adjustments can include a verification statement that it continues to meet the mileage criterion applicable for FY 2023.

Sole Community Hospitals

SCHs are hospitals that by definition are the sole source of inpatient hospital services in a community. Hospitals typically qualify for SCH designation by being a certain distance or drive-time from other hospitals.

CMS finalized a small but potentially beneficial change relevant to hospitals that may be eligible for SCH status following a merger. CMS finalized its proposal to revise current regulations such that, where a hospital's SCH approval is dependent on its merger with another nearby hospital, and the hospital meets the other SCH classification requirements, the SCH classification and payment adjustment would be effective as of the effective date of the approved merger if the Medicare Administrative Contractor receives the complete application within 90 days of CMS's written notification to the hospital of the approval of the merger. As finalized, this change would expedite acquisition of SCH status for hospitals in this circumstance.

Physician-Owned Hospitals

Key Takeaway: CMS finalized changes governing expansion opportunities for grandfathered physician-owned hospitals. Under its new interpretation of the law, meeting the "applicable hospital" or "high Medicaid facility" criteria merely makes a hospital eligible to request an expansion exception; it does not guarantee approval of such a request.

The Affordable Care Act amended the physician self-referral law to effectively bar new physician-owned hospitals and to limit growth of existing facilities. The act grandfathered existing physician-owned hospitals, allowing them to expand operating and procedure room or bed capacity only if they meet statutory criteria as "applicable hospitals" or "high Medicaid facilities," and only subject to the HHS Secretary granting an exception to the general prohibition on expansion. In the CY 2012 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Payment System final rule, CMS established regulatory definitions of "applicable hospital" and "high Medicaid facility" and established a process for hospitals to request such an exception.

In this rule, CMS finalized proposals to revise and clarify its interpretation of the expansion exception process outlined in statute. CMS previously interpreted the statute as providing for *de facto* approval of a hospital's expansion request if the agency determined the hospital met the "applicable hospital" or "high Medicaid facility" criteria. The agency's new interpretation of the statute is that meeting the "applicable hospital" or "high Medicaid facility" criteria merely makes a hospital eligible to request an expansion exception, but it does not guarantee approval of such a request. This interpretation is likely to result in fewer expansion requests being granted.

Requests for Information

Safety Net Hospitals

In the proposed rule, CMS sought input on determining an appropriate basis for identifying safety-net hospitals for Medicare purposes, including the possibility of using the Safety-Net Index developed by MedPAC or an area-level index. The Safety-Net Index is calculated as the sum of (1) the share of the hospital's Medicare volume associated with low-income beneficiaries, (2) the share of the hospital's revenue spent on uncompensated care and (3) an indicator of how dependent the hospital is on Medicare. Area-level indices, such as the Area Deprivation Index and the Social Deprivation Index, aim to measure social disadvantage across geographic areas and would allow CMS to prioritize communities for funding and other assistance.

The request for information (RFI) included about 20 questions soliciting input on factors that should be considered in identifying safety-net hospitals, whether there should be different types of safety-net hospitals, the main challenges facing safety-net hospitals, and whether safety-net hospitals should be responsible for different reporting and compensation requirements than other hospitals. In the final rule, CMS noted that the agency will review the stakeholder input provided and use it to inform future rulemaking on safety-net hospital policy.

Principles for Selecting and Prioritizing LTCH QRP Measures and Concepts Under Consideration for Future Years

In the proposed rule, CMS sought public feedback related to the LTCH QRP. The first RFI section discussed a general framework or set of principles that CMS could use to identify future LTCH QRP measures. The second section drew from an environmental scan conducted to identify measurement gaps in the current LTCH QRP, and measures or measure concepts that could be used to fill these gaps. The final section solicited public comment on the principles for selecting measures for the LTCH QRP, identified measurement gaps, and measures that are available for immediate use or that may be adapted or developed for use in the LTCH QRP.

While many commenters agreed that there is a need to fill measurement gaps, several felt that measures should not be added to the LTCH QRP, citing issues with administrative burden. Commenters suggested that CMS continually evaluate the necessity for new measures and consider utilizing measures that are already available. Commenters encouraged CMS to identify other areas where measurement gaps exist other than those included in the RFI. Several commenters recommended that CMS incorporate measures of health equity in the LTCH QRP.

CMS did not respond to specific comments, but thanked commenters for their input and stated that the agency intends to use this feedback to inform future measure development efforts.

For more information, contact Deborah Godes, Rachel Hollander, Leigh Feldman, Kayla Holgash, Lauren Knizner, Marie Knoll, Kristen O'Brien, Priyadharshini Rathakrishnan, Erica Stocker, Katie Waldo or Eric Zimmerman.