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Fiscal Year 2024 Inpatient Prospective Payment System Proposed Rule
Detailed Summary

On Monday, April 10th, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2024 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System Proposed Rule. The proposed rule provides updates for Medicare fee-for-service payment rates and policies for inpatient hospitals and long-term care hospitals for FY 2024. CMS pays acute care for inpatient stays under the IPPS. Under this payment system, CMS sets base payment rates for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge through Medicare Severity Diagnosis-Related Groups (MS-DRGs). Comments are due to CMS by May 1, 2023.

Proposed Payment for FY 2024
CMS proposes a base FY 2023 IPPS payment update of +2.8%. This is based on a market basket update of 3.0 percent and the multifactor productivity (MFP) adjustment, which CMS estimates a 0.2 percent reduction. This also includes a 0.5 percent increase to the standardized amount per section 414 of the MACRA. CMS will also reduce the market basket increase portion of the formula by one-quarter for hospitals that fail to submit quality data; and a three-quarters reduction of the market basket increase portion of the formula for hospitals not considered "meaningful EHR users."

Data Used in Rate Setting
CMS proposes to use the FY2022 Medicare Provider Analysis and Review (MedPAR) claims file and the FY2021 Healthcare Cost Report Information System (HCRIS) dataset for purposes of FY2024 ratesetting. In past years, CMS had modified their usual ratesetting methodologies to account for the impact of the COVID-19 pandemic, but based on the information available at this time, CMS does not believe there is a reasonable basis to assume there will be a meaningful difference in the number of COVID-19 cases treated at IPPS hospitals in FY2024 relative to FY2022. CMS proposes to resume the usual ratesetting methodologies for FY2024.

Market-Based MS-DRG Relative Weight--Proposed Policy Changes
CMS calculated the proposed FY2024 relative weights based on 19 cost-to-charge-ratios. The proposed methodology uses the FY2022 MedPAR file containing data for approximately 7 million Medicare discharges from IPPS providers as well as data from the FY2021 Medicare cost reports. To the extent possible, all the claims were regrouped using the proposed FY 2024 MS-DRG classifications discussed in sections II.B. and II.C. of the preamble of this proposed rule. The charges for each of the 19 cost groups for each claim were standardized to remove the effects of differences in area wage levels, indirect medical education (IME), and disproportionate share hospital (DSH) payments, and for hospitals located in Alaska and Hawaii, the applicable cost-of-living adjustment. CMS is inviting public comments on the proposals related to recalibration of the proposed FY2024 relative weights and the changes in relative weights from FY2023.

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Proposed FY 2023 Applications for New Technology Add-On Payments
To increase transparency and improve the efficiency of the New Technology Add-on Payment (NTAP) program and application process, CMS is proposing to require NTAP applicants for technologies that are not already FDA market authorized to have a complete and active FDA market authorization application request at the time of submission of NTAP application submission. CMS is also proposing to move the FDA approval deadline from July 1 to May 1, beginning with applications for FY 2025. CMS believes these policy changes would improve the completeness of submitted NTAP applications, allow for a fuller analysis and improved ability for CMS to identify eligibility concerns for the proposed rule, and allow the agency and the public to analyze applications and supporting data to inform a final decision more knowledgeably. CMS is proposing to continue NTAP payments for 11 technologies that will remain eligible in FY 2024. CMS estimates that these 11 technologies will receive $131 million in FY 2024.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals
CMS is proposing revisions to the wage index for acute care hospitals and annual update of the wage data.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024
Medicare makes DSH payments to IPPS hospitals that serve a significantly disproportionate number of low-income patients. In this proposed rule, CMS is proposing to update their estimates of three factors used to determine uncompensated care payments for FY2024. Consistent with the regulation at § 412.106(g)(1)(iii)(C)(11), which was adopted in the FY 2023 IPPS/LTCH PPS final rule, for FY 2024, CMS will use the 3 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 uncompensated care payment methodology for all eligible hospitals. Beginning with FY 2023, CMS established a supplemental payment for Indian Health Service (IHS) and Tribal hospitals and hospitals located in Puerto Rico, to help prevent undue long-term financial disruption to these hospitals due to discontinuing use of the low-income insured days proxy in the uncompensated care payment methodology for these providers. CMS projects Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments combined will decrease in FY2024 by approximately $115 million.

Proposed Payments for Indirect and Direct Graduate Medical Education Costs
The CAA of 2021 established REHs as a new Medicare provider type, effective January 1, 2023. REHs are facilities that that do not provide acute care inpatient hospital services. Only critical access hospitals (CAH) or rural hospitals (or hospitals treated as rural for IPPS payment purposes) with fewer than 50 beds may convert to REH status. REHs and CAHs are included in the section 1861(u) of the Act definition of "provider of services." However, they are excluded from the definition of "hospital" in section 1861(e) of the Act**.** As an alternative to the hospital counting the resident for DGME and IME payment purposes, a CAH may incur the costs of the resident training at the CAH and be paid for the training at 101 percent of reasonable cost. CMS proposes an analogous policy for REHs except the REH would be paid 100 percent rather than 101 percent of reasonable cost under section 1861(v) of the Act that authorizes payment based on reasonable cost principles.

Hospital Readmissions Reduction Program
CMS is not proposing any changes to the Hospital Readmissions Reduction Program.

Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes
CMS is proposing to add one new measure to the Hospital VBP Program. CMS is also providing estimated and newly established performance standards for the FY 2026 through FY 2029 program years.
CMS is proposing to adopt modified versions of the Medicare Spending Per Beneficiary (MSPB) Hospital measure beginning with the FY 2028 program year. Beginning in FY 2030, CMS is proposing to adopt a modified version of the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure.

Rural Community Hospital Demonstration Program
Hospitals participating in the Rural Community Hospital Demonstration Program are not eligible to receive empirically justified Medicare DSH payments and uncompensated care payments under section 1886(r) of the Act because they are not paid under the IPPS (78 FR 50625 and 79 FR 50008). This program was originally authorized for a 5-year period, and The Consolidated Appropriations Act, 2021 amended section 410A of Pub. L. 108–173 to extend the program for an additional 5-year period. The period of participation for the last hospital in the demonstration under this most recent legislative authorization would extend until June 30, 2028. As this program is budget neutral in nature, the neutrality offset amount for FY 2024 is the amount determined under section V.M.3.c.(1). of the preamble of this proposed rule, representing the difference applicable to FY2023 between the sum of the estimated reasonable cost amounts that would be paid under the demonstration for covered IP services to the 26 hospitals eligible to participate in FY2024 and the sum of the estimated amounts that would generally be paid if the demonstration had not been implemented. The estimated neutrality offset amount is $37.6 million.

Proposed Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure in the Hospital IQR Program, PCHQR Program, and LTCH QRP
CMS is proposing to modify the COVID–19 Vaccination Coverage among Health Care Personnel (HCP) measure to replace the term "complete vaccination course" with the term "up to date" regarding recommended COVID-19 vaccines beginning with the Quarter 4 (Q4) calendar year (CY) 2023 reporting period/FY 2025 payment determination for the Hospital IQR Program, and the FY 2025 program year for the LTCH QRP and the PCHQR Program.

Hospital Inpatient Quality Reporting (IQR) Program
In the FY 2024 IPPS/LTCH PPS proposed rule, CMS proposes adopting three new quality measures into the Hospital Inpatient Quality Reporting (IQR) program. While two focus on hospital harm and are not attributed to radiologic care, the third, *Excessive radiation dose or inadequate image quality for diagnostic computed tomography (CT) in adults,* addresses radiation dosing. CMS also proposes removing the *Medicare spending per beneficiary (MSPB)* hospital cost measure beginning with the FY 2028 payment determination with plans to adopt the updated version proposed for adoption into the Hospital Value-Based Purchasing Program. CMS is also proposing two changes to current IQR program policies related to data submission, reporting, and validation, as well as requesting comments on the potential future inclusion of geriatric measures.
CMS is also proposing to adopt a health equity scoring change that will reward excellent care in underserved populations, such that a health equity adjustment would be added to hospitals' Total

Performance Scores (TPS) based on both a hospital's performance on existing Hospital VBP Program measures and the proportion of individuals with dual eligibility status that a hospital treats.

Safety Net Hospitals--- Request for Information

CMS has made advancing health equity the first pillar in its Strategic Plan, this includes evaluating policies to determine how CMS can support safety-net providers. CMS is interested in public feedback on the challenges faced by safety-net hospitals, and potential approaches to help safety-net hospitals meet those challenges.