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CMS Issues FY 2024 Proposed Medicare Inpatient and Long-Term Care Hospital Payment Rule

On Monday (April 10), the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2024 proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System. In a press release, CMS Administrator Chiquita Brooks-LaSure said, "This proposed rule reflects our person-centric approach to better measure health care quality and safety in hospitals to reduce preventable harm and our commitment to ensure that people with Medicare in rural and underserved areas have improved access to high-quality health care."

The rule proposes to increase FY 2024 acute care hospital operating payments by about 2.8%, compared with FY 2022. CMS estimates the overall impact of the rule would result in an increase of about $2.7 billion in payments to acute care hospitals paid under the IPPS in FY 2024.

CMS expects the LTCH standard payment rate to increase by 2.9% and LTCH PPS payments for discharges paid the LTCH standard payment rate to decrease by approximately 2.5% or $59 million. Medicare disproportionate share hospital payments and Medicare uncompensated care payments under the proposal would decrease next year by about $115 million, and additional payments for inpatient cases involving new medical technologies would be reduced by $460 million.

Throughout the rule, CMS proposes several ways to increase health equity, an ongoing priority for the Biden administration. CMS also proposes updates to hospital quality and value-based payment programs, among other changes. CMS will accept public comments on the proposed rule through June 9.

- Press Release, Fact Sheet, Proposed Rule

Summary of key provisions

FY 2024 hospital payment rates. CMS proposes increasing FY 2024 acute care hospital operating payments by about 2.8%, compared with FY 2023, for hospitals that are meaningful users of electronic health records and submit quality measure data. This 2.8% payment update is the summation of a 3.0% hospital market basket increase and a 0.2% productivity cut. CMS estimates proposed changes to operating and capital payments would result in a $3.2 billion increase in FY 2024 IPPS payments, compared with FY 2023. However, CMS estimated that the rule's cumulative changes -- including those to uncompensated care payments and new technology add-on payments -- would lead to an increase of about $2.7 billion in payments to acute care hospitals in FY 2024.

To calculate payment rate changes, CMS proposes returning to the historical practice of using the most recently available inpatient hospital utilization data available, which would be FY 2022 data. Unlike past years, CMS said it will not make any COVID-related adjustments to its rate setting methodology as it does not expect to see a meaningful difference in COVID-19 hospitalizations between FY 2022 and FY 2024.

Table: Proposed FY 2024 Percentage Increases for the IPPS

	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
Proposed Market Basket Rate-of-Increase	3.0	3.0	3.0	3.0
Proposed Productivity Adjustment	-0.2	-0.2	-0.2	-0.2
Proposed Quality Data Adjustment	0.0	0.0	-0.75	-0.75
Proposed Meaningful EHR User Adjustment	0.0	-2.25	0.0	-2.25
Proposed Percentage Change to FY 2023 Standardized Amount	**2.8**	**.55**	**2.05**	**-0.2**

Individual hospital payment rates will vary further based on hospitals' participation in the Hospital Readmissions Reduction Program (HRRP), the Hospital Inpatient Quality Reporting (IQR) Program, the Medicare Promoting Interoperability (PI) program, the Hospital-Acquired Condition (HAC) Reduction Program, and the Hospital Value-Based Purchasing (VBP) Program.

For FY 2024, CMS expects the LTCH standard payment rate to increase by 2.9% and LTCH PPS payments for discharges paid the LTCH standard payment rate to decrease by approximately 2.5% or $59 million due primarily to a projected 4.7% decrease in high-cost outlier payments as a percentage of total LTCH PPS standard Federal payment rate payments. CMS is seeking comment on the methodology used to determine the LTCH PPS outlier threshold for discharges paid the LTCH standard Federal payment rate.

DSH and uncompensated care payments

CMS projects Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments will drop by a combined $161 million in FY 2024, compared with FY 2023. CMS estimated paying about $6.7 billion in uncompensated care payments in FY 2024. As finalized in last year's rule, CMS proposed using the three most recent years of data (FY 2018, FY 2019, and FY 2020) from Worksheet S-10 to calculate uncompensated care payments for FY 2024.

Add-on Payments for New Technology and New COVID-19 Treatments

CMS also projected that new technology add-on payments for inpatient cases will decline by about $466 million as several of the temporary add-on payments are set to expire at the end of FY 2023. In addition, CMS proposed updates to the NTAP application process. For instance, CMS proposed requiring technologies that do not already have FDA authorization to have completed an FDA authorization application request before they apply for NTAP. Beginning with FY 2025, CMS proposed moving the FDA approval deadline from July 1 to May 1.

In addition, the rule clarified that if the COVID-19 public health emergency (PHE) ends on May 11, as is expected, the New COVID-19 Treatments Add-on Payment (NCTAP) will expire at the end of FY 2023 on Sept. 30, meaning hospitals will no longer receive add-on payments for new COVID-19 treatments beginning in fiscal year 2024.

Rural Wage Index

CMS proposed to include hospitals located in urban areas that have been reclassified as a rural hospital under § 412.103 to be included in all rural wage index calculations. CMS would continue to exclude "dual reclass" hospitals. CMS in the rural noted that "these proposals would have significant effects on wage index values."

Low Wage Index updates

For FY 2024, CMS proposed to continue temporary policies finalized in the FY 2020 IPPS rule to address wage index disparities between high and low wage hospitals, citing the need for more time to collect useable data to determine the policy's impact.

Health equity and SDOH

CMS included several proposals aimed at advancing the goals of the CMS Framework for Health Equity 2022-2032. This includes proposing to add 15 new equity categorizations for the FY 2024 IPPS payment impacts, to more explicitly measure the impact of policies on health equity. CMS is also proposing 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, and by proposing several new equity-focused measures across hospital quality programs (see more below).

CMS also proposes to recognize the higher costs that hospitals incur when treating people experiencing homelessness, when hospitals report social determinants of health codes on claims. CMS is proposing to change the severity designation of the three ICD-10-CM diagnosis codes describing homelessness (e.g., unspecified, sheltered, and unsheltered) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes.

CMS also included a Request for Information (RFI) focused on advancing health equity through a focus on safety-net hospitals. CMS is seeking input on the unique challenges faced by safety-net hospitals and the patients they serve, and potential approaches to help safety-net hospitals meet those challenges.

Quality payment program updates

CMS' proposed rule also includes other key updates to hospital quality reporting programs.

Hospital Inpatient Quality Reporting((IQR) Program

For the Hospital IQR Program, CMS proposed adding three new measures beginning with the CY 2025 reporting period. In addition, CMS proposed updating two existing measures beginning with the CY 2025 reporting period, as well as the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure beginning with the fourth quarter of the 2023 calendar year. CMS would change the Vaccination measure to reflect that staff have "up to date" COVID-19 vaccinations. CMS also proposed to remove three measures:

- Hospital-level Risk-standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with the April 1, 2025-March 31, 202,8 reporting period/FY 2030 payment determination;
- Medicare Spending Per Beneficiary (MSPB)—Hospital measure beginning with the CY 2026 reporting period/FY 2028 payment determination; and
- Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC–01) measure beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS notes that it is proposing to remove this measure because measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (that is, "topped out").

CMS also proposed updates to the IQR program validation process, including updates to the Modification of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure beginning with the CY 2025 reporting period and is requesting comment on the potential future inclusion of two geriatric measures. CMS estimated the amount available for value-based incentive payments for FY 2024 discharges is about $1.7 billion.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

For the PCHQR, CMS proposed adding four new measures and to modify an existing measure. Proposed additions include those focused on health equity and SDOH data collection, among others.

Hospital Readmissions Reduction (HRR) and Hospital-Acquired Condition (HAC) Programs

CMS did not propose any changes to the HRRP but clarified that it would resume use of the 30-Day Pneumonia Readmission measure for the FY 2024 program year. For the HAC program, CMS proposed

creating a validation reconsideration process for hospitals beginning with the FY 2025 program year, which would affect CY 2022 discharges. CMS also proposed updating the validation criteria for extraordinary circumstances exceptions (ECEs) beginning with the FY 2027 program year, which would affect CY 2024 discharges. CMS also requested feedback on future HAC measures related to patient safety and health equity.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

Beginning with the FY 2026 LTCH QRP, CMS proposed the adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident level COVID-19 Vaccine) measure and beginning with the FY 2025 LTCH QRP the adoption of the Functional Discharge Score (DC Function) measure. CMS also proposed updates to the COVID-19 Vaccination Coverage among HCP measure, removal of two existing measures, and other scoring and reporting updates.

Promoting Interoperability Updates

CMS proposed several updates to the Promoting Interoperability program. Beginning CY 2025, CMS proposed changing the definition of an EHR reporting period to a "minimum of any continuous 180-day period within CY 2025." In addition, beginning with the CY 2024 EHR reporting period, CMS proposed requiring eligible hospitals and critical access hospitals to attest "yes" to having conducted an annual self-assessment of all nine Safety Assurance Factors for EHR Resilience (SAFER) Guides during the calendar year in which the EHR reporting period occurs. CMS estimated the annual costs associated with proposed SAFER Guides measure changes would range from $8.9 billion to $109 billion beginning with the CY 2024 EHR reporting period.

CMS also proposed adding three new eCQMs beginning with the CY 2025 reporting period.

Other proposed updates (non-exhaustive)

The proposed rule also would:

- Change graduate medical education (GME) payments for Rural Emergency Hospitals (REH), allowing REHs to serve as training sites for Medicare GME payment purposes;
- Clarify the data and information that is required under the physician self-referral law, also known as the Stark Law, specifically regarding physician- or investor-owned hospitals;
- Reinstate program integrity restrictions removed in the 2021 outpatient prospective payment final rule for physician-owned hospitals that meet "high Medicaid facilities" requirements.

If you have questions, please contact Heather Meade or Heather Bell.

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