Issue Brief

FEDERAL ISSUE BRIEF

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April 13,2023

FY 2024 Medicare IPPS and LTCH PPS Proposed Update Issued

The Centers for Medicare & Medicaid Services (CMS) have issued a proposed rule to update the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2024.

This proposed rule would: revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals; make changes relating to Medicare graduate medical education (GME) for teaching hospitals; update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs); and make other policy-related changes.

The document is currently on public display at the ***Federal Register*** office and is scheduled for publication on May 1. A display version of the 1,525-page rule is currently available at: https://public-inspection.federalregister.gov/2023-07389.pdf. A 60-day comment period ending June 9 is provided

The IPPS tables are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled "FY 2024 IPPS Proposed rule Home Page" or "Acute Inpatient—Files for Download."

The LTCH PPS tables are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1785-P.

Comment

CMS has included a four-page table of contents which is helpful, but the table does not reflect the many subsections within each head. The table of contents does contain referenced page numbers.

The table below which is quoted, provides an overview and summary of the costs and benefits associated with major provisions of the rule. (Page 22)

For many payment issues, the rule's Addendum (beginning on page 1,240) contains concise and extremely useful payment information.

This analysis does not follow the rule's organization or heads.

Summary of Costs and Benefits (Page 24)

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Modification to the Rural Wage Index Calculation Methodology	Beginning with FY 2024, we are proposing to include hospitals with § 412.103 reclassification along with geographically rural hospitals in all rural wage index calculations, and to exclude "dual reclass" hospitals (hospitals with simultaneous § 412.103 and MGCRB reclassifications) implicated by the hold-harmless provision at section 1886(d)(8)(C)(ii) of the Act. Changes to the rural wage index which affect the rural floor would be implemented in a budget neutral manner.
Continuation of the Low Wage Index HospitalPolicy	For FY 2024, we are proposing to continue the low wage index hospital policy and the related budget neutrality adjustment.
Medicare DSH Payment Adjustment and Additional Payment for Uncompensated Care and Supplemental Payment	For FY 2024, we are proposing to update our estimates of the three factors used to determine uncompensated care payments. We are proposing to continue to use uninsured estimates produced by OACT as part of the development of the National Health Expenditure Accounts (NHEA) in conjunction with more recently available data in the calculation of Factor 2. As provided in the regulation at § 412.106(g)(1)(iii)(C)(*11*), for FY 2024, we 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. In addition, for FY 2024, we are proposing to follow the same overall methodological approach as was used to calculate Factor 3 for FY 2023. We project that the amount available to distribute as payments for uncompensated care for FY 2024 **would decrease by approximately $161 million**, as compared to our estimate ofthe uncompensated care payments that will be distributed in FY 2023. The uncompensated care payments have redistributive effects, based on a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that are projected to be eligible to receive Medicare DSH payments, and the calculated payment amount is not directly tied to a hospital's number of discharges. **The supplemental payment is not budget neutral and we estimate the impact for FY 2024 to be approximately $90.3 million, which would be an approximately $6 million decrease from our estimate of supplementalpayments in FY 2023.**
Update to the IPPS Payment Rates and Other Payment Policies	As discussed in Appendix A of this proposed rule, acute care hospitals are estimated to experience **an increase of approximately $2.7 billion in FY 2024,** primarily driven by: (1) a combined $3.2 billion increase in FY 2024 operating payments and capital payments, as well as changes in DSH and uncompensated care payments, and (2) a decrease of $466 million resulting from estimated changes in new technology add-on payments, as modeled for this proposed rule.
Update to the LTCH PPS Payment Rates and Other Payment Policies	As discussed in Appendix A of this proposed rule, based on the best available data for the 333 LTCHs in our database, we estimate that the proposed changes to the payment rates and factors that we present in the preamble of and Addendum to this proposed rule, which reflect the proposed update to the LTCH PPS standard Federal payment rate for FY 2024, would result in **an estimated decrease in payments in FY 2024 of approximately $24 million.**
Proposed Changes to the Value-Based Incentive Payments under the Hospital VBP Program	We estimate that there would be no net financial impact to the Hospital VBP Program for the FY 2024 program year in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount of base operating MS-DRG payment amount reductions for the FY 2024 program year and, therefore, **the estimated amount available forvalue-based incentive payments for FY 2024 discharges is approximately $1.7 billion**
Proposal to Modify the COVID-19 Vaccination Coverage among HealthcarePersonnel Measure in the Hospital IQR Program, PCHQR Program, and LTCH QRP	We estimate that the proposed modified version of this measure will have no financial impact on the LTCH QRP, PCHQR Program, or Hospital IQR Program
Proposed Changes to the Hospital-acquiredCondition (HAC) Reduction Program	Across the 400 subsection (d) hospitals selected for validation each year from the HAC Reduction Program, we estimate that our proposed changes in this proposed rule would not result in a change in information collection burden for the FY 2025 program year and subsequent years.
Proposed Changes to the Hospital IQR Program	Across 3,150 IPPS hospitals, we estimate that our proposed changes for the Hospital IQR Program in this proposed rule would result in a total information collection burden decrease of 146,674 hours associated with ourproposed policies, and updated burden estimates and a total cost decrease of approximately $6,748,067 across a 4-year period from the CY 2024 reporting period/FY 2026 payment determination through the CY 2027 reporting period/FY 2029 payment determination.

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Proposed Changes to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	Across 11 PCHs, we estimate that our proposed changes for the PCHQR Program in this proposed rule would result in a total information collection burden increase of 187.2 hours at a cost increase of $6,232. We estimate additional costs of $416,815 annually associated with our proposal to adopt the Documentation of Goals of Care Discussions Among Cancer Patients measure beginning with the FY 2026 program year.
Proposed Changes to the LTCH QRP	Across 330 LTCHs, we estimate that our changes for the LTCH QRP in this proposed rule will result in a total information collection burden decrease of 1,292 hours associated with our proposed policies and updated burden estimates and a total cost decrease of approximately $127,421 across the FY 2025 and FY 2026 LTCH QRP program years.
Proposed Changes to the Medicare Promoting Interoperability Program	Across 4,500 eligible hospitals and CAHs, we estimate that our proposed changes for the Medicare Promoting Interoperability Program in this proposed rule would not result in a change to the information collection burdenfor the CY 2024 EHR Reporting Period and subsequent years. We estimate additional annual costs associated with our proposed modification to the SAFER Guides measure to range from a minimum of $8,916,278 to a maximum of $108,976,725 beginning with the CY 2024 EHR Reporting Period.

I. PROPOSED CHANGES TO PROSPECTIVE PAYMENT RATES FOR HOSPITAL INPATIENT OPERATING COSTS FOR ACUTE CARE HOSPITALS FOR FY 2023 (709 and Addendum Page 1,240, 1,243, 1,289)

Rate Update

For FY 2024, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the national standardized amount.

The increase for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users will be **2.8%**. This reflects a projected hospital market basket update of 3.0% reduced by a 0.2 percentage point multi-factor productivity (MFP) adjustment.

CMS displays four applicable percentage increases as shown in the following table. (Pages 711 and 1,243)

Proposed FY 2024 Applicable Percentage Increases for the 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	3.0	3.0	3.0	3.0
Adjustment for Failure to Submit Quality Data (Reduction of ¼ of market basket increase)	0	0	-0.75	-0.75
Adjustment for Failure to be a Meaningful EHR (Reduction of ¾ of market basket)	0	-2.25	0	-2.25
MFP Adjustment	-0.2	-0.2	-0.2	-0.2
Applicable Percentage Increase Applied to Standardized Amount	**2.8**	**0.55**	**2.05**	**-0.2**

Hospitals that do comply with the quality data submission requirements but are not meaningful EHR users would receive an update of 0.55%, which includes a reduction of three-quarters of the market basket update. (3.0 – 2.25 = .0725 – 0.2 productivity = 1.0055).

Hospitals that fail to comply with the quality data submission requirements but are meaningful EHR users will receive an update of 2.05. This update includes a reduction of one-quarter of the market basket update for failure to submit these data (3.0 -.075 = 2.25.- 0.2 productivity = 1.0205).

Furthermore, hospitals that do not comply with the quality data submission requirements and also are not meaningful EHR users would receive an update of -0.2%. Market basket minus market basket minus 0.2% productivity adjustment (3.0-3.0 = 0 -0.2 = 0.998).

The current (FY 2023) large urban labor rate is $4,310.00 and the non-labor rate is $$2,065.74 for a total of $6,375.74. The other area labor rate is $3,952.96 and the non-labor component is $2,422.78 for a total of $6,375.74.

The following table (Page 1,291) illustrates the changes from the current FY 2023 national standardized amounts to the proposed FY 2024 national standardized amounts. The $6,375.74 amounts are adjusted by the outlier, geographic and the rural demonstration reclassification factors, etc. as shown below resulting in a gross payment rate of $6,846.95. This amount is then further adjusted by multiplying the proposed FY 2024 adjustments.

Comment

CMS, as verified, entered erroneous market basket updates for FY 2024. As noted in red below, we have revised the market basket rates to their correct values.

Changes from Current FY 2023 Standardized Amounts to the Proposed FY 2024 Standardized Amounts

	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
	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 Base Rate *after removing:* 1. FY 2023 Geographic Reclassification BudgetNeutrality (0.984399) FY 2023 Operating Outlier Offset (0.949) 3. FY 2023 Rural Demonstration Budget NeutralityFactor (0.998935)	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,628.54 Nonlabor (32.4%) $2,218.41 *(Combined labor and nonlabor = $6,846.95)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,628.54 Nonlabor (32.4%) $2,218.41 *(Combined labor and nonlabor = $6,846.95)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,628.54 Nonlabor (32.4%) $2,218.41 *(Combined labor and nonlabor = $6,846.95)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,628.54 Nonlabor (32.4%) $2,218.41 *(Combined labor and nonlabor = $6,846.95)*

	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
4. FY 2023 Lowest Quartile Budget NeutralityFactor (0.998146) 5. FY 2023 Cap Policy Wage Index BudgetNeutrality Factor (0.999689)				
	If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,245.11 Nonlabor (38%) $2,601.84 *(Combined labor and nonlabor = $6,846.95)*	If Wage Index is less Than or Equal to1.0000: Labor (62%) $4,245.11 Nonlabor (38%) $2,601.84 *(Combined labor and nonlabor = $6,846.95*	If Wage Index is less Than orEqual to 1.0000: Labor (62%) $4,245.11 Nonlabor (38%) $2,601.84 *(Combined labor and nonlabor = $6,846.95*	If Wage Index is less Than or Equalto 1.0000: Labor (62%) $4,245.11 Nonlabor (38%) $2,601.84 *(Combined labor and nonlabor = $6,846.95*
Proposed FY 2024 Update Factor	1.028	1.0055	1.0205	0.998
Proposed FY 2024 MS-DRG Reclassification and Recalibration Budget Neutrality Factor Before Cap	1.001376	1.001376	1.001376	1.001376
Proposed FY 2024 Cap Policy MS-DRG WeightBudget Neutrality Factor	0.999925	0.999925	0.999925	0.999925
Proposed FY 2024 Wage Index Budget NeutralityFactor	1.000943	1.000943	1.000943	1.000943
Proposed FY 2024 Reclassification Budget Neutrality Factor	0.980959	0.980959	0.980959	0.980959
Proposed FY 2024 Lowest Quartile BudgetNeutrality Factor	0.997371	0.997371	0.997371	0.997371
Proposed FY 2024 Cap Policy Wage Index Budget Neutrality Factor	0.996562	0.996562	0.996562	0.996562
Proposed FY 2024 RCH Demonstration BudgetNeutrality Factor	0.999619	0.999619	0.999619	0.999619
Proposed FY 2024 Operating Outlier Factor	0.949	0.949	0.949	0.949
Proposed National Standardized Amount for FY2024 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4)	**Labor: $4,410.86** **Nonlabor: $2,114.08**	**Labor: $4,314.32** **Nonlabor: $2,067.81**	**Labor: $4,378.68** **Nonlabor: $2,098.66**	**Labor: $4,282.14** **Nonlabor: $2,052.39**
Proposed National Standardized Amount for FY2024 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $4,045.46** **Nonlabor: $2,479.48**	**Labor: $3,956.92** **Nonlabor: $2,425.21**	**Labor: $4,015.95** **Nonlabor: $2,461.39**	**Labor: $3,927.41** **Nonlabor: $2,407.12**

The change between the final FY 2023 full market-basket rate of increase amount of $6,375.74 and the proposed FY 2024 amount of $6,524.94 is $149.20, or a net increase of approximately 2.3%.

These amounts are before other adjustments such as the hospital value-based purchasing program, the hospital readmission program, and the hospital acquired conditions program.

Comment (Page 1,378)

CMS says that 63 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2024 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users.

CMS says 132 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2024 because they are identified as not meaningful EHR users but do submit quality information.

CMS says 32 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2024 because they are identified as not meaningful EHR users and do not submit quality data.

Labor-Share (Pages 654 and 1,246)

For FY 2024, for all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are less than or equal to 1.0000, CMS is proposing to apply the wage index to a labor-related share of 62% of the national standardized amount. This is mandated by statute.

For all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.000, for FY 2024, CMS is proposing to apply the wage index to a proposed labor-related share of 67.6% of the national standardized amount.

Proposed Outlier Payments (Page 1,267-1,285)

CMS is proposing an outlier fixed-loss cost threshold for FY 2024 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, estimated supplemental payment for eligible IHS/Tribal hospitals and Puerto Rico hospitals, and any add-on payments for new technology, plus **$40,732**. The current threshold is $38,859.

CMS' current estimate, using available FY 2022 claims data, is that actual outlier payments for FY 2022 were approximately 6.73% of actual total MS-DRG payments. CMS says it will provide an estimate of actual FY 2023 outlier payments in the FY 2025 IPPS/LTCH PPS proposed rule.

Comment

Once again, CMS argues that to make retroactive adjustments for errors in forecasting outlier payments "would remove an important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized."

This rationale is irrational. There is a need to make adjustments for errors in estimations. The skilled nursing PPS has an error correction process that changes the SNF market basket factors prospectively. CMS should be doing the same for its PPS programs, including errors in outlier payments.

Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2024 (Page 1,299, 1,312, 1,313)

CMS is proposing a FY 2024 Federal capital rate of **$505.54** for FY 2023. The current rate is $483.76.

	FY 2023	FY 2024	Change	Percent Change
Update Factor	1.0250	1.035	1.0350	3.50
GAF/DRG Adjustment Factor	1.0012	0.9992	0.9992	-0.08
Quartile/Cap Adjustment Factor	0.9972	0.9934	0.9962	-0.38
Outlier Adjustment Factor	0.9448	0.9584	1.0143	1.43
Capital Federal Rate	**$483.76**	**$505.54**	1.0450	4.50

Proposed Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2024 (Pages 28, 1,021, 1,316)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico (that is, short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) that are excluded from the IPPS are made on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling.

Accordingly, for FY 2024, the rate-of-increase percentage to be applied to the target amount for these hospitals will be the operating market basket update percentage increase of **3.0%.**

II. PROPOSED CHANGES TO THE HOSPITAL AREA WAGE INDEX (Page 588)

For FY 2024, CMS will continue to use the OMB delineations that were adopted beginning with FY 2015 (based on the revised delineations issued in OMB Bulletin No. 13–01) to calculate the area wage indexes, with updates as reflected in OMB Bulletin Nos. 15–01, 17–01, 18– 04 and 20–01.

The FY 2023 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2019 (the FY 2022 wage indexes were based on data from cost reporting periods beginning during FY 2018). The FY 2023 indexes are located in Table 3 on the CMS website.

Proposed Modification to the Rural Wage Index Calculation Methodology (Page 588)

Beginning with FY 2024, CMS is proposing to include hospitals with § 412.103 reclassification along with geographically rural hospitals in all rural wage index calculations, and to exclude "dual reclass" hospitals (hospitals with simultaneous § 412.103 and Medicare Geographic Classification Review Board (MGCRB) reclassifications) implicated by the hold harmless provision at section 1886(d)(8)(C)(ii) of the Act.

For FY 2024, CMS is continuing to use only the FIPS county codes for purposes of cross-walking counties to CBSAs. For FY 2024, Tables 2 and 3 and the County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File posted on the CMS website reflect the latest FIPS code updates. (Page 593)

Occupational Mix Adjustment to the FY 2023 Wage Index (Page 608)

The FY 2024 occupational mix adjustment is based on the calendar year (CY) 2019 survey. The FY 2025 occupational mix adjustment will be based on a new calendar year (CY) 2022 survey. The final CY 2022 Occupational Mix Survey Hospital Reporting Form is available on the CMS Web site at: https://www.cms.gov/files/zip/2022-occupational-mix-survey-hospital-reporting-form-cms-10079-wage-index-beginning-fy-2025.zip.

Hospitals are required to submit their completed 2022 surveys to their MACs by June 30 2023.

The FY 2023 Occupational Mix *Adjusted* National Average Hourly Wage is **$50.27**. The current rate is $47.73. (Page 610)

The FY 2024 national average hourly wages for each occupational mix nursing subcategory of the occupational mix calculation are as follows; (Page 611)

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$44.43
National LPN and Surgical Technician	$26.90
National Nurse Aide, Orderly, and Attendant	$18.53
National Medical Assistant	$19.51
National Nurse Category	$37.36

Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Permanent Cap on Wage Index Decreases

Proposed Application Rural Floor (Page 613)

By statute, no urban hospital can have a wage index lower than the statewide rural amount. CMS estimates that 596 hospitals would receive the rural floor in FY 2024.

Beginning with FY 2024, CMS is proposing to include hospitals with § 412.103 reclassification along with geographically rural hospitals in all rural wage index calculations, and to exclude "dual reclass" hospitals (hospitals with simultaneous § 412.103 and MGCRB reclassifications) implicated by the hold harmless provision at section 1886(d)(8)(C)(ii) of the Act. (Page 623)

CMS is proposing to continue the policy to apply the deemed urban wage index value for § 412.103 hospitals that also qualify as "Lugar" under section 1886(d)(8)(B) of the Act.

Proposed Imputed Floor (Page 626 and 1393)

The imputed floor adjustment is estimated to increase IPPS operating payments by approximately $249 million. There are an estimated 81 providers in Connecticut, Delaware, Washington D.C., New Jersey, and Rhode Island that will receive the imputed floor wage index.

Proposed State Frontier Floor (Page 628 and 1,393)

For FY 2024, 43 hospitals will receive the frontier floor value of 1.0000 for their FY 2024 wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming. CMS notes that while Nevada meets the criteria of a frontier State, all hospitals within the State currently receive a wage index value greater than 1.0000. Overall, this provision is not budget neutral and is estimated to increase IPPS operating payments by approximately $58 million.

Proposed Continuation of the Low Wage Index Hospital Policy, Budget Neutrality Adjustment (Page 628)

The low wage index increases the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals (the low wage index hospital policy).

For FY 2024, CMS is proposing to continue the low wage index hospital policy and the related budget neutrality adjustment.

For purposes of the low wage index hospital policy, based on the data for this rule, the 25th percentile wage index value across all hospitals for FY 2024 is **0.8615**. The current amount is 0.8427

Proposed Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications (Page 632)

At the time this proposed rule was drafted, the MGCRB had completed its review of FY 2024 reclassification requests. Based on such reviews, there are **621 hospitals** approved for wage index reclassifications by the MGCRB starting in FY 2024.

MGCRB wage index reclassifications are effective for 3 years. There were 262 hospitals approved for wage index reclassifications in FY 2022 that will continue for FY 2024, and 266 hospitals approved for wage index reclassifications in FY 2023 that will continue for FY 2024.

Applications for FY 2025 reclassifications are due to the MGCRB by September 1, 2023.

Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 638)

Table 2 associated with this proposed rule (which is available via the CMS website) includes the proposed out-migration adjustments for the FY 2024 wage index. In addition, Table 4A contains a ''List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act'' consists of the following: A list of counties that are eligible for the out-migration adjustment for FY 2024 identified by FIPS county code, the proposed FY 2024 out-migration adjustment, and the number of years the adjustment will be in effect.

Proposed Reclassification from Urban to Rural Under Section 1886(d)(8)(E) of the Act Implemented at 42 CFR 412.103 (Page 640)

Under section 1886(d)(8)(E) of the Act, a qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB.

Specifically, section 1886(d)(8)(E) of the Act provides that, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital that satisfies certain criteria, the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located.

III. PROPOSED OTHER DECISIONS AND CHANGES to the IPPS OPERATING SYSTEM (Page 701)

Proposed Changes to MS-DRGs Subject to Post-acute Care Transfer Policy and MS-DRG Special Payments Policies (§ 412.4)

CMS is proposing to make changes to a number of MS-DRGs, effective for FY 2024. That would impact the transfer policy. CMS has provided the following table identifying such DRGs.

LIST OF PROPOSED NEW OR REVISED MS-DRGs SUBJECT TO REVIEW OF POSTACUTE CARE TRANSFER POLICY STATUS FOR FY 2024							
Proposed New or Revised MS-DRG		Total Cases	Post-acute Care Transfers (55th percentile: 1,042.5)	Short-Stay Post-acute Care Transfers	Percent of Short-Stay Post-acute Care Transfers to all Cases (55th percentile: 10.58201%)	FY 2023 Post-acute Transfer Policy Status	Proposed Post-acute Care Transfer Policy Status
166	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH MCC	7,756	4,105	1,324	17.07%	Yes	Yes
167	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	4,203	1,358	257	6.11%*	Yes	Yes**
168	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	1,462	204*	0	0.00%*	Yes	Yes**
173	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS WITH PRINCIPAL DIAGNOSIS PULMONARY EMBOLISM	1,537	552*	31	2.02%*	New	No
212	CONCOMITANT AORTIC AND MITRAL VALVE PROCEDURES	892	618*	241	27.02%	New	No
275	CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION AND MCC	3,468	1,629	291	8.39%*	New	No
276	CARDIAC DEFIBRILLATOR IMPLANT WITH MCC	3,832	1,780	411	10.73%	New	Yes
277	CARDIAC DEFIBRILATOR IMPLANT WITHOUT MCC	4,106	903*	141	3.43%*	New	Yes**

LIST OF PROPOSED NEW OR REVISED MS-DRGs SUBJECT TO REVIEW OF POSTACUTE CARE TRANSFER POLICY STATUS FOR FY 2024							
Proposed New or Revised MS-DRG		Total Cases	Post-acute Care Transfers (55th percentile: 1,042.5)	Short-Stay Post-acute Care Transfers	Percent of Short-Stay Post-acute Care Transfers to all Cases (55th percentile: 10.58201%)	FY 2023 Post-acute Transfer Policy Status	Proposed Post-acute Care Transfer Policy Status
278	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL VASCULAR STRUCTURES WITH MCC	516	281*	66	12.79%	New	No
279	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL VASCULAR STRUCTURES WITHOUT MCC	972	296*	42	4.32%*	New	No
321	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH INTRALUMINAL DEVICE WITH MCC OR 4+ ARTERIES/INTRALUMINAL DEVICES	40,805	11,818	1,077	2.64%*	New	No
322	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH INTRALUMINAL DEVICE WITHOUT MCC	56,680	5,328	565	1.00%*	New	No
323	CORONARY INTRAVASCULAR LITHOTRIPSY WITH INTRALUMINAL DEVICE WITH MCC	2,081	704*	106	5.09%*	New	No
324	CORONARY INTRAVASCULAR LITHOTRIPSY WITH INTRALUMINAL DEVICE WITHOUT MCC	2,161	281*	18	0.83%*	New	No
325	CORONARY INTRAVASCULAR LITHOTRIPSY WITHOUT INTRALUMINAL DEVICE	405	64*	3	0.74%*	New	No
397	APPENDIX PROCEDURES WITH MCC	1,186	401*	45	3.79%*	New	No
398	APPENDIX PROCEDURES WITH CC	3,820	700*	111	2.91%*	New	No
399	APPENDIX PROCEDURES WITHOUT CC/MCC	3,071	221*	0	0.00%*	New	No

* As described in the policy at 42 CFR 412.4(f)(6)(iv), MS-DRGs that share the same base MS-DRG will all qualify under the special payment transfer policy if any one of the MS-DRGs that share that same base MS-DRG qualifies.

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 723)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Case-mix

Rural hospitals with fewer than 275 beds can qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2023 must have a CMI value for FY 2021 that is at least—**1.8067** (national--all urban); or the median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region	-MixIndex Value
1. New England (CT, ME, MA, NH, RI, VT)	1.5284
2. Middle Atlantic (PA, NJ, NY)	1.5771
3. East North Central (IL, IN, MI, OH, WI)	1.6712
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7382
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.6569
6. East South Central (AL, KY, MS, TN)	1.6593
7. West South Central (AR, LA, OK, TX)	1.8334
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.86195
9. Pacific (AK, CA, HI, OR, WA)	1.8116

A hospital must also have the number of discharges for its cost reporting period that began during FY 2021 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- The median number of discharges for urban hospitals in the census region in which the hospital is located.

All census regional discharge numbers are greater than 5,000.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 730)

Under sections 1886(d)(12)(C)(i) and 1886(d)(12)(C)(i)(III) of the Act, as amended, for FY 2023 and FY 2024, a low-volume hospital must be more than 15 road miles from another subsection (d) hospital and have less than 3,800 discharges during the fiscal year. In addition, under section 1886(d)(12)(D)(ii) of the Act, the low-volume hospital payment adjustment is determined using a continuous linear sliding scale ranging from 25% for low-volume hospitals with 500 or fewer discharges to 0% for low-volume hospitals with greater than 3,800 discharges.

CMS is proposing that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria.

A hospital 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 it continues to meet both the discharge and the mileage criteria.

Indirect Medical Education (IME) Payment Adjustment Factor (§ 412.105) (Page 744)

The IME formula multiplier remains unchanged at 1.35.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Page 743)

In summary, CMS is proposing that effective for portions of cost reporting periods beginning on or after October 1, 2023, a rural emergency hospitals (REH) may decide to be a non-provider site such that if the requirements at 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g) are met, a hospital can include the FTE residents training at the REH in its direct GME and IME FTE counts for Medicare payment purposes, or, the REH may decide to incur direct GME costs and be paid based on reasonable costs for those training costs. CMS is proposing to add a new paragraph (d) at 42 CFR 419.92 to implement these provisions.

IV. PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHs) FOR FY 2024 (§ 412.106) (Page 655)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25% of the amount they previously would have received under the statutory formula for Medicare DSH payments.

Section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the remaining estimate of 75% of uncompensated care payment is the product of three factors.

The 3 factors in determining the amount of such payments are as follows.

Calculation of Factor 1 for FY 2023 (Page 652)

This factor represents CMS' estimate of 75% (100% minus 25%) of the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The Office of the Actuary's January 2023 estimate of Medicare DSH payments for FY 2024 is approximately $13.621 billion. Therefore, $3.405 billion (or 25% of the total amount of estimated Medicare DSH payments for FY 2024).

Factor 1 for FY 2024 will be **$10,216,040,319.50** which is equal to 75% of the total amount of estimated Medicare DSH payments for FY 2024 ($13,621,387,092.50 minus $3,405,346,733.00).

Calculation of Factor 2 for FY 2023 (Page 670)

"The projected rates of uninsurance for CY 2021 and 2022 reflect the estimated impact of the COVID–19 pandemic. As required by section 1886(r)(2)(B)(ii) of the Act, the Chief Actuary of CMS has certified these estimates."

- Percent of individuals without insurance for CY 2013: 14.0%.
- Percent of individuals without insurance for CY 2023: 9.3%.
- Percent of individuals without insurance for CY 2024: 9.2%.
- Percent of individuals without insurance for FY 2023 (0.25 times 0.093) + (0.75 times 0.092)= 9.2%.
- 1- |((0.14)-.092)/0.14| = 1-0.3429= 0.6571 (65.71%).
- The final Factor 2 for FY 2023 will be **65.71%**.

- The proposed FY 2024 uncompensated care amount is **$10,216,040,319.50***0.6571 = ***$6,712,960,093.94***

The following shows the 75% yearly amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" was $6.767 billion
- The FY 2019 "pool" was $8.273 billion
- The FY 2020 "pool" was $8.351 billion
- The FY 2021 "pool" was $8.290 billion
- The FY 2022 "pool" was $7.192 billion
- The FY 2023 "pool" is $6.874 billion
- Proposed FY 2024 pool will be $6.713 billion

The pool amount for FY 2024 would be $161 million less than the current FY 2023 amount.

Calculation of Factor 3 for FY 2023 (Page 677)

Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive Medicare DSH payments in the fiscal year for which the uncompensated care payment is to be made.

For FY 2024 and subsequent fiscal years, CMS finalized a policy of using a 3-year average of the uncompensated care data from the 3 most recent fiscal years for which audited data are available to determine Factor 3.

CMS is using audited cost reports from FY 2018, FY 2019, and 2020.

CMS is proposing to calculate the average of FY 2019, FY 2021, and FY 2022 historical discharge data, rather than a 3-year average of the most recent 3 years of discharge data from FY 2020, FY 2021, and FY 2022.

V. PROPOSED CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 43)

Comment

This is an extensive and detailed section regarding MS-DRGs and coding. The section, including new technologies is more than 500 pages.

Proposed Changes to Specific MS-DRG Classifications (Page 55)

Listed below are the specific MS-DRG items CMS is addressing in this rule.

1. Diseases and Disorders of the Nervous System: Epilepsy with Neurostimulator (Page 57)

CMS says it believes that further analysis of cases reporting a neurostimulator generator inserted into the skull with the insertion of a neurostimulator lead into the brain (including cases involving the use of the RNS® neurostimulator) and a principal diagnosis of epilepsy is needed in connection with CMS' analysis of the claims data for MS-DRGs 023 through 027 prior to proposing any further reassignment of these cases, to ensure clinical coherence between these cases and the other cases with which they may potentially be grouped. CMS is not proposing to reassign cases describing a neurostimulator generator inserted into the skull with the insertion of a neurostimulator lead into the brain (including cases involving the use of the RNS® neurostimulator) from MS-DRG 023 to MS-DRG 021. CMS is also not proposing to create a new MS-DRG for cases involving a craniectomy/craniotomy with device implant at this time.

2. Retinal Artery Occlusion (Page 69)

CMS is proposing to reassign ICD-10-CM diagnosis codes H34.10, H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, and H34.239 from MDC 02 MS-DRG 123 to MS-DRGs 124 and 125, effective October 1, 2023. CMS is also proposing to add the procedure codes describing the administration of a thrombolytic agent listed previously to MS-DRG 124. CMS notes that the procedure codes describing the administration of a thrombolytic agent are not designated as operating room procedures for purposes of MS-DRG assignment ("non-O.R. procedures"), therefore, as part of the logic for MS-DRG 124, CMS is also proposing to designate these codes as non-O.R. procedures affecting the MS-DRG. Lastly, CMS is also proposing to change the titles of MS-DRGs 124 and 125 from "Other Disorders of the Eye, with and without MCC, respectively" to "Other Disorders of the Eye with MCC or Thrombolytic Agent, and without MCC, respectively" to better reflect the assigned procedures.

3. Ultrasound Accelerated Thrombolysis (USAT) for Pulmonary Embolism (PE) (Page 76)

CMS says it believes the clinical and data analyses support creating a new base MS-DRG to distinguish cases reporting a principal diagnosis of pulmonary embolism (PE) and ultrasound accelerated

thrombolysis (USAT) or standard CDT procedure with or without thrombolytic(s) from other cases currently grouping to MS-DRGs 166, 167, and 168. CMS believes a new MS-DRG would reflect more appropriate payment for USAT and standard catheter-directed thrombolysis (CDT) procedures in the treatment of PE. USAT is also referred to as ultrasound-assisted thrombolysis or ultrasound enhanced thrombolysis.

For FY 2024, CMS is proposing to create new base MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis with Principal Diagnosis Pulmonary Embolism).

4. Respiratory Infections and Inflammations Logic (Page 89)

CMS is proposing to correct the logic for case assignment to MS-DRG 177 by excluding the 15 diagnosis codes from the first logic list "Principal Diagnosis with Secondary Diagnosis" from acting as an MCC when any one of the listed codes is reported as a secondary diagnosis with a diagnosis code from the second logic list "or Principal Diagnosis" reported as the principal diagnosis

5. Surgical Ablation (Page 91)

CMS is proposing to create a new base MS-DRG for cases reporting an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure in MDC 05. The proposed new MS-DRG is proposed MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures).

6. *External Heart Assist Device* (Page 102)

FY 2024, is proposing to reassign ICD-10-PCS code 02HA0RZ when reported as a standalone procedure from MDC 05 in MS-DRG 215 to Pre-MDC MS-DRGs 001 and 002. Under this proposal, procedure code 02HA0RZ will no longer need to be reported as part of a procedure code combination or procedure code "cluster" to satisfy the logic for assignment to MS-DRGs 001 and 002.

7. *Ultrasound Accelerated Thrombolysis for Deep Venous Thrombosis* (Page 113)

CMS says it believes the clinical and data analyses support creating a new base MS-DRG to distinguish cases reporting USAT or standard CDT procedure of peripheral vascular structures with or without thrombolytic(s) from other cases currently grouping to MS-DRGs 252, 253, and 254. CMS says it believes a new MS-DRG would reflect more appropriate payment for USAT and standard CDT procedures of peripheral vascular structures.

8. *Coronary Intravascular Lithotripsy* (Page 126)

CMS is proposing to create a new MS-DRG for cases describing coronary intravascular lithotripsy without an intraluminal device. These proposed new MS-DRGs are proposed MS-DRG 323 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC), proposed MS-DRG 324 (Coronary Intravascular Lithotripsy with Intraluminal Device without MCC) and proposed MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device).

CMS is proposing to delete MS-DRGs 246, 247, 248, and 249, and create a new base MS-DRG with a two-way severity level split for cases describing percutaneous cardiovascular procedures with intraluminal device in MDC 05. These proposed MS-DRGs are proposed MS-DRG 321 (Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices) and proposed MS-DRG 322 (Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC).

CMS is proposing to add the procedure codes from current MS-DRGs 246, 247, 248, and 249 to the proposed MS-DRGs 321 and 322. CMS is also proposing to revise the titles for MS-DRGs 250 and 251 from "Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC, and without MCC, respectively" to "Percutaneous Cardiovascular Procedures without Intraluminal Device with MCC, and without MCC, respectively" to better reflect the ICD-10-PCS terminology of "intraluminal devices" versus "stents" as used in the procedure code titles within the classification.

9. *Shock* (Page 140)

CMS is proposing the deletion of MS-DRGs 222, 223, 224, 225, 226, and 227, and the creation of three new MS-DRGs. These proposed MS-DRGs are MS-DRG 275 (Cardiac Defibrillator Implant with Cardiac Catheterization and MCC), MS-DRG 276 (Cardiac Defibrillator Implant with MCC) and MS-DRG 277 (Cardiac Defibrillator Implant without MCC).

10. *Appendicitis* (Page 150)

CMS is proposing to delete MS-DRGs 338, 339, 340, 341, 342, and 343 and proposing to create new MS-DRGs 397 Appendix Procedures with MCC, MS-DRG 398 Appendix Procedures with CC, and MS-DRG 399 Appendix Procedures without CC/MCC for FY 2024. These proposed new MS-DRGs would no longer require a diagnosis in the definition of the logic for case assignment. CMS is also proposing to include the current list of appendectomy procedures in the logic for case assignment of appendix procedures for the proposed new MS-DRGs.

11. *Alcoholic Hepatitis* (Page 158)

CMS is proposing to maintain the structure of MS-DRGs 432, 433, and 434 for FY 2024.

12. *Spinal Fusion* *(Page 165)*

CMS agrees that its findings appear to indicate that cases reporting the performance of a procedure utilizing an aprevo™ customized interbody spinal fusion device reflect a higher consumption of resources. However, due to the concerns expressed with respect to suspected inaccuracies of the coding and therefore, reliability of the claims data, CMS believes further review is warranted.

13. *Complications of Arteriovenous Fistulas and Shunts* (Page 173)

CMS is not proposing to add the following eight ICD-10-CM codes to the list of principal diagnosis codes for MS-DRGs 673, 674, and 675 when reported with a procedure code describing the insertion of a TIVAD or a tunneled vascular access device: T82.510A, T82.511A, T82.520A, T82.521A, T82.530A, T82.531A, T82.590A and T82.591A.

14. *Percutaneous Endoscopic Resection of Colon* (Page 180)

CMS is proposing to add ICD-10-PCS procedure code 0DTN4ZZ to MDC 11. Under this proposal, cases reporting procedure code 0DTN4ZZ with a principal diagnosis of vesicointestinal fistula (diagnosis code N32.1) in MDC 11 would group to MS-DRGs 673, 674, and 675.

15. *Open Excision of Muscle* (Page 182)

CMS is proposing to add 28 procedure codes listed previously to MDC 05. Under this proposal, cases reporting a procedure code describing the open excision of muscle with a principal diagnosis of gangrene, not elsewhere classified (diagnosis code I96) in MDC 05 would group to MS-DRG 264.

16. *Open Replacement of Skull with Synthetic Substitute* (Page 185)

CMS is proposing to add ICD-10-PCS procedure code 0NR00JZ to MDC 09. Under this proposal, cases reporting procedure code 0NR00JZ with a principal diagnosis in MDC 09 (such as encounter for other plastic and reconstructive surgery following medical procedure or healed injury) would group to MS-DRGs 579, 580, and 581.

17. *Endoscopic Dilation of Ureters with Intraluminal Device* (Page 188)

CMS is proposing to add ICD-10-PCS procedure codes 0T768DZ, 0T778DZ and 0T788DZ to MDC 05. Under this proposal, cases reporting procedure code 0T768DZ, 0T778DZ or 0T788DZ with a principal diagnosis of hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease (I13.0) in MDC 05 would group to MS-DRG 264.

18. Occlusion of Splenic Artery (Page 191)

CMS is not proposing to move any cases reporting procedure codes from MS-DRGs 981 through 983 to MS-DRGs 987 through 989 or vice versa.

19. *Operating Room (O.R.) and Non-O.R. Procedures* (Page 195)

CMS is not proposing changes to the designation of the 22 codes that describe the open drainage of subcutaneous tissue and fascia listed in the previous table for FY 2024.

20. *Proposed Changes to the MS-DRG Diagnosis Codes for FY 2024* (Page 205)

CMS says it continues to solicit feedback regarding the guiding principles, as well as other possible ways it can incorporate meaningful indicators of clinical severity.

Proposed Additions and Deletions to the Diagnosis Code Severity Levels for FY 2024
(Page 218)

The following tables identify the proposed additions and deletions to the diagnosis code MCC severity levels list and the proposed additions and deletions to the diagnosis code CC severity levels list for FY 2024 and are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

- Table 6I.1—Proposed Additions to the MCC List—FY 2024;
- Table 6I.2— Proposed Deletions to the MCC List—FY 2024;
- Table 6J.1— Proposed Additions to the CC List—FY 2024; and
- Table 6J.2— Proposed Deletions to the CC List—FY 2024

Proposed CC Exclusions List for FY 2024 (Page 219)

The ICD-10 MS-DRGs Version 40.1 CC Exclusion List is included as Appendix C in the ICD-10 MS-DRG Definitions Manual, which is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html, and includes two lists identified as Part 1 and Part 2.

Part 1 is the list of all diagnosis codes that are defined as a CC or MCC when reported as a secondary diagnosis. For all diagnosis codes on the list, a link is provided to a collection of diagnosis codes which, when reported as the principal diagnosis, would cause the CC or MCC diagnosis to be considered as a Non-CC. Part 2 is the list of diagnosis codes designated as an MCC only for patients discharged alive; otherwise, they are assigned as a Non-CC.

CMS has developed

- Table 6G.1.— Proposed Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2024;
- Table 6G.2.— Proposed Principal Diagnosis Order Additions to the CC Exclusions List--FY 2024;
- Table 6H.1.— Proposed Secondary Diagnosis Order Deletions to the CC Exclusions List--FY 2024; and
- Table 6H.2.—Proposed Principal Diagnosis Order Deletions to the CC Exclusions List--FY 2024.

For Table 6G.1, each secondary diagnosis code proposed for addition to the CC Exclusion List is shown with an asterisk and the principal diagnoses proposed to exclude the secondary diagnosis code are provided in the indented column immediately following it.

For Table 6G.2, each of the principal diagnosis codes for which there is a CC exclusion is shown with an asterisk and the conditions proposed for addition to the CC Exclusion List that will not count as a CC are provided in an indented column immediately following the affected principal diagnosis.

For Table 6H.1, each secondary diagnosis code proposed for deletion from the CC Exclusion List is shown with an asterisk followed by the principal diagnosis codes that currently exclude it.

For Table 6H.2, each of the principal diagnosis codes is shown with an asterisk and the proposed deletions to the CC Exclusions List are provided in an indented column immediately following the affected principal diagnosis.

Tables 6G.1., 6G.2., 6H.1., and 6H.2. are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

CMS has identified a total of 668 diagnosis codes currently listed on various principal diagnosis collection lists that are not able to be reported as a principal diagnosis based on the ICD-10-CM Official Guidelines for Coding and Reporting. In addition, these codes are listed on the Medicare Code Editor (MCE) code edit lists for Unacceptable Principal Diagnosis or Manifestations not allowed as Principal Diagnosis.

Table 6H.3- Principal Diagnosis Codes for Removal from CC Exclusion List – FY 2024 listing each of these 668 diagnosis codes, including the code descriptions, the applicable MCE edit, and the current principal diagnosis collection list(s) where each code is currently listed and from which the code would be removed for the final FY 2024 V41 GROUPER.

Proposed Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (Page 222)

To identify new, revised and deleted diagnosis and procedure codes, for FY 2024, CMS has developed;

- Table 6A.—New Diagnosis Codes–FY 2024;
- Table 6B.—New Procedure Codes–FY 2024;
- Table 6C.—Invalid Diagnosis Codes–FY 2024;
- Table 6E.—Revised Diagnosis Code Titles–FY 2024.

These tables are not published in the Addendum to this proposed rule, but are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

Proposed Changes to the Medicare Code Editor (MCE) (Page 223)

The Medicare Code Editor (MCE) is a software program that detects and reports errors in the coding of Medicare claims data. Patient diagnoses, procedure(s), and demographic information are entered into the Medicare claims processing systems and are subjected to a series of automated screens. The MCE screens are designed to identify cases that require further review before classification into an MS-DRG.

Proposed Changes to Surgical Hierarchies (Page 233)

CMS has identified numerous items that it is revising. These include proposing to revise the surgical hierarchy for the MDC 04 (Diseases and Disorders of the Respiratory System) MS-DRGs; proposing to revise the surgical hierarchy for the MDC 05 (Diseases and Disorders of the Circulatory System) MS-DRGs; proposing to delete MS-DRGs 222, 223, 224, 225, 226, and 227 (Cardiac Defibrillator Implant with and without Cardiac Catheterization with and without AMI/HF/Shock with and without MCC, respectively); proposing to delete MDC 05 MS-DRGs 246 and 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents and without MCC, respectively; and proposing to delete MDC 05 MS-DRGs 248 and 249 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Arteries or Stents and without MCC, respectively). There are others. Please refer to the rule.

Proposed Replaced Devices Offered without Cost or with a Credit (Page 252)

The existing MS-DRGs currently subject to the replaced device policy is displayed in the rule's table on page 273.

VI. ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY *2023* (Page 272)

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'') under the IPPS.

Proposed FY 2024 Status of Technologies Receiving New Technology Add-On Payments for FY 2023 (Page 289)

The table below lists the technologies for which CMS is proposing to continue making new technology add-on payments for FY 2024 because they are still considered "new" for purposes of new technology add-on payments.

Proposed Continuation of Technologies Approved for FY 2023 New Technology Add-On Payments Still Considered New for FY 2024 Because 3-Year Anniversary Date Will Occur on or After April 1, 2024 (Page 292)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Proposed Maximum NTAP Amount for FY 2023	Coding Used to Identify Cases Eligible for NTAP
1	*Intercept® (PRCFC)*	*05/05/2021*	*10/1/2021*	*5/05/2024*	86 FR 45149 through 45150 86 FR 67875 87 FR 48913	$2,535.00	30233D1 or 30243D1 in combination with one of the following D62, D65, D68.2, D68.4 or D68.9
2	*Rybrevant™*	*05/21/2021*	*10/1/2021*	*05/21/2024*	86 FR 44988 through 44996 87 FR 48913	$6,405.89	XW033B7 or XW043B7
3	*StrataGraft®*	*06/15/2021*	*10/1/2021*	*06/15/2024*	86 FR 45079 through 45090 87 FR 48913	$44,200.00	XHRPXF7

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Dateof Entry onto U.S. Market	Previous Final Rule Citations	Proposed Maximum NTAPAmount for FY 2023	Coding Used to IdentifyCases Eligible for NTAP
4	*aprevo® Intervertebral BodyFusion Device*	*6/30/2021(TLIF)*	*10/1/2021*	*6/30/2024 (TLIF)*	86 FR 45127 through 45133 86 FR 67874 through 67876 87 FR 48913	$40,950.00	XRGA0R7 or XRGA3R7 orXRGA4R7 or XRGB0R7 orXRGB3R7 or XRGB4R7 or XRGC0R7 or XRGC3R7 or XRGC4R7 or XRGD0R7 or XRGD3R7 or XRGD4R7
5	*Hemolung Respiratory Assist System (RAS)*	*11/15/2021 (other)*	*10/1/2022*	*11/15/2024 (other)*	87 FR 48937 through 48948	$6,500.00	5A0920Z without U07.1*
6	*Livtencity™*	*12/2/2021*	*10/1/2022*	*12/2/2024*	87 FR 48948 through 48954	$32,500.00	XW0DX38 or XW0G738 or XW0H738
7	*Thoraflex Hybrid Device*	*04/19/2022*	*10/1/2022*	*04/19/2025*	87 FR 48974 through 48975	$22,750.00	X2RX0N7 in combination with X2VW0N7
8	*ViviStim*	*04/29/2022*	*10/1/2022*	*04/29/2025*	87 FR 48975 through 48977	$23,400.00	X0HQ3R8
9	*GORE TAG Thoracic BranchEndoprosthesis*	*05/13/2022*	*10/1/2022*	*05/13/2025*	87 FR 48966 through 48969	$27,807.00	02VW3DZ in combinationwith 02VX3EZ
10	*Cerament® G*	*05/17/2022*	*10/1/2022*	*05/17/2025*	87 FR 48961 through 48966	$4,918.55	XW0V0P7
11	*iFuse Bedrock Granite ImplantSystem*	*05/26/2022*	*10/1/2022*	*05/26/2025*	87 FR 48969 through 48974	$9,828.00	XNH6058 or XNH6358 orXNH7058 or XNH7358 or XRGE058 or XRGE358 or XRGF058 or XRGF358

The table below lists the technologies for which CMS is proposing to discontinue making new technology add-on payments for FY 2024 because they are no longer "new" for purposes of new technology add-on payments.

Proposed Discontinuation of Technologies Approved for FY 2023 New Technology Add-On Payments No Longer Considered New for FY 2024 Because 3-Year Anniversary Date Will Occur Prior To April 1, 2024

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
1	*TECARTUS®*	*7/4/2020*	*10/1/2021*	*7/4/2023*	86 FR 45090 through 45104 87 FR 48913
2	*VEKLURY®*	*7/1/2020*	*10/1/2021*	*7/1/2023*	86 FR 45104 through 45116 87 FR 48909 through 48914
3	*Zepzelca™*	*6/15/2020*	*10/1/2021*	*6/15/2023*	86 FR 45116 through 45126 87 FR 48912 through 48913
4	*aScope® Duodeno*	*7/17/2020*	*10/1/2021*	*7/17/2023*	86 FR 45133 through 45135 87 FR 48912 through 48916
5	*Caption Guidance™*	*9/15/2020*	*10/1/2021*	*9/15/2023*	86 FR 45135 through 45138 87 FR 48911 through 48913

Technology		Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
6	*aprevo® Intervertebral Body Fusion Device*	*12/3/2020 (ALIF and LLIF)*	*10/1/2021*	*12/3/2023 (ALIF and LLIF)*	86 FR 45127 through 45133 86 FR 67874 through 67876 87 FR 48913
7	*Cosela™*	*2/12/2021*	*10/1/2021*	*2/12/2024*	86 FR 45008 through 45017 87 FR 48912 through 48913
8	*ShockWave C2 Intravascular Lithotripsy (IVL) System*	*2/12/2021*	*10/1/2021*	*2/12/2024*	86 FR 45151 through 45153 87 FR 48913
9	*ABECMA®*	*3/26/2021*	*10/1/2021*	*3/26/2024*	86 FR 45028 through 45035 87 FR 48911 through 48925
10	*Harmony™ Transcatheter Pulmonary Valve (TPV)System*	*03/26/2021*	*10/1/2021*	*3/26/2024*	86 FR 45146 through 45149 87 FR 48913
11	*Recarbrio™ (HABP/VABP)*	*6/4/2020*	*10/1/2021*	*6/4/2023*	86 FR 45157 through 45158 86 FR 67874 87 FR 48914
12	Fetroja® (HABP/VABP)	*9/25/2020*	*10/1/2021*	*9/25/2023*	86 FR 45156 through 45157 86 FR 67876 87 FR 48913
13	*DARZALEX FASPRO®*	*01/15/2021*	*10/1/2022*	*01/15/2024*	87 FR 48925 through 48937
14	*CARVYKTI™*	*03/26/2021*	*10/1/2022*	*03/26/2024*	87 FR 48920 through 48925
15	*Hemolung Respiratory Assist System (RAS)*	*04/22/2020 (COVID-19)*	*10/1/2022*	*04/22/2023 (COVID-19)*	87 FR 48937 through 48948

FY 2024 Applications for New Technology Add-On Payments (Traditional Pathway) (Page 298)

CMS finalized a policy to publicly post online applications for new technology add-on payment beginning with FY 2024 applications.

CMS received 27 applications for new technology add-on payments for FY 2024 under the traditional new technology add-on payment pathway. In accordance with the regulations under § 412.87(e), applicants for new technology add-on payments must have received FDA approval or clearance by July 1 of the year prior to the beginning of the fiscal year for which the application is being considered.

Eight applicants withdrew their applications prior to the issuance of this proposed rule. CMS is addressing the remaining 19 applications.

1. *CYTALUX® (pafolacianine)*. (Page 299)
2. *CYTALUX® (pafolacianine)*. (Page 306)
3. *DuraGraft®.* (Page 314)
4. *Elranatamab.* (Page 328)
5. *epcoritamab,* (Page 339)
6. *glofitamab.* (Page 348)
7. *Lunsumio™ (mosunetuzumab).* (Page 358)
8. *NexoBridTM (anacaulase-bcdb).* (Page 366)
9. *Omidubicel.* (Page 379)

10. *REBYOTA™ (fecal microbiota, live-jslm).* (Page 396)
11. *Sabizabulin.* (Page 407)
12. *SeptiCyte® RAPID.* (Page 416)
13. *SER-109.* (Page 426)
14. *SPEVIGO® (spesolimab).* (Page 438)
15. *TECVAYLI™ (teclistamab-cqyv)* (Page 445)
16. *TERLIVAZ® (terlipressin)* (Page 453)
17. *VANFLYTA® (quizartinib)* (Page 468)
18. *VEST* (Page 478)
19. *XENOVIEW™ (xenon Xe 129 hyperpolarized)* (Page 489)

Proposed FY 2024 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 500)

CMS received 27 applications for new technology add-on payments for FY 2024 under the new technology add-on payment alternative pathway. Seven applicants withdrew applications prior to the issuance of this proposed rule. Of the remaining 20 applications, 16 of the technologies received a Breakthrough Device designation from FDA and 1 has a pending Breakthrough Device designation from FDA. The remaining three applications were designated as a QIDP by FDA.

(1) 4WEB MEDICAL ANKLE TRUSS SYSTEM – CMS is inviting public comments on whether the 4WEB Medical Ankle Truss System meets the cost criterion and to approve new technology add-on payments for the 4WEB Medical Ankle Truss System for FY 2024 subject to the technology receiving FDA marketing authorization as a Breakthrough Device for the indication corresponding to the Breakthrough Device designation by July 1, 2023. (Page 503)

(2) AVEIRTM AR LEADLESS PACEMAKER - CMS is inviting public comments on whether the AveirTM AR Leadless Pacemaker meets the cost criterion and to approve new technology add-on payments for the AveirTM AR Leadless Pacemaker for FY 2024 subject to the technology receiving Breakthrough Device designation and FDA marketing authorization as a Breakthrough Device for the indication corresponding to the Breakthrough Device designation by July 1, 2023. (Page 506)

(3) AVEIR™ LEADLESS PACEMAKER (DUAL-CHAMBER) - Approved pending comments on cost criterion and FDA marketing authorization. (Page 511)

(4) CANARY TIBIAL EXTENSION (CTE) WITH CANARY HEALTH IMPLANTED REPORTING PROCESSOR (CHIRP) SYSTEM - Approved pending comments on cost criterion and FDA marketing authorization. (Page 515)

(5) CERIBELL DELIRIUM MONITOR - Approved subject to the technology receiving FDA marketing authorization as a Breakthrough Device for the indication corresponding to the Breakthrough Device designation by July 1, 2023*.* (Page 519)

(6) CERIBELL STATUS EPILEPTICUS MONITOR - Approved pending comments on cost criterion and FDA marketing authorization. (Page 522)

(7) ECHOGO HEART FAILURE 1.0 - Approved for new technology add-on payments*.* (Page 527)

(8) LIMFLOW SYSTEM - Approved pending FDA marketing authorization. (Page 533)

(9) NELLI® SEIZURE MONITORING SYSTEM - Approved pending FDA marketing authorization. (Page 537)

(10) NUSURFACE® MENISCUS IMPLANT - Disapproved new technology add-on payments for lack of cost criterion (Page 541)

(11) PHAGENYX® SYSTEM - Approved for new technology add-on payments. (Page 544)

(12) SAINT Neuromodulation System - Approved for new technology add-on payments. (Page 548)

(13) Selux NGP System - Approved pending FDA marketing authorization. (Page 551)

(*14) DETOUR System* - Approved for new technology add-on payments. (Page 557)

(15) TOPSTM System - Approved pending FDA marketing authorization. (Page 560)

(16) Total Ankle Talar Replacement - Approved pending comments on cost criterion and FDA marketing authorization. (Page 563)

(17) Transdermal GFR Measurement System utilizing Lumitrace - Approved pending FDA marketing authorization. (Page 566)

Alternative Pathways for Qualified Infectious Disease Products (QIDPs) (Page 569)

(1) taurolidine/heparin - If taurolidine/heparin does not receive FDA approval by July 1, 2023 to receive new technology add-on payments beginning with FY 2023, per § 412.87(e)(3), CMS is proposing to conditionally approve taurolidine/heparin for new technology add-on payments for FY 2024, subject to the technology receiving FDA marketing authorization by July 1, 2024. If taurolidine/heparin receives FDA marketing authorization before July 1, 2024, the new technology add-on payment for cases involving the use of this technology would be made effective for discharges beginning in the first quarter after FDA marketing authorization is granted. If FDA marketing authorization is received on or after July 1, 2024, no new technology add-on payments will be made for cases involving the use of taurolidine/heparin for FY 2024. If taurolidine/heparin receives FDA marketing authorization prior to July 1, 2023, CMs is proposing to continue making new technology add-on payments for taurolidine/heparin in FY 2024. (Page 569)

(2) REZZAYO™ (rezafungin for injection) – Approved if meets cost criterion. (Page 574)

(3) SUL-DUR (sulbactam/durlobactam) - Approved pending FDA marketing authorization. (Page 576)

VII HOSPITAL READMISSIONS REDUCTION PROGRAM: UPDATES AND CHANGES (§§ 412.150 THROUGH 412.154) (Page 770)

The Hospital Readmissions Reduction Program currently includes six applicable conditions/procedures: acute myocardial infarction (AMI); heart failure (HF); pneumonia; elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA); chronic obstructive pulmonary disease (COPD); and coronary artery bypass graft (CABG) surgery program.

There are no proposals or updates in this proposed rule for the Hospital Readmissions Reduction Program.

A hospital subject to the Hospital Readmissions Reduction Program will have an adjustment factor that is between 1.0 (no reduction) and 0.9700 (greatest possible reduction).

CMS estimates that 2,910 hospitals representing 84.12% of all hospitals will be penalized in FY 2024. (Page 1,422)

VIII. HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM: POLICY CHANGES (Page 772)

The Hospital VBP Program is a budget-neutral program funded by reducing participating hospitals' base operating MS-DRG payments each fiscal year by 2.0% and redistributing the entire amount back to the hospitals as value-based incentive payments. The total amount available for value-based incentive payments for FY 2024 is approximately $1.7 billion, based on the December 2022 update of the FY 2022 MedPAR file.

CMS is proposing to:

- Adopt substantive measure modifications to the Medicare Spending Per Beneficiary Hospital measure, including allowing readmissions to trigger new episodes, beginning with the FY 2028 program year.
- Adopt substantive measure modifications to the Hospital-level Risk-standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure, including adding additional mechanical complication ICD-10 codes to the measure, beginning with the FY 2030 program year.
- Adopt the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning with the FY 2026 program year.
- Adopt changes to the administration and submission requirements of the HCAHPS survey measure beginning with the FY 2027 program year.
- Adopt a health equity scoring change for rewarding 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. As part of this proposal.

CMS is also:

- Proposing to modify the TPS maximum to be 110, such that the numeric score range would be 0 to 110.
- Requesting stakeholder feedback on additional health equity changes to the Hospital VBP Program scoring methodology for future consideration.

Comment

This section extends more than 50 pages. The above material is only a snapshot of issues being addressed.

IX. HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM: UPDATES AND CHANGES (42 CFR 412.170) (Page 830)

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by requiring the Secretary to reduce payment by 1.0% for "applicable hospitals," which are subsection (d) hospitals that rank in the worst performing quartile on select measures of hospital-acquired conditions.

CMS it is not proposing to add or remove any measures from the HAC Reduction Program.

CMS is proposing to:

- Establish a validation reconsideration process for hospitals that failed to meet data validation requirements, beginning with the FY 2025 program year, affecting CY 2022 discharges.
- Modify the targeting criteria for data validation to include hospitals that received an Extraordinary Circumstances Exception (ECE) during the data periods validated beginning with the FY 2027 program year, affecting CY 2024 discharges.

In addition, CMS is requesting comment from stakeholders on potential future measures that would advance patient safety and reduce health disparities.

X. PROPOSED CHANGES TO THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM (Page 922)

The Hospital IQR Program is a pay-for-reporting quality program. Hospitals that do not submit quality measure data or fail to meet all Hospital IQR Program requirements are subject to a one-fourth (25%) reduction in their Annual Payment Update under the IPPS.

CMS is proposing to adopt three new quality measures, remove three existing quality measures, and modify three current quality measures. CMS is also proposing two changes to current policies related to data submission, reporting, and validation, as well as requesting comment on the potential future inclusion of geriatric measures and a potential future public-facing geriatric hospital designation.

Specifically, CMS is proposing to adopt three new electronic clinical quality measures (eCQMs) to the list of eCQMs from which hospitals can self-select to meet the eCQM reporting requirements for a given year:

- Hospital Harm — Pressure Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Hospital Harm — Acute Kidney Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level — Inpatient) eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination.

CMS is proposing to modify three current measures:

- Hybrid hospital-wide all-cause risk standardized mortality measure beginning with the FY 2027 payment determination. CMS is proposing to modify this measure to include Medicare Advantage (MA) admissions.
- Hybrid hospital-wide all-cause readmission measure beginning with the FY 2027 payment determination. CMS is proposing to modify this measure to include MA admissions.
- COVID-19 Vaccination among Healthcare Personnel (HCP) measure, beginning with the Quarter 4 CY 2023 reporting period/FY 2025 payment determination. The prior version of this measure reported on the primary vaccination series only, while the proposed measure update would report the cumulative number of HCP who are up to date with recommended COVID-19 vaccinations to align CMS programs with the Centers for Disease Control and Prevention's (CDC's) definition of "up to date" vaccination, keeping the measure relevant if future vaccination guidance evolves. CDC vaccination guidance can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf. This measure modification is a cross-program proposal for the Hospital IQR Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, and the Long-Term Care Hospital Quality Reporting Program (LTCH QRP).

CMS is proposing to remove three measures:

- Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty measure beginning with the FY 2030 payment determination.
- Medicare spending per beneficiary (MSPB) hospital measure beginning with the FY 2028 payment determination. CMS is proposing to remove this measure under the Hospital IQR Program in conjunction with the proposal to adopt the updated measure in the Hospital Value-Based Purchasing Program.
- Elective delivery prior to 39 completed weeks' gestation: Percentage of babies electively delivered prior to 39 completed weeks' gestation measure (also known as PC-01) beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS 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"). While CMS recognizes disparities persist in maternal health, it believes removal of the elective delivery measure will allow for additional meaningful maternal health outcome measures in the future. In the FYs 2022 and 2023 IPPS/LTCH PPS final rules, CMS adopted several measures focused on maternal health, including the Maternal Morbidity structural measure, the Cesarean Birth eCQM, the Severe Obstetrics Complications eCQM, and finalized the creation of the "Birthing-Friendly" hospital quality designation.

CMS is proposing modification of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure beginning with the CY 2025 reporting period/FY 2027 payment determination. These updates include three new web-first modes of survey implementation, removing the survey's prohibition on proxy respondents, extending the data collection period from 42 to 49 days, limiting the number of supplemental survey items to 12, requiring the official Spanish translation for Spanish language-preferring patients, and removing two administration methods that are not used by participating hospitals.

In addition, CMS is requesting comment from stakeholders on the potential future inclusion of two geriatric measures: the geriatric hospital and geriatric surgical structural measures. CMS is also requesting comments regarding the potential future establishment of a publicly reporting hospital designation to capture the quality and safety of patient-centered geriatric care.

CMS presents tables reflecting Summaries of Previously Finalized Hospital IQR Program Measures from FY 2025 through 2028. (Page 966)

Comment

The hospital IOR extends 100 pages. The above material is from a CMS fact sheet. The proposed rule contains much detail.

XI. UPDATES TO THE PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING (PCHQR) PROGRAM (Page 1,012)

The PCHQR Program is a voluntary quality reporting program for the eleven cancer hospitals that are statutorily exempt from the IPPS. CMS collects and publishes data from PCHs on applicable quality measures.

CMS is proposing to:

- Begin public display of the Surgical Treatment Complications for Localized Prostate Cancer measure beginning with data from the FY 2025 program year.
- Adopt four new measures for the PCHQR Program:
  - Facility Commitment to Health Equity beginning with the FY 2026 program year.
  - Screening for Social Drivers of Health beginning with voluntary reporting in the FY 2026 program year and mandatory reporting in the FY 2027 program year.
  - Screen Positive Rate for Social Drivers of Health beginning with voluntary reporting in the FY 2026 program year and mandatory reporting in the FY 2027 program year.
  - Documentation of Goals of Care Discussions Among Cancer Patients beginning with the FY 2026 program year.
- Modify the COVID-19 Vaccination among HCP measure, in alignment with the Hospital IQR Program and LTCH QRP.
- Modify the data submission and reporting requirements for the HCAHPS survey measure, beginning with the FY 2027 program year.

XII. LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM (LTCH QRP*)* (Page 1,060)

LTCHs that do not meet LTCH QRP reporting requirements are subject to a two-percentage points reduction in their annual percentage unit.

CMS is proposing the following:

- Beginning with the FY 2026 LTCH QRP, CMS proposes the adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident level COVID-19 Vaccine) measure.
- Beginning with the FY 2025 LTCH QRP, CMS proposes the adoption of the Functional Discharge Score (DC Function) measure.
- Beginning with the FY 2025 LTCH QRP, CMS proposes to update 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 proposes to remove the Application of Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure.
- Beginning with the FY 2025 LTCH QRP, CMS proposes to remove the Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (Functional Assessment/Care Plan) measure.
- Beginning with the FY 2026 LTCH QRP, CMS proposes to increase the LTCH QRP Data Completion Thresholds for the LCDS Data Items.
- Beginning with the September 2024 Care Compare refresh or as soon as technically feasible, CMS proposes public reporting of the Transfer of Health Information to the Provider — PAC Measure (TOH-Provider) and the Transfer of Health Information to the Patient — PAC Measure (TOH-Patient).

XIII. PROPOSED CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM (Page 1,110)

The following is from a CMS fact sheet.

In 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability Programs for eligible hospitals and critical access hospitals (CAHs)) to encourage eligible professionals, eligible hospitals, and CAHs to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT).

CMS is proposing the following changes to the Medicare Promoting Interoperability Program for eligible hospitals and CAHs:

- Modify requirements for the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure to require eligible hospitals and CAHs to 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, in order to satisfy the definition of a meaningful EHR user under 42 CFR 495.4.

- Amend the definition of "EHR reporting period for a payment adjustment year" for participating eligible hospitals and CAHs to define the EHR reporting period in CY 2025 as a minimum of any continuous 180-day period within CY 2025.
- Amend the definition of "EHR reporting period for a payment adjustment year," for eligible hospitals that have not successfully demonstrated meaningful EHR use in a prior year, to remove the requirement to attest to meaningful use by October 1st of the year prior to the payment adjustment year, beginning with the EHR reporting period in CY 2025.
- Modify the response options related to unique patients or actions, for objectives and measures for the Medicare Promoting Interoperability Program, for which there is no numerator and denominator, and for which unique patients or actions are not counted. The response option would read "N/A (measure is Yes/No)."
- Adopt three new eCQMs for eligible hospitals and CAHs to select as one of their three self-selected eCQMs, in alignment with the Hospital IQR Program, beginning with the CY 2025 reporting period:
  - Hospital Harm — Pressure Injury eCQM;
  - Hospital Harm — Acute Kidney Injury eCQM; and
  - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Hospital Level — Inpatient) eCQM.

XIV. PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2024 (Page 869)

Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Classifications and Relative Weights for FY 2024 (Page 875)

The proposal's table 11, and is available via the Internet on the CMS website, lists the proposed MS-LTC-DRGs and their respective proposed relative weights, proposed geometric mean length of stay, and proposed five-sixths of the geometric mean length of stay (used to identify SSO cases under § 412.529(a)) for FY 2024. CMS is also making available on the website the proposed MS-LTC-DRG relative weights prior to the application of the proposed 10% cap on MS-LTC-DRG relative weight reductions and corresponding proposed cap budget neutrality factor. (Page 903)

Proposed Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2024 (Page 904)

CMS is proposing to update the LTCH PPS standard Federal payment rate by 3.1% less the productivity adjustment of 0.2% point. Resulting in a net increase of 2.9%. For LTCH that fail to provide quality data the 2.9% is reduced by 2.0% for an overall increase of 0.9%. (Page 908)

CMS is proposing to apply an update factor of 1.029 to the FY 2023 LTCH PPS standard Federal payment rate of $46,432.77 to determine the proposed FY 2024 LTCH PPS standard Federal payment rate. (Page 1,319)

CMS is proposing to establish an LTCH PPS standard payment rate of **$47,948.15** (calculated as $46,432.77 x 1.029 x 1.0035335). (Page 1,320)

For LTCHs that fail to submit quality reporting data for FY 2024, CMS is proposing to establish an LTCH PPS standard Federal payment rate of $47,016.21 (calculated as $46,432.77 x 1.009 x 1.0035335) for FY 2024.

For FY 2024, CMS is not proposing any changes to the CBSA-based labor market area delineations as established in OMB Bulletin 20-01 and adopted in the FY 2022 IPPS/LTCH final rule.

The FY 2024 wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS web site.

The proposed labor related share of 68.4%.

Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Page 1,340)

CMS is proposing a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2024 of $94,378 that would result in estimated outlier payments projected to be equal to 7.975% of estimated FY 2024 payments for such cases.. (Page 1,347)

The proposed fixed-loss amount for FY 2024 ($94,378) is significantly higher than the fixed-loss amount for FY 2023 ($38,518).

Proposed High-Cost Outlier Payments for Site Neutral Payment Rate Cases (Page 1,349)

CMS continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2024 is the IPPS fixed-loss amount for FY 2024.

CMS is proposing a fixed-loss amount for site neutral payment rate cases of **$40,732**, which is the same proposed FY 2024 IPPS fixed-loss amount. The current amount is $38,859.

TABLES (Page 1,358)

The following IPPS tables for this rule are generally available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled, "FY 2024 IPPS Proposed Rule Home Page" or "Acute Inpatient-Files- for Download."

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Table 6J.2. Proposed Deletions to the CC List--FY 2024
Table 6P. ICD-10-CM and ICD-10-PCS Codes for Proposed MS-DRG and MCE Changes—FY 2024 (Table 6P contains multiple tables, 6P.1a. through 6P.9a that include the ICD-10-CM and ICD-10-PCS code lists relating to specific proposed MS-DRG and MCE changes or other analyses). In addition, Table 6P.10 – Potential MS-DRG Changes with Application of the Non-CC Subgroup Criteria and Detailed Data Analysis – FY 2024
(Table 6P.10 contains multiple tables, 6P.10a through 6P.10f that include the list of MS-DRGs and data analyses relating to application of the Non-CC subgroup criteria).
Table 8A. Proposed FY 2024 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
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Table 16. Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2024
Table 18. Proposed FY 2024 Medicare DSH Uncompensated Care Payment Factor 3

The following LTCH PPS tables for this FY 2024 final rule are available through the Internet on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1785-P:

Table 8C. Proposed FY 2024 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)
Table 11. Proposed MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from October 1, 2023, through September 30, 2024
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Table 12B. Proposed LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2023, through September 30, 2024

FINAL COMMENTS

This analysis has not discussed a number of issues, including items relating to eCQMs, timing reporting, validations, changes to conditions of participation and deferred compensation plans.

One can appreciate the need and the burden to carefully review these rules. However, the increasing size of the material every year makes it more and more difficult. Too much old and unnecessary history is creating this excessive material. The material suggests CMS is providing a history of the program in addition to updating its rules.

CMS says its goal is to produce payments reflecting quality. Indeed, a noble goal. However, before CMS keeps adding statistical data to mimic quality, it needs to address its own rulemaking. This rule is "careless." It contains numerous errors, has much, too much redundancy, is not concise and to the point in making changes and the case for such changes.

Finally, CMS is not helpful in providing easier access to pertinent section. Yes, this rule does have a limited table of contents, but it is incomplete and does not contain any vital page numbering.

DRG WEIGHTS

Since case-mix is a major determinant for payment purposes, we have, in the past, provided a table to reflect changes in case-mix for the MS-DRGs with the most discharges.

CMS appears to no longer include its Table 7 which contained the number of discharges by DRG. As a result, this aspect of our analysis can no longer be calculated.

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