Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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CMS Releases Final Medicare FY 2024 IPPS and LTCH PPS

The Centers for Medicare & Medicaid Services (CMS) have issued a final 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.

The rule will: revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs; 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 August 28. A display version of the 2,144-page rule is currently available at: https://public-inspection.federalregister.gov/2023-16252.pdf.

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.

Comments

This is one of the more difficult IPPS rules to digest. It maybe the longest as well. What makes it so difficult is the amount of prior and redundant history that truly doesn't help the reader understand the changes being made for FY 2024. One does not need to know the development of an item, only the changes to it for FY 2024.

The final rates for FY 2024 are less than those proposed. Please be very careful in understanding the payments and increases for FY 2024. The market basket is being increased to 3.3% less the productivity adjustment of 0.2% for a net increase of 3.1%. The proposed increase was 2.8%. While CMS says this will result in a net $2.2 billion increase over FY 2023, which includes a reduction payments for new technology of $364 million. The disproportionate share adjustment is $936 million less than the FY 2023 amount and has not been reflected in the $2.2 billion amount.

CMS has included a four-page table of contents which is helpful, but the table does not reflect the many subsections within each major heading. As usual, we are adding page numbers from the display version.

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 1,848) contains concise and extremely useful payment information.

This analysis does not follow the rule's organization.

Questions? Contact Andrew Wheeler, MHA's Vice President of Federal Finance, at 573-893-3700 | ext. 1336 or awheeler@mhanet.com.

4712 Country Club Drive, Jefferson City, Mo. 65109
P.O. Box 60, Jefferson City, Mo. 65102
573/893-3700 | www.mhanet.com

MISSOURI HOSPITAL ASSOCIATION

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 including hospitals with § 412.103 reclassification along with geographically rural hospitals in all rural wage index calculations and only excluding "dual reclass" hospitals (hospitals with simultaneous § 412.103 and MGCRB reclassifications) in accordance with 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, are generally implemented in a budget neutral manner.
Continuation of the Low Wage Index HospitalPolicy	For FY 2024, we are continuing 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 updating our estimates of the three factors used to determine uncompensated care payments. We are continuing to use uninsured estimates produced by OACT as part of the development of the 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 are using 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.
Update to the IPPS Payment Rates and OtherPayment Policies	As discussed in appendix A of this final rule, acute care hospitals are estimated to experience an increase of approximately $2.2 billion in FY 2024, primarily driven by: (1) a combined $2.6 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 $364 million resulting from estimated changes in new technology add-on payments, as projected for this final rule.
Update to the LTCH PPS Payment Rates and Other Payment Policies	As discussed in appendix A of this final rule, based on the best available data for the 333 LTCHs in our database, we estimate that the changes to the payment rates and factors that we present in the preamble of and Addendum of the final rule, which reflect the update to the LTCH PPS standard Federal payment rate for FY 2024, will result in an estimated increase in payments in FY 2024 of approximately $6 million.
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 for value-based incentive payments for FY 2024 discharges is approximately $1.7 billion.
Modification to the COVID-19 Vaccination Coverage among Healthcare Personnel Measure in the Hospital IQR Program, PCHQR Program, and LTCH QRP	We estimate that the modified version of this measure will have no financial impact on the LTCH QRP, PCHQR Program, or Hospital IQR Program
Changes to the Hospital-acquired Condition (HAC) Reduction Program	Across the 400 subsection (d) hospitals selected for validation each year from the HAC Reduction Program, we estimate that our changes in this final rule will not result in a change in information collection burden for the FY 2025 program year and subsequent years.
Changes to the Hospital IQR Program	Across 3,150 IPPS hospitals, we estimate that our changes for the Hospital IQR Program in this final rule will result in a total information collection burden decrease of 144,836 hours associated with our finalized policies, and updated burden estimates and a total cost decrease of approximately $6,834,886 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.
Changes to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program	Across 11 PCHs, we estimate that our changes for the PCHQR Program in this final rule will 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 adoption of 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 final rule will result in a total information collection burden decrease of 1,292 hours associated with our 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.
Changes to the Medicare Promoting Interoperability Program	Across 4,500 eligible hospitals and CAHs, we estimate that our changes for the Medicare Promoting Interoperability Program in this final rule would not result in a change to the information collection burden for the CY 2024 EHR Reporting Period and subsequent years. We estimate additional annual costs associated with our finalized 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. CHANGES TO PROSPECTIVE PAYMENT RATES FOR HOSPITAL INPATIENT OPERATING COSTS FOR ACUTE CARE HOSPITALS FOR FY 2023 (Addendum Page 1,848)

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 **3.1%**. This reflects a projected hospital market basket update of 3.3% reduced by a 0.2 percentage point multi-factor productivity (MFP) adjustment.

CMS displays the four possible applicable percentage increases as shown in the following table. (Pages 989, 1,851, 1917, and 2136)

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	3.3	3.3	3.3	3.3
Adjustment for Failure to Submit Quality Data (Reduction of ¼ of market basket increase)	0	0	-0.825	-0.825
Adjustment for Failure to be a Meaningful EHR (Reduction of ¾ of market basket)	0	-2.475	0	-2.475
MFP Adjustment	-0.2	-0.2	-0.2	-0.2
Applicable Percentage Increase Applied to Standardized Amount	**3.1**	**0.625**	**2.275**	**-0.2**

Hospitals that do comply with the quality data submission requirements but are not meaningful EHR users would receive an update of 0.625%, which includes a reduction of three-quarters of the market basket update and the reduction due to the productivity adjustment (3.3 – 2.475 = 0.825 – 0.2 productivity = **0.625**).

Hospitals that fail to comply with the quality data submission requirements but are meaningful EHR users will receive an update of 2.275%. This update includes a reduction of one-quarter of the market basket update for failure to submit these data (3.3 -0.825 = 2.475- 0.2 productivity = **2.275**).

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 (3.3-3.3 = 0 -0.2 = .**0998).**

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 1,911) illustrates the changes from the current FY 2023 national standardized amounts to the final 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 final FY 2024 adjustments.

Changes from the Current FY 2023 Standardized Amounts to the 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 SubmitQuality Data and is a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is NOT aMeaningful EHR User**
FY 2024 Base Rate *after removing:* 1. FY 2023 Geographic Reclassification BudgetNeutrality (0.984399) 2. FY 2023 Operating Outlier Offset (0.949) 3. FY 2023 Rural Demonstration Budget NeutralityFactor (0.998935) 4. FY 2023 Lowest Quartile Budget NeutralityFactor (0.998146) 5. FY 2023 Cap Policy Wage Index BudgetNeutrality Factor (0.999689)	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)*
	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*
FY 2024 Update Factor	1.031	1.00625	1.02275	0.998
FY 2024 Cap Policy MS-DRG Weights Neutrality Factor	0.999928	0.999925	0.999925	0.999925
FY 2024 Wage Index Budget NeutralityFactor	1.000702	1.000943	1.000943	1.000943
FY 2024 Reclassification Budget Neutrality Factor	0.971295	0.980959	0.980959	0.980959
FY 2024 Low Wage Index Budget Neutrality Factor	0.997402	0.997371	0.997371	0.997371
FY 2024 Cap Policy Wage Index Budget Neutrality Factor	0.999465	0.996562	0.996562	0.996562
FY 2024 Rural Demonstration Budget Neutrality Factor	0.999463	0.999619	0.999619	0.999619
FY 2024 Operating Outlier Factor	0.949	0.949	0.949	0.949
National Standardized Amount for FY2024 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4)	**Labor: $4,392.49** **Nonlabor: $2,105.28**	**Labor: $4,287.05** **Nonlabor: $2,054.74**	**Labor: $4,357.34** **Nonlabor: $2,088.43**	**Labor: $4,251.90** **Nonlabor: $2,037.89**

	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
National Standardized Amount for FY2024 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $4,028.62** **Nonlabor: $2,469.15**	**Labor: $3,931.91** **Nonlabor: $2,409.88**	**Labor: $3,996.38** **Nonlabor: $2,449.39**	**Labor: $3,899.67** **Nonlabor: $2,390.12**

The change between the final FY 2023 full market-basket rate of increase amount of $6,375.74 and the final FY 2024 amount of $6,497.77 is $122.03.

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

CMS says that 65 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. (Page 2,008)

CMS says 110 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. (Page 2009)

CMS says 31 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. (Page 2009)

Labor-Share (Pages 837 and 1,991)

For FY 2024, for all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are less than or equal to 1.0000, CMS will 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 will apply the wage index to a labor-related share of 67.6% of the national standardized amount.

These amounts are unchanged from FY 2023.

Outlier Payments (Pages 1,896 and 1,907)

"Our current estimate, using available FY 2022 claims data, is that actual outlier payments for FY 2022 were approximately 6.78% of actual total MS-DRG payments. Therefore, the data indicate that, for FY 2022, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2022."

CMS is finalizing 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 **$42,750.** The current threshold is $38,859.

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 absolutely irrational. There is a need to make adjustments for errors in estimations. They do not have to be made retroactively. The skilled nursing PPS has an error correction process that changes the SNF market basket factors prospectively. CMS should be doing the same for all its PPS programs, including errors in outlier payments.

Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2024 (Pages 1,222 and 1,919)

CMS will use a FY 2024 Federal capital rate of **$503.83.**

	FY 2023	FY 2024	Change	Percent Change
Update Factor	1.0250	1.0380	1.0380	3.50
GAF/DRG Adjustment Factor	1.0012	0.9885	0.9885	-0.08
Quartile/Cap Adjustment Factor	0.9972	0.9964	0.9992	-0.38
Outlier Adjustment Factor	0.9449	0.9598	1.0157	1.43
Capital Federal Rate	$483.76	**$503.83**	1.0414	4.50

Hospitals reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining eligibility for capital DSH payments. CMS is also finalizing its proposal to amend existing § 412.320(a)(1)(iii) to specify that the exception for an urban hospital that is reclassified as rural as set forth in § 412.103 is effective for discharges occurring on or after October 1, 2006, and before October 1, 2023. That is, for discharges occurring on or after October 1, 2023, for purposes of §412.320, the geographic classifications specified under § 412.64 will apply with no exceptions.

Changes for Hospitals Excluded from the IPPS (Pages 1,227 and 1,936)

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 paid on the basis of reasonable costs based on the hospital's own historical cost experience, subject to a rate-of-increase ceiling.

The FY 2024 rate-of-increase percentage that will be applied to the FY 2023 target amounts in order to calculate the FY 2024 target amounts for children's hospitals, the 11 cancer hospitals, RNHCIs, and short-term acute care hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa will be 3.3%.

II. CHANGES TO THE HOSPITAL AREA WAGE INDEX FOR ACUTE CARE HOSPITALS (Page 747)

For FY 2024, CMS will continue to use Office of Management and Budget (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 2024 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2020.

Occupational Mix Adjustment to the FY 2024 Wage Index (Page 776)

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

The FY 2024 Occupational Mix *Adjusted* National Average Hourly Wage is **$50.34**. (Page 779)

The FY 2024 national average hourly wages for each occupational mix nursing subcategory of the occupational mix calculation are as follows; (Page 780)

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$44.42
National LPN and Surgical Technician	$26.85
National Nurse Aide, Orderly, and Attendant	$18.53
National Medical Assistant	$19.51
National Nurse Category	$37.35

Comment

The average hourly wages for the categories above are either equal to or less than the FY 2023 amounts.

Application of the Rural Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Permanent Cap on Wage Index Decreases (Page 783)

Application of the Rural Floor (Page 783)

By statute, no urban hospital can have a wage index lower than the statewide rural amount. CMS estimates that 646 hospitals will receive the rural floor in FY 2024.

CMS is finalizing its proposal 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 801)

Application of the State Frontier Floor (Page 803)

For FY 2024, 42 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 $60 million. (Page 2023)

Continuation of the Low Wage Index Hospital Policy, Budget Neutrality Adjustment (Page 804)

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 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 **0.8667**. The current amount is 0.8427

Permanent Cap on Wage Index Decreases and Budget Neutrality Adjustment (Page 813)

A hospital's wage index will not be less than 95% of its final wage index for the prior FY.

FY 2024 Wage Index Tables (Page 815)

CMS has included the following wage index tables: Table 2 titled "Case-Mix Index and Wage Index Table by CCN"; Table 3 titled "Wage Index Table by CBSA"; Table 4A titled "List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act"; and Table 4B titled "Counties redesignated under section 1886(d)(8)(B) of the Act (Lugar Counties)." These are available on CMS' website.

Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications (Page 816)

There are **466 hospitals** approved for wage index reclassifications by the MGCRB starting in FY 2024.

MGCRB wage index reclassifications are effective for 3 years. There were 271 hospitals approved for wage index reclassifications in FY 2022 that will continue for FY 2024, and 325 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.

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 823)

"Table 2 includes the out-migration adjustments for the FY 2024 wage index. In addition, Table 4A, "List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act" (also available via the internet on the CMS website), 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 FY 2024 out-migration adjustment, and the number of years the adjustment will be in effect."

Reclassification from Urban to Rural Under Section 1886(d)(8)(E) of the Act Implemented at 42 CFR 412.103 (Page 826)

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. PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHs) FOR FY 2024 (§ 412.106) (Page 841)

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 are as follows.

Calculation of Factor 1 for FY 2024 (Page 856)

This factor represents CMS' estimate of 75% 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 June 2023 Office of the Actuary (OACT) estimate for Medicare DSH payments for FY 2024, without regard to the application of section 1886(r)(1) of the Act, is approximately $13.354 billion.

Therefore, the Factor 1 for FY 2024 is $10,015,191,021.88, which is equal to 75% of the total amount of estimated Medicare DSH payments for FY 2024 ($13,353,588,029.18 minus $3,338,397,007.29).

Calculation of Factor 2 for FY 2024 (Page 870)

"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: 7.7%.
- Percent of individuals without insurance for CY 2024: 8.5% .
- Percent of individuals without insurance for FY 2024 (0.25 times 0.077) + (0.75 times
- 0.085): 8.3% . 1- |((0.14 – 0.083)/0.14)| = 1-0.4071 = 0.5929 (59.29%).
- Therefore, the final Factor 2 for FY 2024 is 59.29%. The final FY 2024 uncompensated care amount is $10,015,191,021.88 * 0.5929 = **$5,938,006,756.87.**

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
- The FY 2024 "pool" will be $5.938 billion

The pool amount for FY 2024 will be $936 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 finalizing its proposal to follow the same methodology used in the FY 2023 IPPS/LTCH PPS final rule to calculate Factor 3 for FY 2024 using data from the most recent 3 years of audited cost reports from FY 2018, FY 2019, and 2020, based on the March 2023 HCRIS extract. (Page 915)

IV. OTHER DECISIONS AND CHANGES to the IPPS OPERATING SYSTEM (Page 966)

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

CMS is making 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. (Page 972)

LIST OF NEW OR REVISED MS-DRGs SUBJECT TO REVIEW OF POSTACUTE CARE TRANSFER POLICY STATUS FOR FY 2024							
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**	**FY 2024 Post-acute Care Transfer Policy Status**
166	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH MCC	7,802	4,100	1,301	16.68%	Yes	Yes
167	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	4,226	1,362	253	5.99%*	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	1,542	555*	30	1.95%*	New	No
212	CONCOMITANT AORTIC AND MITRAL VALVE PROCEDURES	900	621*	238	26.44%	New	No
275	CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION AND MCC	3,488	1,635	291	8.34%*	New	No
276	CARDIAC DEFIBRILLATOR IMPLANT WITH MCC	3,848	1,781	411	10.68%	New	Yes
277	CARDIAC DEFIBRILATOR IMPLANT WITHOUT MCC	517	280*	65	12.57%	New	Yes**

LIST OF NEW OR REVISED MS-DRGs SUBJECT TO REVIEW OF POSTACUTE CARE TRANSFER POLICY STATUS FOR FY 2024							
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	FY 2024 Post-acute Care Transfer Policy Status
278	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL VASCULAR STRUCTURES WITH MCC	4,141	911*	143	3.45%	New	No
279	ULTRASOUND ACCELERATED AND OTHER THROMBOLYSIS OF PERIPHERAL VASCULAR STRUCTURES WITHOUT MCC	977	298*	42	4.30%*	New	No
321	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH INTRALUMINAL DEVICE WITH MCC OR 4+ ARTERIES/INTRALUMINAL DEVICES	40,910	11,829	1,073	2.62%*	New	No
322	PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH INTRALUMINAL DEVICE WITHOUT MCC	56,912	5,335	566	0.99%*	New	No
323	CORONARY INTRAVASCULAR LITHOTRIPSY WITH INTRALUMINAL DEVICE WITH MCC	2,109	713*	107	5.07%*	New	No
324	CORONARY INTRAVASCULAR LITHOTRIPSY WITH INTRALUMINAL DEVICE WITHOUT MCC	2,188	283*	19	0.87%*	New	No
325	CORONARY INTRAVASCULAR LITHOTRIPSY WITHOUT INTRALUMINAL DEVICE	410	64*	3	0.73%*	New	No
397	APPENDIX PROCEDURES WITH MCC	1,186	402*	45	3.79%*	New	No
398	APPENDIX PROCEDURES WITH CC	3,838	701*	112	2.92%*	New	No
399	APPENDIX PROCEDURES WITHOUT CC/MCC	3,094	223*	0	0.00%*	New	No

** Indicates a current postacute care transfer policy criterion that the MS–DRG did not meet.*
*** As described in the policy at 42 CFR 412.4(d)(3)(ii)(D), MS–DRGs that share the same base MS–DRG will all qualify under the postacute care 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 1,004)

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—**1.8065** (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	Case-MixIndex Value
1. New England (CT, ME, MA, NH, RI, VT)	1.5272
2. Middle Atlantic (PA, NJ, NY)	1.5791
3. East North Central (IL, IN, MI, OH, WI)	1.6726
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7392
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.65775
6. East South Central (AL, KY, MS, TN)	1.6620
7. West South Central (AR, LA, OK, TX)	1.8480
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.8582
9. Pacific (AK, CA, HI, OR, WA)	1.8094

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 1,010)

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 requiring 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.

Based on the current law, beginning with FY 2025, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Page 1,028)

CMS is finalizing its proposal that effective for portions of cost reporting periods beginning on or after October 1, 2023, an rural emergency hospital (REH) may decide to be a non-provider site. If the requirements at 42 CFR 412.105(f)(1)(ii)(E) and 413.78(g) and any succeeding regulations 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. In the alternative, the REH may decide to incur direct GME costs and be paid based on reasonable costs for those training costs.

Comment

The above material is extensive. It consumes 45 pages.

Indirect Medical Education (IME) Payment Adjustment Factor (§ 412.105) (Page 1,030)

The IME formula multiplier remains unchanged at 1.35.

V. CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 44)

Comment

This is an extensive and detailed section regarding MS-DRGs and coding. This section and section VI below regarding new technologies is nearly 700 pages.

Changes to Specific MS-DRG Classifications (Page 47)

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

1. Major Diagnostic Category (MDC) 01: (Diseases and Disorders of the Nervous System): Epilepsy with Neurostimulator (Page 67)

CMS is finalizing its proposal to maintain the current assignment of 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), without modification.

2. *Retinal Artery Occlusion* (Page 82)

CMS is finalizing its proposal 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, without modification, effective October 1, 2023. In addition, CMS is finalizing its proposal to add the procedure codes describing the administration of a thrombolytic agent listed previously to MS-DRG 124.

As part of the logic for MS-DRG 124, CMS is also finalizing its proposal to designate the 10 ICD-10-PCS procedure codes describing the administration of a thrombolytic agent listed previously as non-O.R. procedures affecting the MS-DRG. Lastly, CMS is finalizing its proposal 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."

3. Ultrasound Accelerated Thrombolysis (USAT) for Pulmonary Embolism (PE) (Page 90)

CMS is finalizing its proposal to create new MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis with Principal Diagnosis Pulmonary Embolism), without modification. CMS is also finalizing its proposal to define the logic for the new MS-DRG using the previously listed diagnosis codes for PE and the previously listed procedure codes for USAT and CDT, as identified and discussed in CMS' analysis of the claims data in association with the proposed rule. CMS will continue to monitor the claims data for this new MS-DRG after implementation to determine if additional refinements are warranted.

4. Respiratory Infections and Inflammations Logic (Page 111)

CMS is finalizing its proposal to correct the logic for case assignment to MS-DRG 177, with modification. CMS is finalizing the exclusion of 11 diagnosis codes listed in the first logic list entitled "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 entitled "or Principal Diagnosis" when reported as the principal diagnosis.

5. Surgical Ablation (Page 116)

For FY 2024, taking into consideration that it clinically requires greater resources to perform an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure, CMS will 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 new MS-DRG is MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures).

6. External Heart Assist Device (Page 141)

CMS is finalizing its proposal to reassign ICD-10-PCS code 02HA0RZ (Insertion of short-term external heart assist system into heart, open approach) from MDC 05 in MS-DRG 215 to Pre-MDC MS-DRGs 001 and 002 when reported as a standalone procedure, without modification, effective October 1, 2023. Under this finalization, 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 156)

CMS is finalizing its proposal to create new MS-DRG 278 (Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures with MCC) and new MS-DRG 279 (Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures without MCC), without modification. CMS is also finalizing its proposal to define the logic for the new MS-DRGs using the previously listed procedure codes for USAT and CDT, as identified and discussed in CMS' analysis of the claims data in Table 6P.5a associated with the proposed rule. CMS will continue to monitor the claims data for these new MS-DRGs after implementation to determine if additional refinements are warranted.

8. Coronary Intravascular Lithotripsy (Page 175)

CMS is finalizing its proposal to create new MS-DRG 323 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC), new MS-DRG 324 (Coronary Intravascular Lithotripsy with Intraluminal Device without MCC) and new MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device) in MDC 05, without modification, effective October 1, 2023.

CMS is finalizing its proposal, without modification, to delete MS-DRGs 246, 247, 248, and 249 for FY 2024. CMS is also finalizing its proposal to create new MS-DRG 321 (Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices) and new MS-DRG 322 (Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC). Accordingly, CMS is finalizing its proposal to reassign the procedure codes from current MS-DRGs 246, 247, 248, and 249 to the new MS-DRGs 321 and 322.

Lastly, CMS is finalizing its proposal to revise the titles of 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" effective October 1, 2023.

9. Shock (Page 197)

CMS is finalizing its proposal to delete MS-DRGs 222, 223, 224, 225, 226, and 227. CMS is also finalizing its proposal to create new MS-DRG 275 (Cardiac Defibrillator Implant with Cardiac Catheterization and MCC), new MS-DRG 276 (Cardiac Defibrillator Implant with MCC), and new MS-DRG 277 (Cardiac Defibrillator Implant without MCC) in MDC 05, without modification, effective October 1, 2023. CMS is also finalizing its proposal to designate the procedure codes describing cardiac catheterization as non-O.R. procedures affecting the MS-DRG.

10. *Appendicitis* (Page 216)

CMS is finalizing its proposal to delete MS-DRGs 338, 339, 340, 341, 342, and 343 and to create MS-DRGs 397, 398, and 399 (Appendix Procedures with MCC, with CC, and without CC/MCCC, respectively), without modification. These finalized new MS–DRGs no longer require a diagnosis in the definition of the logic for case assignment. CMS is also finalizing its proposal to include the current list of appendectomy procedures in the logic for case assignment of appendix procedures for the finalized new MS–DRGs

11. Alcoholic Hepatitis (Page 228)

CMS is finalizing its proposal to maintain the structure of MS–DRGs 432, 433, and 434, without modification.

12. Spinal Fusion (Page 238)

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 247)

CMS is finalizing for FY 2024, without modification, its proposal to not 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 255)

CMS is finalizing its proposal to add ICD-10-PCS procedure code 0DTN4ZZ to MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract), without modification, effective October 1, 2023.

15. Open Excision of Muscle (Page 257)

CMS is finalizing its proposal to add the 28 ICD-10-PCS codes that describe the open excision of muscle listed previously to MDC 05 (Diseases and Disorders of the Circulatory System), without modification, effective October 1, 2023.

16. Open Replacement of Skull with Synthetic Substitute (Page 261)

CMS is finalizing its proposal to add ICD-10-PCS procedure code 0NR00JZ to MDC 09 (Diseases and Disorders of the Circulatory System), without modification, effective October 1, 2023.

17. Endoscopic Dilation of Ureters with Intraluminal Device (Page 265)

CMS is finalizing its proposal to add ICD-10-PCS procedure codes 0T768DZ, 0T778DZ, and 0T788DZ to MDC 05 (Diseases and Disorders of the Circulatory System), without modification, effective October 1, 2023.

18. Occlusion of Splenic Artery (Page 269)

CMS is finalizing its proposal to add the nine procedure codes that describe the occlusion of the splenic artery to MDC 16 (Diseases and Disorders of Blood, Blood Forming Organs and Immunologic Disorders) in MS-DRGs 799, 800, and 801, without modification, effective October 1, 2023. CMS is also finalizing its proposal to revise the titles of MDC 16 MS-DRGs 799, 800, and 801 from "Splenectomy with MCC, with CC, and without CC/MCC, respectively" to "Splenic Procedures with MCC, with CC, and without CC/MCC, respectively" to better reflect the assigned procedures.

19. Operating Room (O.R.) and Non-O.R. Procedures (Page 275)

CMS is not changing the designation of 22 codes that describe the open drainage of subcutaneous tissue and fascia for FY 2024.

20. Changes to the MS-DRG Diagnosis Codes for FY 2024 (Page 289)

CMS is finalizing changes to the severity levels for diagnosis codes Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness), from Non-CC to CC for FY 2024.

CMS is finalizing its proposal, without modification, to maintain the current severity level designation of diagnosis codes K76.72 (Hepatic encephalopathy), N14.11 (Contrast-induced nephropathy), and S06.2XAA (Diffuse traumatic brain injury with loss of consciousness status unknown, initial encounter) for FY 2024.

Additions and Deletions to the Diagnosis Code Severity Levels for FY 2024 (Page 314)

The following tables associated with this final rule reflect the finalized severity levels under Version 41 of the ICD-10 MS-DRGs for FY 2024 and are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS

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

CC Exclusions List for FY 2024 (Page 315)

The finalized CC Exclusions List as displayed in Tables 6G.1, 6G.2, 6H.1, 6H.2, and 6K, rule reflect the severity levels under V41 of the ICD–10 MS–DRGs. CMS has developed:

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

Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (Page 318)

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

- Table 6A.--New Diagnosis Codes,
- Table 6B.--New Procedure Codes,
- Table 6C.--Invalid Diagnosis Codes,
- Table 6D.--Invalid Procedure Codes,
- Table 6E.--Revised Diagnosis Code Titles and
- Table 6F.--Revised Procedure Code Titles for this final rule.

Changes to the Medicare Code Editor (MCE) (Page 324)

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.

Refer to the rule's pages 324-340 for specific changes.

Changes to Surgical Hierarchies (Page 340)

CMS has identified numerous items that it is revising. Refer to the rule's page 340.

Replaced Devices Offered without Cost or with a Credit (Page 361)

The existing MS-DRGs currently subject to the replaced device policy is displayed in the rule's table on page 362.

VI. ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY *2023* (Page 384)
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.

FY 2024 Status of Technologies Receiving New Technology Add-On Payments for FY 2023 (Page 409)

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

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 407)

	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
4	*aprevo® Intervertebral Body Fusion 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 or XRGA4R7 or XRGB0R7 or XRGB3R7 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 Branch Endoprosthesis*	*05/13/2022*	*10/1/2022*	*05/13/2025*	87 FR 48966 through 48969	$27,807.00	02VW3DZ in combination with 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 Implant System*	*05/26/2022*	*10/1/2022*	*05/26/2025*	87 FR 48969 through 48974	$9,828.00	XNH6058 or XNH6358 or XNH7058 or XNH7358 or XRGE058 or XRGE358 or XRGF058 or XRGF358

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

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 (Page 413)

	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
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 414)

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. Subsequently, four applicants withdrew their respective applications for sabizabulin, DuraGraft, VEST, and omidubicel prior to the issuance of this final rule.

In addition, two applicants, Daiichi Sankyo and Pfizer, for Vanflyta and elranatamab respectively, did not receive FDA approval for their technologies by July 1, 2023. Therefore, Vanflyta and elranatamab are not eligible for consideration for new technology addon payments for FY 2024. Of the remaining 13 applications, CMS is not approving the applications for NexoBrid™, SeptiCyte® RAPID, and XENOVIEW™.

CMS is approving the remaining 10 applications, with 4 of the applications considered as 2 technologies due to substantial similarity, for a total of **8 new approvals** for new technology add-on payments for FY 2024. They are as follows:

1. *CYTALUX® (pafolacianine)* first indication (Page 415)

   Cases involving the use of CYTALUX® that are eligible for new technology add-on payments will be identified by ICD–10–PCS codes: 8E0U0EN (Fluorescence guided procedure of female reproductive system using pafolacianine, open approach), 8E0U3EN (Fluorescence guided procedure of female reproductive system using pafolacianine, percutaneous approach), 8E0U4EN (Fluorescence guided procedure of female reproductive system using pafolacianine, percutaneous endoscopic approach), 8E0U7EN (Fluorescence guided procedure of female reproductive system using pafolacianine, via natural or artificial opening), or 8E0U8EN (Fluorescence guided procedure of female reproductive system using pafolacianine, via natural or artificial opening endoscopic).

   The maximum new technology add-on payment for a case involving the use of CYTALUX® is $2,762.50.

2. *CYTALUX® (pafolacianine),* second indication (Page 427)

   Cases involving the use of CYTALUX® that are eligible for new technology add-on payments will be identified by ICD–10–PCS codes: 8E0W0EN (Fluorescence guided procedure of trunk region using pafolacianine, open approach), 8E0W3EN (Fluorescence guided procedure of trunk region using pafolacianine, percutaneous approach), 8E0W4EN (Fluorescence guided procedure of trunk region using pafolacianine, percutaneous endoscopic approach), 8E0W7EN (Fluorescence guided procedure of trunk region using pafolacianine, via natural or artificial opening), or 8E0W8EN (Fluorescence guided procedure of trunk region using pafolacianine, via natural or artificial opening endoscopic).

   The maximum new technology add-on payment for a case involving the use of CYTALUX® is $2,762.50.

3. *EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm),* (Page 443)

   Cases involving EPKINLY™ will be identified by ICD-10-PCS procedure code XW013S9 (Introduction of epcoritamab monoclonal antibody into subcutaneous tissue, percutaneous approach, new technology group 9). Cases involving COLUMVI™ that are eligible for new technology add-on payments will be identified by ICD-10-PCS procedure code XW033P9 (Introduction of glofitamab antineoplastic into peripheral vein, percutaneous approach, new technology group 9) or XW043P9

(Introduction of glofitamab antineoplastic into central vein, percutaneous approach, new technology group 9).

The maximum new technology add-on payment for a case involving the use of EPKINLY™ or COLUMVI™ is $6,504.07.

4. *Lunsumio™ (mosunetuzumab)* (Page 474)

   Cases involving the use of Lunsumio™ that are eligible for new technology add-on payments will identified by ICD–10–PCS codes: XW03358 (Introduction of mosunetuzumab antineoplastic into peripheral vein, percutaneous approach, new technology group 8), or XW04358 (Introduction of mosunetuzumab antineoplastic into central vein, percutaneous approach, new technology group 8).

   The maximum new technology add-on payment for a case involving the use of Lunsumio™ is $17,492.10.

5. *REBYOTA™ (fecal microbiota, live-jslm) and VOWST™ (fecal microbiota spores, livebrpk)* (Page 499)

   Cases involving REBYOTA™ payments will be identified by ICD-10-PCS procedure code XW0H7X8 (Introduction of broad consortium microbiota-based live biotherapeutic suspension into lower GI, via natural or artificial opening, new technology group 8). Cases involving VOWST™ payments will be identified by ICD-10-PCS procedure code XW0DXN9 (Introduction of SER-109 into mouth and pharynx, external approach, new technology group 9).

   The maximum new technology add-on payment for a case involving the use of REBYOTA™ or VOWST™ is $6,789.25.

6. *SPEVIGO® (spesolimab).* (Page 558)

   Cases involving the use of SPEVIGO® that are eligible for new technology add-on payments will be identified by ICD–10–PCS code XW03308 (Introduction of spesolimab monoclonal antibody into peripheral vein, percutaneous approach, new technology group 8).

   The maximum new technology add-on payment for a case involving the use of SPEVIGO® is $33,236.45.

7. *TECVAYLI™ (teclistamab-cqyv)* (Page 572)

   Cases involving the use of TECVAYLI™ that are eligible for new technology add-on payments will be identified by ICD–10–PCS code XW01348.

   The maximum new technology add-on payment for a case involving the use of TECVAYLI™ is $8,940.54.

8. *TERLIVAZ® (terlipressin)* (Page 588)

   Cases involving the use of TERLIVAZ® that are eligible for new technology add-on payments will be identified by ICD–10–PCS codes: XW03367 (Introduction of terlipressin into peripheral vein, percutaneous approach, new technology group 7) or XW04367 (Introduction of terlipressin into central vein, percutaneous approach, new technology group 7).

The maximum new technology add-on payment for a case involving the use of TERLIVAZ® is $16,672.50.

FY 2024 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 635)

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 the proposed rule. Subsequently, prior to the issuance of this final rule, seven additional applicants withdrew their respective applications for Selux NGP System, Total Ankle Talar Replacement, Transdermal GFR Measurement System utilizing Lumitrace, Ceribell Delirium Monitor, NUsurface, 4WEB Ankle Truss System, and the Nelli® Seizure Monitoring System. One applicant, LimFlow (the applicant for the LimFlow System), did not meet the July 1 deadline for FDA approval or clearance of the technology and, therefore, the technology is not eligible for consideration for new technology add-on payments for FY 2024. Of the remaining 12 applications, CMS is approving 11 and conditionally approving 1 for new technology add-on payments for FY 2024.

Alternative Pathway for Breakthrough Devices

1. *AveirTM AR Leadless Pacemaker* (Page 637)

   Cases involving the use of the AveirTM AR Leadless Pacemaker that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code X2H63V9 (Insertion of dual-chamber intracardiac pacemaker into right atrium, percutaneous approach, new technology group 9).

   The maximum new technology add-on payment for a case involving the use of AveirTM AR Leadless Pacemaker is $10,725.

2. *Aveir™ Leadless Pacemaker (Dual-Chamber)* (Page 648)

   Cases involving the use of Aveir™ Leadless Pacemaker that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure codes X2H63V9 (Insertion of dual-chamber intracardiac pacemaker into right atrium, percutaneous approach, new technology group 9) in combination with X2HK3V9 (Insertion of dual-chamber intracardiac pacemaker into right ventricle, percutaneous approach, new technology group).

   The maximum new technology add-on payment for a case involving the use of Aveir™ Leadless Pacemaker is $15,600.

3. *Canary Tibial Extension (CTE) with Canary Health Implanted Reporting Processor (CHIRP) System* (Page 654)

   Cases involving the use of the CTE with CHIRP System that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure codes XNHG0D9 (Insertion of tibial extension with motion sensors into right tibia, open approach, new technology group 9) or XNHH0D9 (Insertion of tibial extension with motion sensors into left tibia, open approach, new technology group 9).

   The maximum new technology add-on payment for a case involving the use of the CTE with CHIRP System is $850.85 for one knee or $1,701.70 for two knees.

4. *CERIBELL STATUS EPILEPTICUS MONITOR* (Page 660)

Cases involving the use of the Ceribell Status Epilepticus Monitor that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code XX20X89 (Monitoring of brain electrical activity, computer-aided detection and notification, new technology group 9).

The maximum new technology add-on payment for a case involving the use of the Ceribell Status Epilepticus Monitor is $913.90.

5. *DETOUR System* (Page 667)

Cases involving the use of the DETOUR System that are eligible for new technology add-on payments will be identified by one of the following ICD–10–PCS procedure codes: X2KH3D9 (Bypass right femoral artery using conduit through femoral vein to superficial femoral artery, percutaneous approach, new technology group 9), X2KH3E9 (Bypass right femoral artery using conduit through femoral vein to popliteal artery, percutaneous approach, new technology group 9), X2KJ3D9 (Bypass left femoral artery using conduit through femoral vein to superficial femoral artery, percutaneous approach, new technology group 9), or X2KJ3E9 (Bypass left femoral artery using conduit through femoral vein to popliteal artery, percutaneous approach, new technology group 9).

The maximum new technology add-on payment for a case involving the use of the DETOUR is $16,250.

6. *EchoGo Heart Failure 1.0* (Page 672)

Cases involving the use of EchoGo Heart Failure 1.0 that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code XXE2X19 (Measurement of cardiac output, computer-aided assessment, new technology group 9).

The maximum new technology add-on payment for a case involving the use of EchoGo Heart Failure is $1,023.75.

7. *Phagenyx® System* (Page 679)

Cases involving the use of the Phagenyx® System that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code XWHD7Q7 (Insertion of neurostimulator lead into mouth and pharynx, via natural or artificial opening, new technology group 7).

The maximum new technology add-on payment for a case involving the use of the Phagenyx® System is $3,250.

8. *SAINT Neuromodulation System* (Page 684)

Cases involving the use of the SAINT Neuromodulation System that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code X0Z0X18 (Computer-assisted transcranial magnetic stimulation of prefrontal cortex, new technology group 8).

The maximum new technology add-on payment for a case involving the use of the SAINT Neuromodulation System is $12,675.00.

9. *TOPSTM System* (Page 691)

Cases involving the use of the TOPS™ System that are eligible for new technology add-on payments will be identified by ICD–10–PCS code XRHB018 (Insertion of posterior spinal motion preservation device into lumbar vertebral joint, open approach, new technology group 8) in combination with ICD-10-CM code M48.062 (Spinal stenosis, lumbar region, with neurogenic claudication).

The maximum new technology add-on payment for a case involving the use of the TOPS™ System is $11,375.

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

1. *taurolidine/heparin* (Page 696)

Cases involving the use of taurolidine/heparin that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code XY0YX28 (Extracorporeal introduction of taurolidine anti infective and heparin anticoagulant, new technology group 8).

The maximum new technology add-on payment for a case involving the use of taurolidine/heparin is $17,111.25.

2. REZZAYO™ *(rezafungin for injection)* (Page 701)

Cases involving the use of REZZAYO™ that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure codes: XW033R9 (Introduction of rezafungin into peripheral vein, percutaneous approach, new technology group 9) or XW043R9 (Introduction of rezafungin into central vein, percutaneous approach, new technology group 9).

The maximum new technology add-on payment for a case involving the use of REZZAYO™ is $4,387.50.

3. *XACDURO® (sulbactam/durlobactam)* (Page 705)

Cases involving the use of XACDURO® that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure codes XW033K9 (Introduction of sulbactam-durlobactam into peripheral vein, percutaneous approach, new technology group 9) or XW043K9 (Introduction of sulbactam/ durlobactam into central vein, percutaneous approach, new technology group 9) in combination with one of the following ICD-10-CM codes: Y95 and J15.6 (describing HABP due to Acinetobacter baumannii); or J95.851 and B96.89 (describing VABP due to Acinetobacter baumannii).

The maximum new technology add-on payment for a case involving the use of XACDURO® is $13,680.

VII HOSPITAL READMISSIONS REDUCTION PROGRAM: UPDATES AND CHANGES (§§ 412.150 THROUGH 412.154) (Page 1,073)

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 were no proposals or updates 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 2,855 hospitals representing 84.12% of all hospitals will be penalized in FY 2024. (Page 2,067)

VIII. HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM: POLICY CHANGES (Page 1,075)

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:

- Adopting 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.
- Adopting 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.
- Adopting the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning with the FY 2026 program year.
- Adopting changes to the administration and submission requirements of the HCAHPS survey measure beginning with the FY 2027 program year.
- Adopting 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.
- Modifying the TPS maximum to be 110, such that the numeric score range would be 0 to 110.
- Codifying are the measure removal factors, the health equity scoring change, and modification of the TPS, numeric, score range, and the minimum number of cases.

Comment

This section extends more than 120 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 1,197)

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 did not propose to add or remove any measures from the HAC Reduction Program.

CMS is:

- Establishing a validation reconsideration process for hospitals that failed to meet data validation requirements, beginning with the FY 2025 program year, affecting CY 2022 discharges.
- Modifying 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.

X. CHANGES TO THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM
(Page 1,295)

CMS is finalizing the adoption of 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 finalizing modifications to three current measures:

- Hybrid hospital-wide all-cause risk standardized mortality measure beginning with the FY 2027 payment determination. CMS is finalizing modification of this measure to include Medicare Advantage (MA) admissions.
- Hybrid hospital-wide all-cause readmission measure beginning with the FY 2027 payment determination. CMS is finalizing modification of this measure to include MA admissions.
- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure beginning with the FY 2025 payment determination. The prior version of this measure reported on the primary vaccination series only, while the updated version of the measure reports 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 change 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 removing three measures:

- Hospital-level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure beginning with the April 1, 2025, through March 31, 2028, reporting period/FY 2030 payment determination. CMS is finalizing removal of this measure under the Hospital IQR Program in conjunction with the adoption of the recent updates to this measure in the Hospital Value-Based Purchasing Program.

- Medicare Spending Per Beneficiary (MSPB) Hospital measure beginning with the CY 2026 reporting period/FY 2028 payment determination. CMS is finalizing removal of this measure under the Hospital IQR Program in conjunction with the adoption of the recent updates to this 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 beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS is finalizing the removal of 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"). The measure has been topped out for the last six performance periods. While CMS recognizes disparities persist in maternal health, it believes removal of the Elective Delivery measure will create room to add additional meaningful maternal health outcome measures in the future.

CMS is finalizing updates to the data submission and reporting requirements for 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, removal of the survey's prohibition on proxy respondents, extension of 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 a 2021 mode experiment, these changes, which are also being made in the Hospital VBP and PCHQR Programs, resulted in higher response rates and better representation of younger, Spanish language-preferring, racial and ethnic minority, and maternity care patients.

CMS presents tables reflecting Summaries of Previously Finalized Hospital IQR Program Measures from FY 2025 through 2028. (Beginning on Page 1,416)

XI. UPDATES TO THE PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING (PCHQR) PROGRAM (Page 1,474)

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 finalizing the following:

- Beginning public display of the Surgical Treatment Complications for Localized Prostate Cancer measure beginning with data from the FY 2025 program year.
- Adoption of 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.
- Modifying the COVID-19 Vaccination among HCP measure, in alignment with the Hospital IQR Program and LTCH QRP.

- Modifying 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 1,546)

LTCHs that do not meet LTCH QRP reporting requirements are subject to a 2.0 percentage point reduction in their annual percentage update.

CMS is finalizing the following:

- Beginning with the FY 2026 LTCH QRP, CMS is adopting 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 is adopting the Functional Discharge Score (DC Function) measure.
- Beginning with the FY 2025 LTCH QRP, CMS is adopting 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 is adopting the removal of 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 is adopting the removal of 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 is adopting 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 is seeking 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).

Comment

The hospital, IQR, PPS-Exempt Cancer Quality Reporting and the LTCH QRP IOR extend more than 300 pages. The above material is from a CMS fact sheet. The rule simply contains too much detail.

XIII. CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM (Page 1,630)

The following is from a CMS fact sheet.

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

- Modifying 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.

- Amending 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.
- Amending the definition of "EHR reporting period for a payment adjustment year" such that eligible hospitals that have not successfully demonstrated meaningful EHR use in a prior year will not be required 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.
- Modifying 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 for these objectives and measures would read "N/A (measure is Yes/No)."
- Adopting three new eCQMs eligible hospitals, and CAHs can 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
    - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level - Inpatient) eCQM

XIV. PHYSICIAN SELF-REFERRAL LAW: PHYSICIAN-OWNED *HOSPITALS* (Page 1,681)

The following is from CMS' fact sheet

For a hospital to submit claims and receive Medicare payment for services referred by a physician owner or investor (or a physician whose family member is an owner or investor), the hospital must satisfy all of the requirements of either the whole hospital exception or the rural provider exception to the physician self-referral law, commonly referred to as the "Stark Law."

To use the rural provider exception or the whole hospital exception, a hospital may not increase the aggregate number of operating rooms, procedure rooms, and beds above that for which the hospital was licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider agreement in effect as of March 23, 2010, but did have a provider agreement in effect on December 31, 2010, the effective date of such agreement), unless CMS has granted an exception to the prohibition on expansion. A hospital may request an exception to the prohibition on expansion of facility capacity using the process established in the calendar year (CY) 2012 hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system final rule.

CMS is:

- Revising the regulations to clarify that CMS will only consider expansion exception requests from eligible hospitals, clarifying the data and information that must be included in an expansion exception request, identifying factors that CMS will consider when making a decision on an expansion exception request, and revising certain aspects of the process for requesting an expansion exception.

- Reinstating, with respect to hospitals that meet the criteria for "high Medicaid facilities," program integrity restrictions on the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity that were removed in the CY 2021 OPPS/ASC final rule.

XV. CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2024 (Page 1,242)

Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Classifications and Relative Weights for FY 2024 (Page 1,279)

The rule's table 11, available via the Internet on the CMS website, lists the 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 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.

Comment

The rule says a copy of table 11 is available in section VI of the addendum. We cannot find such.

Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2024 (Pages 1,280 and 1,938)

CMS is establishing an annual update to the LTCH PPS standard Federal payment rate of 3.3% (that is, the most recent estimate of the LTCH PPS market basket increase of 3.5% less the productivity adjustment of 0.2 percentage point).

For LTCH that fail to provide quality data the 3.3% is reduced by 2.0% for an overall increase of 1.3%. (Page 1,939)

> CMS is applying an update factor of 1.033 to the FY 2023 LTCH PPS standard Federal payment rate of $46,432.77 to determine the FY 2024 LTCH PPS standard Federal payment rate. CMS has determined a FY 2024 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 1.0031599

Thus, the LTCH PPS standard payment rate for FY 2024 is **$48,116.62** (calculated as $46,432.77 x 1.033 x 1.0031599). (Page 1,940)

For LTCHs that fail to submit quality reporting data for FY 2024, CMS the LTCH PPS standard Federal payment rate is $47,185.03 (calculated as $46,432.77 x 1.013 x 1.0031599).

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.

CMS is finalizing a total labor-related share for FY 2024 of 68.5% (the sum of 64.3% for the labor-related share of operating costs and 4.2% for the labor-related share of capital-related costs). The current rate is 68.0%. (Page 1,947)

Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Page 1,973)

For LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 7.975% of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

CMS currently estimates that actual high-cost outlier payments accounted for 11.1 and 11.9% of total LTCH PPS standard Federal payment rate payments in FY 2021 and FY 2022, respectively. CMS also currently projects that in FY 2023, high-cost outlier payments will be approximately 10.9% of the estimated total LTCH PPS standard Federal payment rate payments.

CMS is "establishing a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2024 of **$59,873** that will result in estimated outlier payments projected to be equal to 7.975% of estimated FY 2024 payments for such cases." (Page 1,978)

High-Cost Outlier Payments for Site Neutral Payment Rate Cases (Page 1,978)

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 establishing a fixed-loss amount for site neutral payment rate cases of **$42,750**, which is the same FY 2024 IPPS fixed-loss amount.

TABLES (Page 1,988)

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 Rule Home Page" or "Acute Inpatient-Files- for Download."

Table 2.	Case-Mix Index and Wage Index Table by CCN—FY 2024 Final Rule
Table 3.	Wage Index Table by CBSA—FY 2024 Final Rule
Table 4A.	List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2024 Final Rule
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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:

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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.