American College of Radiology™

Fiscal Year 2024 Inpatient Prospective Payment System Final Rule
Detailed Summary

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

Finalized Payment Updates for FY 2024
CMS finalized a base FY 2023 IPPS payment update of +3.1%. This is based on a market basket update of 3.3 percent, reduced by a statutorily required 0.2 percentage point multifactor productivity (MFP) adjustment. CMS will also reduce the market basket increase portion of the formula by one-quarter for hospitals that fail to submit quality data; and a three-quarters reduction of the market basket increase portion of the formula for hospitals not considered "meaningful EHR users."

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

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

FY 2024 Applications for New Technology Add-On Payments
To increase transparency and improve the efficiency of the New Technology Add-on Payment (NTAP) program and application process, CMS finalized the policy to require NTAP applicants for technologies that

are not already FDA market authorized to have a complete and active FDA market authorization application request at the time of submission of NTAP application submission. CMS will move the FDA approval deadline from July 1 to May 1, beginning with applications for FY 2025. CMS believes these policy changes would improve the completeness of submitted NTAP applications, allow for a fuller analysis and improved ability for CMS to identify eligibility concerns for the proposed rule, and allow the agency and the public to analyze applications and supporting data to inform a final decision more knowledgeably.

CMS received 27 applications for new technology add-on payments for FY 2024 under the traditional new technology add-on payment pathway. Eight applicants withdrew their applications prior to the release of the FY 2024 IPPS proposed rule. CMS is approving the 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.

Changes to the Hospital Wage Index for Acute Care Hospitals

CMS finalized the FY 2024 wage index update using wage data from cost reporting periods beginning in FY 2019. For FY 2024, CMS will continue temporary policies finalized in the FY 2021 IPPS final rule to address disparities in wage index affecting low-wage index hospitals. This includes many rural hospitals. CMS believes it is appropriate to continue these policies because currently, only one relevant year of data is available (from FY 2020) to measure the impacts. CMS will continue to obtain and review additional data.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

Medicare makes DSH payments to IPPS hospitals that serve a significantly disproportionate number of low-income patients.

CMS finalized the proposal to update their estimates of three factors used to determine uncompensated care payments for FY 2024. Consistent with the regulation at §412.106(g)(1)(iii)(C)(11), which was adopted in the FY 2023 IPPS/LTCH PPS final rule, for FY 2024, CMS will use the 3 most recent years of audited data on uncompensated care costs from Worksheet S–10 of the FY 2018, FY 2019, and FY 2020 cost reports to calculate Factor 3 in the uncompensated care payment methodology for all eligible hospitals.

States use section 1115 demonstrations to test changes to their Medicaid programs that generally cannot be made using other Medicaid authorities. For FY 2024, CMS finalized the policy regarding the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations in the Medicaid fraction of a hospital's disproportionate patient percentage (DPP) used in the DSH calculation. Under this finalized policy, only the days of those patients who receive from the demonstration either health insurance that covers inpatient hospital services, or premium assistance that covers 100% of the premium cost to the patient (which the patient uses to purchase health insurance), are to be included.

Beginning with FY 2023, CMS established a supplemental payment for Indian Health Service (IHS) and Tribal hospitals and hospitals located in Puerto Rico, to help prevent undue long-term financial disruption to these hospitals due to discontinuing use of the low-income insured days proxy in the uncompensated care payment methodology for these providers. This payment was established to help to mitigate the

impact of the decision to discontinue the use of low-income insured days as proxy for uncompensated care costs for these hospitals and to prevent undue long-term financial disruption for these providers. CMS projects Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments combined will decrease in FY 2024 by approximately $115 million.

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

Hospital Readmissions Reduction Program
CMS did not finalize any changes to the Hospital Readmissions Reduction Program.

Hospital Value-Based Purchasing (VBP) Program
CMS finalized the proposal to adopt modified versions of the Medicare Spending Per Beneficiary (MSPB) Hospital measure beginning with the FY 2028 program year, as well as the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with the FY 2030 program year. CMS finalized the proposal to adopt the Severe Sepsis and Septic Shock: Management Bundle measure beginning with the FY 2026 program year.

CMS finalized the proposal to adopt changes to the data submission and reporting requirements of the HCAHPS survey measure under the VBP program to be in alignment with the Hospital IQR Program, beginning with program year FY 2027.

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

would generally be paid if the demonstration had not been implemented. The estimated neutrality offset amount is $37.7 million.

Modification of the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) Measure in the Hospital IQR Program, PCHQR Program, and LTCH QRP

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

Hospital Inpatient Quality Reporting (IQR) Program

CMS finalized the adoption of three new quality measures into the Hospital Inpatient Quality Reporting (IQR) program as proposed in the FY 2024 IPPS/LTCH PPS proposed rule. While two focus on hospital harm and are not attributed to radiologic care, the third, Excessive radiation dose or inadequate image quality for diagnostic computed tomography (CT) in adults, addresses radiation dosing. CMS has also finalized the proposal to remove the Medicare spending per beneficiary (MSPB) hospital cost measure beginning with the FY 2028 payment determination with plans to adopt the updated version proposed for adoption into the Hospital Value-Based Purchasing Program. CMS has accepted two changes to current IQR program policies related to data submission, reporting, and validation.

CMS also finalized the proposal to revise health equity scoring so that it will reward excellent care in underserved populations, such that a health equity adjustment would be added to hospitals' Total Performance Scores (TPS) based on both a hospital's performance on existing Hospital VBP Program measures and the proportion of individuals with dual eligibility status that a hospital treats.