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BY:

**Chad Krcil**
Managing Director, The BDO Center for Healthcare Excellence & Innovation

**Venson Wallin**
Managing Director, The BDO Center for Healthcare Excellence & Innovation

# CMS Releases Final FY 2024 Medicare Inpatient Prospective Payment System (IPPS) Regulations

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# At a Glance

Per the BDO 2023 Healthcare CFO Outlook Survey, the healthcare system is showing some improvement after navigating the effects of the COVID pandemic for more than three years. In order to close gaps in the continuum of care, healthcare organizations need to find a new way forward. The healthcare industry's rocky path through the pandemic has forced CFOs to find innovative solutions for patient care, cash and coordination, and creativity to face both long-term and short-term challenges.

To continue to lead their organizations and prioritize these initiatives, organizations will also need to focus on changing Medicare policies and updated payment rates, given the effects they will have on margins.

Each year the Centers for Medicare & Medicaid Services (CMS) publishes the proposed, and then final, rules for the Inpatient Prospective Payment System (IPPS), updating Medicare payment

regulations and rates. The final rule for FY 2024 was released on August 1, 2023.

**Highlights Include:**

- Increase in IPPS operating payments for FY 2024 is estimated to be $2.2 billion.
- Uncompensated care payments (UCC) and Disproportionate Share payments, as well as other payments, are estimated to decrease by over $950 million.
- CMS made permanent the cap on 5% decrease to a hospital's wage index regardless of circumstances for decline in FY 2023 and this continues in FY 2024.
- Graduate medical education payment revisions were made regarding Rural Emergency Hospitals (REH). This change was made to address rural health access concerns and allow training of residents in rural areas.
- CMS is utilizing the best data available to set FY 2024 rates by using March 2023 update to the FY 2022 MedPAR claims data and most recent cost report data from the March 23 HCRIS update.

**Quality Care incentive changes will affect Medicare payments as follows:**

- Hospital Readmissions Reduction (HRR) Program-DRG payments reduction will impact 2,356 hospitals.
- Hospital Acquired Conditions (HAC) Reduction Program for FY 2024 will introduce a validation reconsideration process.
- Value Based Incentive based Payment Program (VBP)- Budget Neutral with an expected pool of $1.7 billion available for VBP incentives.
- Health Equity impacts will continue to expanded the measurement of policies on health equity in FY 2024 by adding 15 new health equity categorizations for IPPS payment impacts.
- FY 2024 rules change the Social Determinants of health diagnosis codes for homelessness from non-complication or comorbidity to complication or

comorbidity.

# Finalized Rates

Below is a table showing the final rate increases for FY 2024 based on four scenarios on whether the provider submits quality data and is a meaningful user of Electronic Health Records (EHR).

## Table 1

| **FY 2023** | **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 per Affordable Care Act (ACA) | - | - | (0.825) | (0.825) |
| Adjustment for Failure to be a Meaningful EHR user per ACA | - | (2.475) | - | (2.475) |
| | | | | |

| | | | | |
|---|---|---|---|---|
| MFP Adjustment under Section per ACA | (0.2) | (0.2) | (0.2) | (0.2) |
| Applicable Percentage Increase applied to Standardized Amount | 3.1 | 0.625 | 2.275 | (0.2) |
| Documentation and Coding Adjustment – American Tax Payer Relief Act of 2012 (Section 414 of the Medicare Access and Chip Reauthorization Act of 2015) | 0.0 | 0.0 | 0.0 | 0.0 |
| Increase in Operating Rates | 3.1 | .0625 | 2.275 | 0.2 |

Table 1A shows the updated National Adjusted Operating Standardized amounts based on the rate updates per Table 1A For FY 2024, the full increase for a hospital that reports quality data and is a Meaningful EHR user will be 3.1%.

## Table 1A.

**National Adjusted Operating Standardized Amounts; Labor/Nonlabor (67.6% Labor Share/32.4% Nonlabor Share If Wage Index Is Greater Than 1)**

| Hospital Submitted Quality Data and is a Meaningful EHR User Update = 3.1% | | Hospital Submitted Quality Data and is NOT a Meaningful EHR User Update = 0.625% | | Hospital Did NOT Submit Quality Data and is a Meaningful EHR User Update = 2.275% | | Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User Update = (0.2%) | |
|---|---|---|---|---|---|---|---|
| Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related |
| $4,392.49 | $2,105.28 | $4,287.05 | $2,054.74 | $4,357.34 | $2,088.44 | $4,251.90 | $2,037.89 |

## Table 1B.

**National Adjusted Operating Standardized Amounts; Labor/Nonlabor (62% Labor Share/38% Nonlabor Share If Wage Index Is Less Than or Equal To 1)**

| Hospital Submitted Quality Data and is a Meaningful EHR User Update = 3.1% | | Hospital Submitted Quality Data and is NOT a Meaningful EHR User Update = 0.625% | | Hospital Did NOT Submit Quality Data and is a Meaningful EHR User Update = 2.275% | | Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User Update = (0.2%) | |
|---|---|---|---|---|---|---|---|
| Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related | Labor-related | Nonlabor-related |
| $4,028.62 | $2,469.15 | $3,931.91 | $2,409.88 | $3,996.38 | $2,499.39 | $3,899.67 | $2,390.12 |

The rate increases, coupled with other changes to IPPS payment policies, will increase IPPS operating payments by approximately 3.1%. The overall increase in IPPS payments in FY 2022 will be approximately $2.2 billion in increased Medicare payments in FY 2024 as shown in Table 2.

This increase is significantly driven by the increase in IPPS rates as shown in Table 1.

# Capital Payments

Per Table 1C, the capital rate increased by 4.14% to $503.83 for FY 2024 which will increase capital payments by $474,000,000 per Table 2.

## Table 1C. Capital Standard Federal Payment Rate

| | **FY 2023 Rate** | **FY 2024 Rate** |
|---|---|---|
| National | $483.76 | $503.83 |

## Table 2

| | |
|---|---|
| Operating Payments\DSH\UCC | $2,100,000,000 |
| Capital Payments | $474,000,000 |
| New Technology Add-On Payments | $(346,000,000) |
| **Estimated Increase in Payments** | **$2,210,000,000** |

The combined IPPS operating payment and uncompensated care payments increased by $2,200,000,000—it is important to note that this includes a $950 million decrease in uncompensated care payments as outlined in the Disproportionate Share Hospital (DSH) and Uncompensated Care section of this summary.

The below summary of the FY 2024 IPPS Medicare rules will highlight the changes that will drive the increased rates and additional Medicare payments for FY 2024.

The impacts do not include the 2% Medicare sequestration reduction. This reduction began in FY 2013 and would have run through 2028 without legislation to discontinue this reduction or increase the length of time it is in effect. The Coronavirus Aid, Relief, and Economic Security (CARES) Act passed for COVID-19 relief for healthcare providers temporarily halted the sequestration reduction beginning May 1, 2020-Dec 31, 2020, thus extending the sequestration

period through 2030 absent any further regulations. On April 15, 2021, President Biden signed into law a bill that extended the pause on the 2% sequestration cut through the end of 2021 and was again extended through March 31, 2022. 1% sequestration was in effect April 1-June 30, 2022 and the full 2% began July 1, 2022.

# FY 2024 MS-DRG Relative Weights

FY 2007 ushered in a new era of relative DRG weights based on Medicare cost report data instead of charges. The data utilized in the cost-based weighting methodology for setting the Medicare Severity Diagnosis Related Groups (MS-DRG) weights are claims data from the FY 2022 MEDPAR file using diagnostic and procedure data for all Medicare inpatient bills and cost report data from the HCRIS data set that is three years prior to the IPPS fiscal year, which is FY 2021 Medicare cost reports.

In FY 2024, CMS will update 19 national average cost to charge ratios (CCRs) based on FY 2021 Medicare cost report data and the FY 2022 MEDPAR file that will be utilized for updating FY 2024 MS-DRGs are identified in Table 3 CCRS.

## Table 3

| **Group** | **2024 Final 19 CCRs** |
|---|---|
| Routine Days | 0.422 |
| Intensive Days | 0.345 |
| Drugs | 0.187 |
| Supplies & Equipment | 0.297 |
| Implantable Devices | 0.293 |
| Therapy Services | 0.288 |
| Laboratory | 0.106 |
| Operating Room | 0.167 |

| | |
|---|---|
| Cardiology | 0.094 |
| Cardiac Catheterization | 0.100 |
| Radiology | 0.136 |
| MRI | 0.070 |
| CT Scans | 0.034 |
| Emergency Room | 0.147 |
| Blood | 0.270 |
| Other Services | 0.344 |
| Labor & Delivery | 0.359 |
| Inhalation Therapy | 0.147 |
| Anesthesia | 0.071 |

# MS-DRG Documentation and Coding Adjustment

The methodology for MS-DRG adoption in FY 2008 created an $11 billion overpayment due to documentation and coding that did not reflect real changes in case mix. The American Taxpayer Relief Act of 2012 (ATRA) required an adjustment to FY 2014-2017 to recoup this amount. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) instituted a 0.5% positive adjustment to Medicare payments for FY 2018-2023 to standardize the payments. The 0.5% adjustment is no longer reflected in the market basket update for FY 2024 per Table 1. Commenters per the final rule are concerned that the past adjustments have only repaid 2.9588 of the total 3.9% reduction. CMS contends in the final 2024 rule that based on Section 414 of the MACRA and Section 15005 of the 21st Century Cures Act the levels of positive adjustments were to occur for FYs 2018-2023 and that FY 2023 is the final prescribed adjustment.

## Outlier Payment

Additional payments are made in addition to MS-DRG payments for high-cost cases. To qualify for outlier payments, a case must have incurred costs that are more than the combined payment for the case including MS-DRG, indirect medical education (IME), DSH uncompensated care and new technology payments plus the outlier threshold amount. The outlier amount for FY 2024 will be $42,750. The outlier threshold is estimated to result in outlier payments that are 5.12% of operating DRG payments and 5.31% of capital payments.

To fund the operating and capital outlier payments, CMS will apply an adjustment of 0.949 to the operating standardized amount and 0.959757 to the capital federal rate.

# Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

Section 3133 of the Affordable Care Act modified the Medicare disproportionate share hospital payment methodology beginning in FY 2014. Also, beginning in FY 2014, DSH hospitals began receiving 25% of the amount they previously would have been reimbursed under the traditional Medicare DSH formula. The remaining 75% adjusted for the percent of uninsured will be paid through the uncompensated care reimbursement methodology outlined below and updated for FY 2024.

### FACTOR 1

Estimate of 75% (100% minus 25%) of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year FY 2024:

$13,353,588,029 * 75 = $10,015,191,022 = Uncompensated Care Pool

$13,353,588,029 * 25 = $ 3,338,397,008 = Empirical DSH payments

### FACTOR 2

The Affordable Care Act established Factor 2 in the calculation of the uncompensated care payment. Specifically, the Act provides that for FYs 2014, 2015, 2016 and 2017, a factor equal to 1

minus the percent change in the percent of individuals under the age of 65 who are uninsured as determined by comparing the percent of such individuals who are uninsured in 2013, the last year before coverage expansion under the Affordable Care Act, to that same percent for the year in question.

In FY 2018 and forward, the act authorized the use of data sources other than Congressional Budget Office (CBO) estimates to determine the uninsured percentage as determined by the Secretary based on data from the Census Bureau or other source determined appropriate by the Secretary and certified by the Chief Actuary of CMS. The Act also does not require that the percentage of individuals be limited to those under the age of 65 for FY 2018 and forward.

The criteria that was set for determining a data source are as follows:

- The source accounts for the full U.S. population
- Comprehensively accounts for both public and private health insurance coverage
- Utilized data from the Census Bureau
- Timeliness of the estimates
- Continuity of the estimates over time
- Accuracy of estimates
- Availability of projections

The source determined in FY 2018 that meets these criteria is data from CMS' Office of the Actuary (OACT), derived as part of the development of the National Health Expenditure Accounts (NHEA) which represents official estimates of the economic activity within healthcare according to CMS. This data estimated the uninsured rate for 2013 was 14% and for 2024 is 9.20%.

Based on this information the calculation of Factor 2 for FY 2022 is as follows: 1-((0.14-0.083)/0.14) =1-0.4071=0.5929

**FACTOR 3**

Factor 3 is a hospital-specific value that identifies the share of the estimated uncompensated care amount for each hospital receiving Medicare DSH payments.

The hospital's Cost of Uncompensated care is from the Medicare cost report, WS S-10 Ln 30- comprised of the following elements:

- Cost of charity care (Line 23)
- Non-Medicare and non-reimbursable Medicare bad debt (Line 29)

CMS will utilize the data from FY 2018, 2019 and 2020 Medicare cost reports as these are the most recent audited data and the results of those audits are available for FY 2024. The methodology will average these three years for factor three to determine the UC costs.

Below is a summary of the three factors used for the uncompensated care payments since FY 2014:

| FYE | DSH Estimate | Factor 1 (75% of total DHS) | Percentage of Uninsured | Factor 2 Percentage | Factor 2 Dollar Amount |
|---|---|---|---|---|---|
| 2014 | 12,772,000,000 | 9,579,000,000 | 17.00% | 94.30% | 9,032,997,000 |
| 2015 | 13,383,462,196 | 10,037,596,647 | 13.75% | 76.19% | 7,647,644,885 |
| 2016 | 13,411,096,528 | 10,058,322,396 | 11.50% | 63.69% | 6,406,145,534 |
| 2017 | 14,396,635,710 | 10,797,467,782 | 10.00% | 55.36% | 5,977,483,146 |
| 2018 | 15,552,939,524 | 11,664,704,643 | 8.15% | 58.01% | 6,766,695,164 |
| 2019 | 16,294,703,939 | 12,221,027,954 | 9.48% | 67.51% | 8,250,415,972 |
| 2020 | 16,583,455,657 | 12,437,591,743 | 9.40% | 67.14% | 8,350,599,096 |
| 2021 | 15,170,673,476 | 11,378,005,107 | 10.02% | 72.86% | 8,290,014,521 |
| 2022 | 13,984,752,728 | 10,488,564,546 | 9.60% | 68.57% | 7,192,008,709 |
| 2023 | 13,948,974,706 | 10,461,731,029 | 9.2% | 65.71% | 6,874,403,459 |
| 2024 | 13,353,588,029 | 10,015,191,022 | 8.3% | 59.29% | 5,938,006,757 |

The projected decrease in payments for UCC for FY 2024 from FY 2023 is $936 million which is a 13.62 percent decrease in payments for UC and DSH payments.

CMS has also used this final rule to finalize the proposed change to Section 1115 days that can be included in the Medicaid fraction of the DSH payment calculation. The resulting impact of the reduction in days due to this new policy will be to decrease Medicare DSH payments. The days reduction could also significantly impact 340B qualification as well as increase the risk of hospitals not qualifying for DSH and uncompensated care payments.

Days for these patients can be included under the following conditions:

- Health insurance covers inpatient hospital services
- Assistance covering 100% of the patient's premium
- The premium must be utilized to by health insurance covering inpatient hospital services
- Patient cannot be entitled to Medicare Part A
- Days of patients paid from demonstration uncompensated care pools must be excluded 10

# Other DSH Day Developments

Over the past year, there have been some additional developments based on long standing disputes over inclusion of days in the Medicare Fraction or Medicaid Fraction as described below:

**Exhausted PT A Non-Covered Days**

- Supreme Court Decision in June, 2023
- Empire Health Foundation
- Days are entitled to Pt A Benefits therefore they should be included in Medicare fraction and excluded from the Medicaid fraction
- Issue is still being litigated regarding entitled to Supplemental Security Income (SSI) benefits

**Part C Days**

- Azar v. Allina Health Services – June, 2019
- Azar case ordered CMS to vacate policy of including Part C days in Medicare fraction
- CMS issued a finalized policy on June 7, 2023
- Policy states Part C days should be included in Medicare fraction for discharges prior to October 2013 with an effective date of August 8, 2023
- Revised NPRs will be issued
- Challenges based on this revised policy can be submitted through appeals of these NPRs

# Capital DSH Reimbursement

Urban hospitals with 100 or more beds are eligible for Capital DSH under current regulations. This policy excluded Capital DSH payments to urban hospitals that reclassified as rural. Toledo Hospital v. Becerra in September of 2021 ruled that this interpretation was incorrect. The final rule finalized this proposal effective for discharges occurring on or after October 1, 2023. CMS also made clear that this rule is not retroactive and the prior rules excluding payment for DSH capital prior to October 1, 2023 is still in effect.

# Medicare Bad Debts

Medicare beneficiaries are responsible for their share of related covered services in the form of deductibles and coinsurance Medicare provides reimbursement for Medicare bad debt created when Medicare beneficiaries cannot pay the deductible and coinsurance amounts. An allowable Medicare bad debt must meet all the criteria set forth in Section 413.89(e)and the Provider Reimbursement Manual (PRM), Chapter 3, Section 308. Congress passed legislation implementing a moratorium stopping the HHS Secretary from making changes to Medicare bad debt reimbursement policies that were in effect on Aug 1, 1987. This prohibition was known as the Bad Debt Moratorium. The moratorium was repealed by Congress in the Middle-Class Tax Relief and Job Creation Act of 2012, effective for cost reporting periods beginning on or after Oct. 1, 2012.

With no prohibition in place, in FY 2021, CMS clarified Medicare bad debt policies that have generated litigation and questions over the past years. The changes updated and put into code longstanding Medicare bad debt principles by revising Section 413.89, Bad Debts, Charity and Courtesy allowances. BDO's insight article on CMS FY 2021 Medicare IPPS regulations dated

October 2020 summarized these changes.

There were no significant changes to Medicare bad debt regulations in FY 2024 rules but there were changes in reporting requirements as identified below along with DSH and Charity Care reporting per Transmittal 18.

# Transmittal 18

Prior to the FY 2024 rule being issued, on December 29, 2022, Transmittal 18 was released. This transmittal was effective for all cost reports beginning after October 1, 2022. The first cost reporting period affected by these changes is FYE: 9/30/2023. Specifically, the transmittal implemented additional Exhibits or changes to existing Exhibits for reporting of the following data:

- Medicare bad debts
- Medicaid Eligible days for DSH
- Charity Care charges by patient
- Total bad debts by patients

The new requirements introduced or revised reporting of elements for these areas which will increase the complexity of reporting for reimbursement on the Medicare cost report. Along with increased work involved it will also bring increased compliance scrutiny and MAC audit risk.

# 340B Drug Developments

The 340B Drug discount program provides an avenue for qualified hospitals to purchase drugs at a discounted rate and then CMS will reimburse at ASP+6% up to FYE 2018. At this point, CMS changed the reimbursement to ASP-22.5% sparking a long legal battle between hospitals and CMS. Due to the United States District Court for the District of Columbia and the United States Supreme Court's outcomes in the American Hospital Association vs. Becerra, the 340B reimbursement reduction was vacated and the ASP+6% reimbursement methodology was reinstated. CMS was advised to develop remedy options for repayment of the amounts that were reduced. CMS released a proposed rule on July 7, 2023 which outlines how the hospital's will be made whole due to the reversal of the ASP-22.5% payment policy for drugs purchased through the 340B program from January 2018-September 27, 2022.

Hospitals had until September 5, 2023, which was extended to September 11, 2023, to provide comments on the proposed rule. CMS is proposing to provide a lump sum payment for claims from January 1, 2018 through September 27, 2022 that would be owed to them under the reinstated ASP+6% methodology. The impact of this change would be reduced by the number of claims that had been reprocessed for claims between January 1, 2022-September 27, 2022. The results of this repayment would be budget neutral by implementing a -0.5 percent adjustment to the annual outpatient prospective payment (OPPS) updates for non-drug OPPS services. The reduction would start January 1, 2025 and remain in effect until the entire amount of the additional 340B payments had been recovered. It is estimated that this will take 16 years. The amount that is estimated to be repaid is $10.5 billion. Around $1.5 billion has been reprocessed leaving an estimated $9 billion in payments to sill be paid to hospitals.

## Safety Net Hospitals

CMS utilized the proposed 2024 IPPS rules to invite comments regarding the identification of safety net hospitals. The Medicare Payment Advisory Commission (MedPAC) has identified two methodologies to assist in identifying these hospitals. MedPAC has developed a methodology which would take the current DSH and UCC payments and distribute them based on the Safety Net Index (SNI) for hospitals developed by MedPAC. The SNI would access how a hospital performs as a safety net hospital. Also, in the financial interest of safety net hospitals, MedPAC recommends adding $2 billion dollars to this pool of funds. The other measure being considered is an area-level index. This index would look at socioeconomic factors related to health equity disparities in the local community a hospital serves. The final rule states that CMS is committed to reviewing submitted comments to drive future areas of considerations, policies, and regulations.

# FY 2024 Wage Index

The IPPS labor portion of the payments are adjusted for differences in hospital’s cost of labor which is known as the wage index adjustment. In updating prospective payments to hospitals, the standardized amounts need to be adjusted for differences in wage levels in a geographic area when compared to the national average hospital wage level. The wage index information utilized for FY 2024 is from cost report periods beginning in FY 2020. The occupational mix information will be from the 2019 Occupational Mix Survey. FY 2024 occupational mix adjusted national average hourly wage is $50.39.

**Continuation of the Low Wage Index Hospital Policy**

In FY 2020, CMS adopted a policy to provide an opportunity to low wage index hospitals to increase compensation by increasing their wage index values. The goal is to decrease disparities between high wage and low wage hospitals. The policy was to be budget- neutral based on an adjustment to the standardized amounts for all hospitals.

The phase-in period for this was four years to allow these increases to be reflected in the wage index calculation. This policy is to continue in FY 2024. Hospitals with a wage index value below the 25-percentile would be increased by half the difference between the final wage index value for the hospital and the 25-percentile wage index value for all hospitals. The FY 2024 25-percentile wage index value for all hospitals is 0.8667. The process will again be budget-neutral by applying a factor to the standardized amount. Like FY 2023,

a 5% cap is placed on any decrease in a hospital's wage index due to any reason causing the decline so the hospital's final wage index for FY 2024 will not be less than 95% of its FY 2023 wage index value. CMS will continue the permanent cap of 5% from one year to the next on wage index decreases.

**Imputed Rural Floor**

The imputed floor was established to ensure that urban hospitals wage index may not be less than the wage index of hospitals located in rural areas of the state. Beginning in FY 2024, CMS will include reclassified hospitals data with the geographical rural hospitals data to calculate wage index for the rural floor.

# Medical Education

Approved teaching hospitals are paid for their medical education training programs for direct costs and indirect costs as outlined below.

**Graduate Medical Education (GME)**

Hospitals with an approved teaching program are paid for direct costs of GME based on the

weighted number of residents and Medicare patient load (percentage of the hospital's Medicare inpatient days) in the Medicare cost reporting period and the hospital's per resident amount.

**Indirect Medical Education Payment Adjustment Factor**

Teaching hospitals receive an add on payment to their DRG payment to reimburse hospitals for the increased cost of treatment compared to non-teaching hospitals.

The IME formula has a multiplier factor used to calculate the IME payment. The factor is set each year by statute. The factor has been 1.35 for discharges occurring since FY 2008 The factor for FY 2024 will continue to be 1.35.

**Rural Emergency Hospitals (REHS) GME**

In response to the access to medical care in rural areas CMS is allowing REHs to train physicians and serve as a training location for Medicare GME reimbursement.

**New Covid-19 Treatments Add-on Payment (NCTAP)**

NCTAP were instituted during the pandemic to provide additional reimbursement to hospitals in treating COVID patients. The payments were to continue until the end of the fiscal year in which the PHE was declared to have ended. PHE was ended as of May 11, 2023. NCTAP add-ons will continue until September 30, 2023.

**Medicare Dependent Hospitals (MDH)**

MDH status provides an extra payment to support small rural hospitals. These hospitals must have admissions from Medicare patients of at least 60%, has 100 or less beds and not a Sole Community Hospital. The MDH will then be paid the higher of the federal rate or the IPPS rate and an additional 75% of the difference in the IPPS rate and the inflation adjusted costs based on their base year.

The Further Continuing Appropriations and Extensions Act of 2023 continued MDH status through FY 2023. MDH status continued in effect through FY 2024 due to the Consolidated Appropriations Act of 2023.

**Low Volume Hospitals**

Hospitals meeting certain criteria for low volume status would receive an additional payment under

IPPS starting in FY 2005. When this payment was first established, a hospital had to have less than 200 total discharges and be located more than 25 road miles from the nearest hospital. The regulations were amended for FYs 2019-2022.

For these FYs the hospital must have less than 3,800 total discharges and be more than 15 miles from the nearest hospital. The hospitals will receive an additional 25% payment adjustment based on the total per discharge payments including capital, DSH, IME and outlier payments for hospitals with 500 or fewer discharges and reduced based on a linear sliding scale for hospitals with more discharges with a complete elimination of this payment for hospitals with more than 3,800 discharges in a fiscal year. These criteria and additional payment continued for FY 2023 through the Further Continuing appropriations and Extensions Act of 2023. The Consolidated Appropriations Act of 2023 continued the extension for FY 2023.

**Quality Star Rating Program**

Under the Hospital Star rating structure, CMS reports on measures comparing hospitals and publishes this information on the Hospital Compare website. This reporting has caused issues with hospitals regarding how the data is developed. Hospitals have expressed these concerns and CMS had committed to modifications. In the CY 2021 OPPS/ASC final rule, CMS finalized the methodology to calculate Star Ratings for FY 21 and subsequent years based on the below. No changes have been proposed or finalized for FY 2024.

- Updated calculation of ratings to a more simplified methodology such as adopting a simple average of scores instead of the variable model.
- Reduce total measure groups from seven to five: mortality, safety of care, readmission, patient experience, and timely and effective care.
- Increase comparability of star ratings by peer grouping hospitals which will reduce provider burdens, improve predictability of the star ratings and increase comparability between hospitals. This grouping will capture key differences for hospitals by size, patient volume, case mix and service mix.

# Hospital Readmissions Reduction Program (HRRP)

This program reduces a hospital's Operating DRG payment for excess readmissions for certain conditions exceeding expected levels. No changes will occur with this program in FY 2024.

The annual reduction is capped at 3% for a payment adjustment factor of 97. CMS estimated 2,356 hospitals will have their base operating DRG payments reduced by their FY 2024 hospital-specific payment adjustment factors.

## Value-Based Incentive Payments Under the Hospital VBP Program

The VBP Program provides hospitals with value-based incentives based on performance measures in a respective year. The payments are funded for FY 2024 based on a reduction of 2% to the base operating DRG payment for discharges occurring for that year. The pool of money will fund incentive payments based on a hospital's Total Performance Score (TPS). Health equity factors will be included in this score in FY 2024. The payments are budget-neutral which means the total amount available for these payments must equal the reduced payments in that year FY 2024 available pool for VBP incentives will be approximately $1.7 billion.

## Hospital Acquired Conditions (HAC) Reduction Program

The HAC program provides hospitals an incentive to reduce hospital acquired conditions. The 1% reduction applies to hospitals that rank in the worst performing quartile (25%) of all hospitals. In FY 2025 a validation reconsideration methodology will be implemented for those hospitals that did not meet requirements.

## Hospital Inpatient Quality Reporting Program (IQR)

The IQR is a pay-for-reporting quality program. Hospitals that fail to comply with these requirements receive reduced payments. The reduced payment amounts to a quarter point reduction in the standard IPPS rate. FY 2024 changes includes:

- Add 3 new measures called Hospital Harm to advance health equity.
- Modify 3 existing measures to include MA admissions and increase COVID-19 Healthcare resources vaccination reporting.
- Eliminate 3 measures to allow for additional measure in the future for relevant health outcomes.

- Updating submission and reporting for Healthcare Providers and Systems (HCAHPS).

In addition, updates are being made to the data submission and reporting requirements for the Hospital Consumer Assessment of HCAHPS survey. The updates will start in FY 2025 with effects impacting FY 2027 payments.

# Health Equity

The final rule continues to expand on the CMS Framework for Health Equity 2022-2032. This plan puts forth measures for hospitals to document health equity policies' effects on their patient population. The final rule adds 15 new health equity elements. This plan outlines 5 priorities:

- Expand the collection, reporting, and analysis of standardized health equity data.
- Assess causes of disparities within CMS programs and address inequities in policies and operations to close gaps.
- Build capacity of health care organizations and the workforce to reduce health and health care disparities.
- Advance language access, health literacy, and the provision of culturally tailored services.
- Increase all forms of accessibility to health care services and coverage.

These Health Equity measures will be incorporated into reimbursement methodologies. Providers can receive bonus payments called the Health Equity Adjustment Bonus. Through this methodology they can earn up to 10 bonus points in their Hospital Value Based score.

The first group is under the Facility Commitment to Measure Health Equity which is mandatory in FY 26. The next category is the Screening for Social Drivers of Health which is voluntary in FY 26 and mandatory in FY 27. The last group is Screen Positive Rate for Social Drivers of health. These measurements are voluntary in FY 26 and mandatory beginning in FY 27.

# Social Determinants of Health

CMS has identified homelessness as a factor in increasing the use of resources in an inpatient setting. Due to this CMS has changed the diagnosis codes for homelessness from non-complication or comorbidity to complication or comorbidity. The change in this designation provides updates for increased resource consumption and clinical characteristic of patients.

# Critical Access Hospitals (CAHS)

The Frontier Community Health Integration Project (FCHIP) demonstration allows entities to develop and test new models of care to improve access to better delivery of acute care, extended care and other healthcare services to Medicare beneficiaries without an increase in costs. This was to be budget neutral. The baseline period for the budget neutrality measurement was from Aug 1, 2016 through July 31, 2019.

The program allows models of care under telehealth, skilled nursing services and ambulance services. The 10 CAHs were selected for participation with the goal of budget neutrality that will produce savings through reduced transfers and admissions to other healthcare providers. The demonstration was extended from January 1, 2022-June 30, 2027. If the baseline period analysis of claims and other documents such as Medicare cost reports shows increased payments over the three-year period, CMS would recoup these expenditures by reducing payments to all CAHs. The budget neutrality methodology will be utilized in the period of extension.

# LTCH PPS Payment Rates

LTCHs have been reimbursed under a structure that pays an LTCH PPS standard federal payment when the site-neutral payment criteria are met for exclusion. If the criteria for exclusion from site-neutral payments are not met, they will be paid on a site-neutral payment rate. These exclusions include:

- Cases do not have primary diagnosis related to psychiatric or rehab (the DRG criterion).
- Case must be preceded by a discharge from an acute care hospital which included at least a three-day stay in an intensive care unit (the ICU criterion).
- Case must be preceded by discharge from an acute care hospital and the LTCH discharge must be based on at least 96 hours of ventilator services in the LTCH (the ventilator criterion).

An LTCH will be paid the PPS standard federal rate if the DRG criterion is met and either the ICU or the ventilator criterion is met.

**Specific items that will drive the increased payments for are outlined below:**

- LTCH PPS payments will increase from $46,433 in FY 2023 to $48,116 in FY 2024.

- If LTCHs do not meet the quality program reporting requirements a two percent decrease will be applied to the standard payment.
- High-cost outlier threshold for LTCH IPPS will increase to $59,873 in FY 2024. This is an increase of 55% from the FY 2023 amount of $38,518.
- Site neutral outlier threshold amount will increase by 10% for FY 2023 amount of $38,859 to $42,750 for FY 2024.
- The expiration of the Public Health Emergency on May 11, 2023 eliminates the requirement that site neutral payments are suspended in favor of all cases paid at LTCH PPS rate. Going forward site neutral cases will be reimbursed at the site neutral rate.

**The table below shows the payment increase in FY 2024 LTCH payments:**

| | |
|---|---|
| LTCH Site-Neutral Payments | $ 10 million |
| LTCH PPS Payments | $ (4 million) |
| **Overall LTCH Payment Increase** | **$ 6 million** |

# BDO Takeaways

Per the 2023 CFO Outlook Survey, healthcare facilities are seeing improvement with some sectors doing better than others. Financial recovery is slow and struggling in certain areas with financial distress causing issues with meeting bond and loan covenants.

The cost of patient care continues to rise. CMS regulations ignores inflation challenges facing patient care due to increased labor costs and supply chain breakdowns causing increased prices for drugs and supplies. The new regulations increase payment rates by a small percentage to hospitals but decrease payments to hospitals that serve low-income patients due to a decrease in UCC/DSH payments of $950 million.

By improving the reimbursement initiatives, healthcare organizations can focus on the changes from the FY 2024 regulations to evolve and determine strategic paths to implement new reimbursement methodologies for FY 2024. This will support healthcare leaders concerned about government reimbursement in implementing innovative ideas to

reduce expenses, enhance reimbursement, and improve overall margins.

## Have Questions? Contact Us