National Rural Health Association

Fiscal Year (FY) 2024 Inpatient Prospective Payment System Final Rule

On August 1, the Centers for Medicare and Medicaid Services (CMS) put forth its FY 2024 Inpatient Prospective Payment System (IPPS) final rule. Please find CMS' fact sheet here and NRHA's summary below.

Overall, NRHA is pleased to see that CMS finalized a higher payment rate for hospitals than proposed. For reference, please find our comment on the proposed rule here. If you have any questions or concerns, contact NRHA's Regulatory Affairs Manager Alexa McKinley (amckinley@ruralhealth.us).

Key provisions include:

Payment update. CMS finalized a **3.1% payment increase** over FY 2023 which is a modest update from the 2.8% in the proposed rule. NRHA is pleased to see an increase from the proposal but will continue to work with the agency and Congress to make sure rural hospitals receive adequate payments.

However, NRHA is concerned about the significant decrease in disproportionate share payments and uncompensated care payments, which will decrease by a combined $957 million, compared with the $115 million decrease originally proposed.

CMS cites new data from its actuaries showing a lower uninsured rate next year than initially anticipated. CMS updated its calculation for estimates of uninsured individuals for determining uncompensated care payments. CMS finalized an estimate of 8.5% of individuals without insurance compared to the 9.2% in the proposed rule. In our comment, NRHA asked CMS to reconsider its calculation due to the Medicaid unwinding process and the number of individuals being disenrolled from Medicaid. While 2023 initially showed all-time low uninsurance rates, millions have lost Medicaid coverage since states began redetermining eligibility in April. **NRHA encourages CMS to keep the fiscal year 2023 uninsured rate in place for next year** and to pause scheduled DSH cuts until the Medicaid redetermination process plays out.

Rural Emergency Hospitals (REHs). Beginning October 1, 2023, REHs may be considered a non-provider site for Medicare Graduate Medical Education (GME) purposes and may include FTE residents training in direct GME and indirect medical education FTE counts.

Additionally, REHs may choose to incur the costs of training residents and receive 100% of reasonable costs. Many commenters, including NRHA, asked CMS to reimburse 101% of reasonable costs for residency training because that is what CAHs receive. CMS declined to do so because they do not believe that there is a statutory basis.

CMS is also finalizing requirements related to applying to convert to an REH. These requirements are the same as those published in CMS' January guidance memo and include:

- A plan for initiating REH services, including mandatory emergency department and observation care.
- A detailed transition plan that lists the specific services that the REH will retain, modify, add, and discontinue.
- A detailed description of other outpatient services that the hospital intends to furnish.
- Information on how the hospital intends to use the additional monthly facility payment.

Low wage index. CMS will continue its low wage index policy through FY 2024, which increases the wage index for hospitals with a value below the 25th percentile. NRHA asked CMS to continue the policy through FY 2030 to ensure the agency has sufficient data to evaluate the policy's effectiveness and we hope to see this policy continued in next year's IPPS rulemaking cycle.

Rural reclassification. In response to various court decisions, CMS is finalizing its proposal to interpret section 1886(d)(8)(E) of the Social Security Act to mean that hospitals that reclassified to rural must be treated the same as geographically rural hospitals for the wage index calculation. Essentially, reclassification functions the same as if the hospital had physically relocated to a geographically rural area. Thus, all reclassified hospitals and geographically rural hospitals will be included in the calculation of the rural floor and wage index for rural areas in a state. Reclassified hospitals that also have an MGCRB reclassification will not be included.

Low Volume Hospitals (LVH) & Medicare Dependent Hospitals (MDH). The Consolidated Appropriations Act of 2023 extended the qualifying criteria and payment adjustment for LVHs as well as the MDH designation through FY 2024. CMS is implementing both of these extensions in this final rule.

As a reminder, hospitals should submit their written request for LVH status to their MAC by September 1, 2023, to receive the add-on payment adjustment beginning October 1, 2023. Hospitals must submit their requests with written verification indicating that they meet the mileage and discharge criteria. Hospitals must do so for each fiscal year that they are seeking the LVH payment adjustment.

Health equity. CMS is adding a health equity adjustment to the Hospital Value-Based Purchasing Program scoring methodology. Hospitals may now earn up to 10 bonus points depending upon performance on existing quality measures and the proportion of dually eligible beneficiaries served.

CMS is also changing the severity designation of the three ICD-10-CM diagnosis codes describing homelessness to complication or comorbidity. This will recognize the higher costs that hospitals incur when treating patients experiencing homelessness.

Hospital Inpatient Quality Reporting Program (IQR). CMS is adopting three new measures, modifying three measures, and removing three measures as outlined in its proposed rule.

Measures being added beginning with CY 2025 reporting period/FY 2027 payment determination:

- Hospital Harm – Pressure Injury electronic clinical quality measure (eCQM)
- Hospital Harm – Acute Kidney Injury eCQM
- Excessive Radiation eCQM

Measures being modified:

- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure beginning with the FY 2027 payment determination.
- Hybrid Hospital-Wide All-Cause Readmission measure beginning with the FY 2027 payment determination.
- COVID-19 Vaccination Coverage among HCP measure beginning with the Q4 CY 2023 reporting period/FY 2025 payment determination.

Measures being removed:

- Hospital-level Risk-standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure beginning with the April 1, 2025-March 31, 2028 reporting period/FY 2030 payment determination.
- Medicare Spending Per Beneficiary (MSPB) Hospital measure beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Elective Delivery (PC–01) measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

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