Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

SEPTEMBER 2023

FY24 MEDICARE IPPS FINAL RULE (CMS-1785-F)

On Aug. 1, the Centers for Medicare & Medicaid Services (CMS) posted the fiscal year 2024 (FY24) Medicare Inpatient Prospective Payment System (IPPS) final rule effective Oct. 1, 2023 through Sept. 30, 2024. CMS finalized a net 3.1% rate increase for FY24.

IPPS Rate Update: CMS finalized a 3.3% market basket update, and a 0.2 percentage point Affordable Care Act (ACA)-mandated productivity reduction. The market basket update for hospitals that fail to submit quality data will decrease by an additional .25%, and hospitals that were not meaningful users of electronic health records (EHRs) in FY20 will be subject to a .75% reduction of the initial market basket. Hospitals that fail to meet both requirements will be subject to a 0.2% payment decrease.

	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
Percentage increase applied to standardized amount	3.1%	0.625%	2.275%	-0.2%

Wage Index:

Labor-related Share – For FY24, CMS will continue using a labor-related share of 67.6% for those hospitals with wage indices greater than 1.0 and 62% for those hospitals with wage indices less than or equal to 1.0.

Rural Floor – Per statute, the area wage index value of any urban hospital may not be less than the area wage index applicable to hospitals located in rural areas in the same state — known as the "rural floor" policy. Following developments in court proceedings in *Citrus v. Becerra*, CMS finalized a policy to include the wage data of hospitals that have reclassified as rural under §412.103 in the rural floor calculation for FY23 and beyond.

Low-Wage Index Hospital Policy – CMS will continue its policy to increase wage index values for low-wage hospitals. Under this policy, for hospitals with a wage index value below the 25th percentile, the agency increased the hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. This policy was scheduled to expire after FY23; however, CMS indicated that it only has one year of data under the policy to determine whether it has successfully

resulted in hospitals raising wages to get a higher wage index. For this reason, CMS will continue the low-wage index policy for FY24.

Permanent Cap on Wage Index Decreases – For FY24, CMS will continue to apply a 5% cap on all wage index decreases each year, regardless of the reason. Additionally, it finalized that it would implement this policy in a budget neutral manner. This permanent change was made in the FY23 final rule because CMS recognizes that significant year-to-year changes in the wage index can occur due to external factors beyond a hospital's control.

The final FY24 wage index values for geographic areas in Illinois are listed in Table 3 in File 2 under "FY24 Final Rule Tables".

Disproportionate Share Hospital (DSH) Payment Changes: For FY24, CMS estimates that the total amount of Medicare DSH payments that would have been made under the former statutory formula is $13.35 billion. As such, CMS finalized that hospitals would receive 25% of these funds, or $3.34 billion.

The remaining $10.02 billion will flow into the 75% pool, which is then adjusted to reflect changes in the percentage of uninsured. CMS estimates that the percentage of uninsured for FY24 will be 8.3%; a decrease from its proposed uninsured rate of 9.2%. Thus, after inputting that rate into the statutory formula, it will retain 59.29% — or $5.94 billion — of the 75-percent pool in FY24.

Thus, the total DSH funds that CMS anticipates paying out in FY24 are $9.28 billion, a $957 million decrease as compared to FY23. This is a larger cut than what the agency proposed, which was estimated at $115 million. The near billion-dollar cut is driven by the agency's projection that the percentage of uninsured will decrease — from 9.2% in FY23 to 8.3% in FY24.

Graduate Medical Education (GME) Payments: CMS finalized the policy included in the proposed rule that hospitals may count residents training in "non-provider" sites for direct GME and Independent Medical Evaluation (IME) payment as long as the non-provider setting requirements and other regulations applicable to CAHs are met.

Medicare Severity Diagnosis Related Groups (MS-DRGs): The finalized total number of payable DRGs is 764 (compared to 765 for FY23), with 70% of DRG weights changing by less than +/- 5%.

CMS finalized the proposal to change the severity level designation to three social determinants of health (SDOH) for FY24:

- Z59.00 – Homelessness, unspecified;
- Z59.01 – Sheltered homelessness; and
- Z59.02 – Unsheltered homelessness.

CMS finalized the proposal to continue delaying the application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY24.

Low-Volume Hospitals: The Consolidated Appropriations Act of 2023 (CAA, 2023) extended the low-volume hospital criteria though FY24. The current payment adjustment formula for hospitals with between 500 and 3,800 total discharges was finalized at:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

To receive the enhanced payments beginning Oct. 1, 2023, a hospital must make a written request for low-volume status that is received by its Medicare Administrative Contractor (MAC) by Sept. 1, 2023.

Medicare-Dependent, Small Rural Hospital (MDH) Program: The MDH program has been extended through FY24 as granted by the CAA, 2023. Any provider that was classified as an MDH as of Sept. 30, 2022, will generally continue to be classified as an MDH as of Oct. 1, 2022, with no need to reapply for MDH classification. CMS did not propose any other changes regarding eligibility or payments for the MDH program though FY24.

Sole Community Hospital (SCH) Status: CMS finalized, for SCH applications received on or after Oct. 1, 2023, where a hospital's SCH approval is dependent on its merger with another nearby hospital and the hospital meets the other SCH classification requirements, that the SCH classification and payment adjustment will be effective as of the effective date of the approved merger if the MAC receives the complete application within 90 days of CMS' written notification to the hospital of the approval of the merger.

Hospital Quality Reporting and Value Programs:

Medicare Value-Based Purchasing (VBP) Program – CMS finalized the addition of Severe Sepsis and Septic Shock Management Bundle (SEP-01) beginning with the FY26 VBP program. CMS also finalized two measure updates. For the Medicare Spending per Beneficiary (MSPB) measure (starting with the FY28 program), CMS finalized using an updated version that permits readmissions to trigger new episodes, adding a new variable to the MSPB risk model indicating whether a patient had an inpatient stay in the 30 days prior to an episode start date, and a methodological change. For the Total Hip Arthroplasty/Total Knee Arthroplasty Complications measure (starting with the FY30 program), CMS finalized using an expanded measure cohort to include index admission diagnoses and in-hospital co-morbidity data from Medicare Part A claims.

CMS also finalized including a Health Equity Adjustment (HEA) to the VBP program. Specifically, CMS finalized rewarding high quality performance for hospitals that care for large numbers of dually eligible patients by adding up to ten bonus points to a hospital's VBP Total Performance Score. This is part of CMS' initiative to advance health equity through the Medicare program.

Medicare Readmissions Reduction Program (RRP) – CMS did not propose any changes to the RRP. The RRP continues to impose penalties of up to 3% of base IPPS payments for having "excess" readmission rates for selected conditions when compared to expected rates.

Medicare Hospital Acquired-Condition (HAC) Reduction Program – Program penalties, a 1% reduction to all Medicare inpatient payments for hospitals in the top (worst performing) quartile of risk-adjusted national HAC rates, will resume in FY24. Starting in FY24 CMS will add the COVID-19 diagnosis as a risk variable to the patient safety indicator (PSI) composite measure. CMS also finalized validation changes to the five healthcare-associated infection (HAI) measures used in the HAC program beginning with the FY25 program year. The finalized process would be

similar to the reconsideration process already used for measures in the Hospital Inpatient Quality Reporting program.

Sources:

Medicare Program; Final Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes. Available from: Federal Register: Public Inspection: Medicare Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes, etc. Accessed Aug. 31, 2023.