Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

MAY 2023

FY 2024 MEDICARE IPPS PROPOSED RULE (CMS-1785-P)

On April 10, the Centers for Medicare & Medicaid Services (CMS) posted the fiscal year (FY) 2024 Medicare Inpatient Prospective Payment System (IPPS) proposed rule, effective Oct. 1, 2023 through Sept. 30, 2024. CMS published this proposed rule in the *Federal Register* on May 1.

CMS estimates a 2.8%, or $2.7 billion, increase in aggregate payments for acute care hospitals in FY 2024 relative to FY 2023. This includes increased operating and capital payments and decreases due to changes in new technology add-on payments.

Comments on this proposed rule are due to CMS by June 9.

IPPS Rate Update: CMS proposed a 2.8% net market basket update, which includes 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 .75%, and hospitals that do not meet meaningful use requirements are subject to a 2.25% reduction to the initial market basket.

	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	2.8%	0.55%	2.05%	-0.2%

Wage Index: The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FY 2024, CMS proposes to continue to apply a labor-related share of 67.6% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

FY 2024 Proposed Wage Index Information for Illinois Hospitals:

Core Based Statistical Area	Wage Index	Geographic Adjustment Factor (GAF)	FY 2024 Average Hourly Wage	FY 2023 Wage Index FR Corrected
Bloomington	0.9802	0.9864	43.4499	0.9225

Cape Girardeau	0.9802	0.9864	36.1564	0.8458
Carbondale-Marion	0.9802	0.9864	40.8341	0.8458
Champaign-Urbana	0.9802	0.9864	45.3603	0.8976
Chicago-Naperville-Evanston	1.0257	1.0175	52.5515	1.0380
Danville	0.9802	0.9864	47.6418	0.9481
Decatur	0.9802	0.9864	45.1728	0.8805
Elgin	1.0670	1.0454	51.7770	1.0262
Kankakee	0.9802	0.9864	45.9251	0.9105
Lake County	0.9802	0.9864	50.1509	1.0591
Peoria	0.9802	0.9864	42.0224	0.8558
Rock Island	0.9802	0.9864	39.3368	0.8458
Rockford	0.9802	0.9864	47.4648	0.9632
St. Louis	0.9802	0.9864	46.8177	0.9339
Springfield	0.9802	0.9864	45.8083	0.8549
Rural	0.9802	0.9864	42.4085	0.8458

Wage Index – Rural Floor: CMS now fully agrees with the court's decision in *Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*, and has proposed to treat §412.103 (redesignated rural) hospitals the same as geographically rural hospitals for the wage index calculation. Additionally, CMS proposed including hospitals with solely §412.103 reclassification along with geographically rural hospitals in all rural wage index calculations. Those hospitals with both §412.103 and MGCRB reclassifications (dual reclassification) would be excluded due to the hold harmless policy adopted in the FY 2006 final rule.

Disproportionate Share Hospital (DSH) Payment Changes: CMS estimated the empirically justified, or traditional, 25% DSH amount to be $3.41 billion. The remaining 75%, or Uncompensated Care (UCC) pool, is estimated at $10.22 billion. After adjusting the UCC pool for the uninsured rate, CMS estimates the total will be approximately $6.71 billion. CMS will continue to use a three-year average of the three most recently audited Medicare cost report S-10 worksheets to determine the distribution of DSH uncompensated care payments.

Graduate Medical Education (GME) Payments: In the calendar year (CY) 2023 Outpatient Prospective Payment System (OPPS) final rule, CMS finalized payment policies and conditions of participation (CoP) with respect to the new REH provider type established in the Consolidated Appropriations Act (CAA) of 2021. Commenters in the OPPS final rule requested that CMS designate REHs as GME eligible facilities similar to critical access hospitals (CAH). As such, CMS proposed that effective for cost reporting periods on or after Oct. 1, 2023, a hospital may include full-time equivalent (FTE) residents training at an REH in its direct GME and indirect

medical education (IME) FTE counts as long as it meets the non-provider setting requirements and other regulations that would be applicable to CAHs.

Medicare Severity Diagnosis Related Groups (MS-DRGs): The total number of payable DRGs is proposed to be 764 (compared to 765 for FY 2023), with 71.6% of DRG weights changing by less than +/- 5.

CMS also proposed changing the severity level for the following diagnosis codes related to homelessness from NonCC to CC for FY 2024:

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

CMS proposed to continue delaying the application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2024.

Low-Volume Hospitals: The CAA of 2023 extended the 2023 low-volume hospital criteria thought FY 2024. The current payment adjustment formula for hospitals with between 500 and 3,800 total discharges is:

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

CMS proposed to continue to use the discharge and mileage criteria, as well as the above formula to determine and calculate low-volume payment adjustments for FY 2024.

In FY 2025 and subsequent years, the criteria for the low-volume hospital adjustment will return to more restrictive levels. In order to receive a low-volume adjustment subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

A hospital that qualified for the low-volume hospital payment adjustment for FY 2023 may continue to receive the adjustment for FY 2024 without reapplying if it meets both the proposed discharge and mileage criteria.

Medicare-Dependent, Small Rural Hospital (MDH) Program: The MDH program has been extended through FY 2024 as granted by the CAA of 2023. Any provider that was classified as an MDH as of Dec. 23, 2022 was reinstated as a MDH effective Dec. 24, 2022 without the need to reapply. CMS did not propose any other changes regarding eligibility or payments for the MDH program though FY 2024.

Sole Community Hospitals (SCH) Status: CMS has proposed to modify the effective date for SCH status in cases where there is a merger that allows two hospitals to operate under a single provider agreement but one hospital was not eligible for SCH classification due to its proximity to a nearby like hospital. For SCH applications received on or after Oct. 1, 2023, where a hospital's SCH approval is dependent on a merger with another nearby hospital and the applying hospital meets other SCH classification requirements, CMS proposed that the SCH and payment adjustment would be effective as of the approved merger effective date if the Medicare

Administrative Contractor (MAC) receives the complete application within 90 days of CMS' written notification to the hospital of the approval of the merger. If the MAC does not receive this complete application within 90 days, the SCH classification would be effective as of the date the MAC receives the application. CMS also proposed that the effective date of the rural reclassification of these hospitals be effective on the same day as the SCH classification.

Medicare Value-Based Purchasing (VBP) Program: CMS proposed the addition of Severe Sepsis and Septic Shock Management Bundle (SEP-01) beginning with the FY 2026 VBP program. CMS also proposed two measure updates. For the Medicare Spending per Beneficiary (MSPB) measure (starting with the FY 2028 program), CMS proposed 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 FY 2030 program), CMS proposed using an expanded measure cohort to include index admission diagnoses and in-hospital co-morbidity data from Medicare Part A claims.

CMS also proposed including a Health Equity Adjustment (HEA) to the VBP program. Specifically, CMS proposed 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 proposal 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. Due to COVID-19 impacts, the FY 2024 RRP will only use data from July 1, 2019 – Dec. 31, 2019, and July 1, 2020 – June 30, 2022. The data applicable to the FY 2024 RRP program is still being reviewed and corrected by hospitals; therefore CMS has not yet posted factors for the FY 2024 program. CMS expects to release the final FY 2024 RRP factors in the fall of 2023.

Medicare Hospital Acquired-Condition (HAC) Reduction Program: Due to COVID-19, CMS did not impose HAC program penalties in FY 2023. However, program penalties will resume in FY 2024. Starting in FY 2024 CMS will add the COVID-19 diagnosis as a risk variable to the patient safety indicator (PSI) composite measure. CMS also proposed validation changes to the five healthcare-associated infection (HAI) measures used in the HAC program beginning with the FY 2025 program year. The proposed process would be similar to the reconsideration process already used for measures in the Hospital Inpatient Quality Reporting program.

Sources:

Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership. Available from: https://www.federalregister.gov/documents/2023/05/01/2023-07389/medicare-program-proposed-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals. Accessed May 10, 2023.