SUMMARY OF FINAL RULE – September 2023

FFY 2024 Inpatient Prospective Payment System

In the Aug. 2 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its final rule describing federal fiscal year (FFY) 2024 policies and rates for Medicare's inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS). The policy and payment provisions in the final rule will be effective for FFY 2024 discharges, beginning Oct. 1, 2023.

The following is a comprehensive summary of the final rule's acute care hospital provisions. Payment and policy changes for the FFY 2024 LTCH PPS final rule are addressed in a separate summary.

For Additional Information

Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742 or mhoward@calhospital.org, or Chad Mulvany, vice president of federal policy, at (202) 270-2143 or cmulvany@calhospital.org. Facility-specific CHA DataSuite analyses were sent under separate cover. Questions about CHA DataSuite should be directed to Alenie Reth, data analytics coordinator, at areth@calhospital.org.

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FFY 2024 Payment Changes

The table below lists the federal operating and capital rates for FFY 2024 compared to the rates currently in effect for FFY 2023. These rates include all market basket (MB) increases and reductions as well as the application of annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g., penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program and Electronic Health Records (EHR) Meaningful Use Program, quality penalties/payments, disproportionate share hospitals, etc.).

	Final FFY 2023	Final FFY 2024	Percent Change
Federal Operating Rate	$6,375.74	**$6,497.77** (proposed at $6,524.94)	**+1.91%** (proposed at +2.34%)
Federal Capital Rate	$483.79	**$503.83** (proposed at $505.54)	**+4.14%** (proposed at +4.50%)

The standardized amount does not include the 2% Medicare sequester reduction that began in 2013 and will continue until at least 2030 under current law. The sequester reduction is applied as the last step in determining the payment amount for submitted claims and does not affect the underlying methodology used to calculate MS-DRG weights or standardized amounts.

The following table provides details for the annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2024.

	Federal Operating/Hospital Specific Rate	Federal Capital Rate
Market Basket/Capital Input Price Index Update	**+3.3%** (proposed at +3.0%)	**+2.9%** (proposed at +3.5%)
ACA-Mandated Productivity Adjustment	**-0.2 percentage point (PPT)** (as proposed)	**—**
Forecast Error Adjustment	**—**	**+0.9%**
Lowest Quartile Wage Index Adjustment	**-0.07%** (proposed at -0.08%)	**-0.08%** (proposed at -0.38%)
Wage Index Cap Policy	**-0.00%** (proposed at -0.31%)	
MS-DRG Weight Cap Policy	**-0.01%** (as proposed)	**-0.01%** (as proposed)

All Other Annual Budget Neutrality Adjustments	**-1.06%** (proposed at -0.05%)	**+0.43%** (proposed at +1.19%)
Net Rate Update	***+1.91%*** (proposed at +2.34%)	***+4.14%*** (proposed at +4.50%)

Effects of the Inpatient Quality Reporting and Electronic Health Records Incentive Programs

The IQR MB penalty imposes a 25% reduction to the full MB, and the EHR Meaningful Use penalty imposes a 75% reduction to the full MB; therefore, the entirety of the full MB update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2024 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (3.3% MB less 0.2 PPT productivity adjustment)	**+3.1%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.3%)	—	**-0.825 PPT**	—	**-0.825 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.3%)	—	—	**-2.475 PPT**	**-2.475 PPT**
Adjusted Net Market Basket Update (prior to other adjustments)	***+3.1%***	***+2.275%***	***+0.625%***	***-0.2%***

CMS estimates that 65 hospitals will not receive the full MB rate of increase because they failed the quality data submission process or chose not to participate in IQR; 110 hospitals will not receive it because they are not meaningful EHR users; and 31 hospitals are estimated to be subject to both reductions.

Impact Analysis — California

The CHA DataSuite analysis estimates that as a result of the final rule California hospitals will experience an increase of 8.0% overall Medicare hospital inpatient payments as compared to FFY 2023.

IPPS FFY 2024 Final Rule Analysis

Estimated Change in Medicare Payments
FFY 2024 Final Rule Compared to FFY 2023 Final Rule with Correction Notice

California

Group Impact Summary	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2023 IPPS Payments	$11,575,237,000		$816,205,800		$12,391,442,800	
Estimated FFY 2024 IPPS Payments	$12,457,401,000		$924,763,100		$13,382,164,100	
Total Estimated Change FFY 2023 to FFY 2024	$882,164,000	7.6%	$108,557,300	13.3%	$990,721,300	8.0%

Group Impact Detail	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Provider Type Changes	$0	0.0%	$21,009,800	2.6%	$21,009,800	0.2%
Marketbasket Update (Includes BN)	$244,784,300	2.1%	$27,899,900	3.4%	$272,684,100	2.2%
ACA-Mandated Marketbasket Reduction	($22,019,100)	-0.2%	N/A	N/A	($22,019,100)	-0.2%
Forecast Error Adjustment	$0	0.0%	$7,566,500	0.9%	$7,566,500	0.1%
MS-DRG Weight 10% Reduction Cap BN	($872,000)	0.0%	($92,900)	0.0%	($964,900)	0.0%
WI/GAF (Wage Data and Reclassification)	$742,910,200	6.4%	$54,668,100	6.7%	$797,578,300	6.4%
> Removal of Previous Rural Floor BN	*$67,200,100*	*0.6%*	*$4,555,700*	*0.6%*	*$71,755,800*	*0.6%*
> Removal of Previous Rural Floor WI	*($83,736,700)*	*-0.7%*	*($6,212,100)*	*-0.8%*	*($89,948,900)*	*-0.7%*
> Change due to WI and LS (Prior to Rural Floor)	*$8,986,700*	*0.1%*	*$1,422,300*	*0.2%*	*$10,409,000*	*0.1%*
> Current Rural Floor WI	*$954,712,900*	*8.3%*	*$69,041,200*	*8.5%*	*$1,023,754,100*	*8.3%*
> Current Rural Floor BN	*($204,252,800)*	*-1.8%*	*($14,138,900)*	*-1.7%*	*($218,391,700)*	*-1.8%*
> Change in LS (Isolated from Previous Breakouts)	*$0*	*0.0%*	*N/A*	*N/A*	*$0*	*0.0%*
WI/GAF (Other Changes)	($6,359,100)	-0.1%	($695,800)	-0.1%	($7,054,900)	-0.1%
> Expiration of Previous 5% Stop Loss BN	*$3,459,600*	*0.0%*	*$328,200*	*0.0%*	*$3,787,700*	*0.0%*
> Expiration of Previous 5% Stop Loss WI	*$4,409,500*	*0.0%*	*$299,300*	*0.0%*	*$4,708,800*	*0.0%*
> Current 5% Stop Loss WI	*$860,200*	*0.0%*	*$58,700*	*0.0%*	*$918,900*	*0.0%*
> Current 5% Stop Loss BN	*($4,288,000)*	*0.0%*	*($400,800)*	*-0.1%*	*($4,688,700)*	*0.0%*
> Removal of Previous Bottom Quartile BN	*$20,662,100*	*0.2%*	*$1,961,000*	*0.2%*	*$22,623,200*	*0.2%*
> Removal of Previous Bottom Quartile WI	*$0*	*0.0%*	*$0*	*0.0%*	*$0*	*0.0%*
> Current Bottom Quartile Increase	*$0*	*0.0%*	*$0*	*0.0%*	*$0*	*0.0%*
> Current Bottom Quartile BN	*($31,462,500)*	*-0.3%*	*($2,942,200)*	*-0.4%*	*($34,404,700)*	*-0.3%*
DSH: UCC Payment Changes	($61,777,300)	-0.5%	N/A	N/A	($61,777,300)	-0.5%
> DSH UCC Distribution Factor Change	*$1,865,800*	*0.0%*	*N/A*	*N/A*	*$1,865,800*	*0.0%*
Change in Hospital Specific Rate	$0	0.0%	N/A	N/A	$0	0.0%
MS-DRG Updates	($4,860,800)	0.0%	($375,900)	-0.1%	($5,236,700)	0.0%
Quality Based Payment Adjustments	($15,199,500)	-0.1%	($1,889,000)	-0.2%	($17,088,500)	-0.1%
> VBP	*$12,992,100*	*0.1%*	*N/A*	*N/A*	*$12,992,100*	*0.1%*
> RRP	*($2,248,500)*	*0.0%*	*N/A*	*N/A*	*($2,248,500)*	*0.0%*
> HAC	*($25,943,000)*	*-0.2%*	*($1,889,000)*	*-0.2%*	*($27,832,000)*	*-0.2%*
Net Change due to Low Volume Adjustment	$5,557,300	0.1%	$466,700	0.1%	$6,024,000	0.1%

The values shown in the table above do not include the 2.0% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. It is estimated that sequestration will reduce FFY 2024 IPPS-specific payments by: $267,643,300.

However, the impact will vary based on the type of hospital. CMS' detailed impact estimates are displayed in Table I of the final rule, which is partially reproduced below.

Hospital Type	All Final Rule Changes
All Hospitals	3.1%
Urban	3.1%
Urban Pacific	6.4%
Rural	3.5%
Rural Pacific	5.4%

Outlier Payments

CMS believes using a methodology that incorporates historic cost report outlier reconciliations to develop the outlier threshold is a reasonable approach and would provide a better predictor for the upcoming fiscal year. Therefore, for FFY 2024, CMS incorporates total outlier reconciliation dollars from the FFY 2018 cost reports into the outlier model using a similar methodology to FFY 2020.

CMS will also use the estimated per-discharge Indian Health Service/Tribal and Puerto Rico supplemental payments in the calculation of the outlier fixed-loss cost threshold, consistent with the policy of including estimated uncompensated care (UCC) payments.

CMS sets the outlier payments at 5.12% of total IPPS payments. To achieve this level of outlier payments, CMS finalizes a fixed-loss threshold of $42,750 (proposed at $40,732) FFY 2024. This threshold is 10% higher than the current (FFY 2023) outlier threshold of $38,859.

Medicare Disproportionate Share Hospital (DSH) — Uncompensated Care DSH

Medicare makes DSH and UCC payments to IPPS hospitals that serve a number of low-income patients above a certain threshold. Low income is defined as Medicare-eligible patients who also receive supplemental security income, and Medicaid patients who are not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC, the proportion of inpatient days for each of these subsets of patients is used.

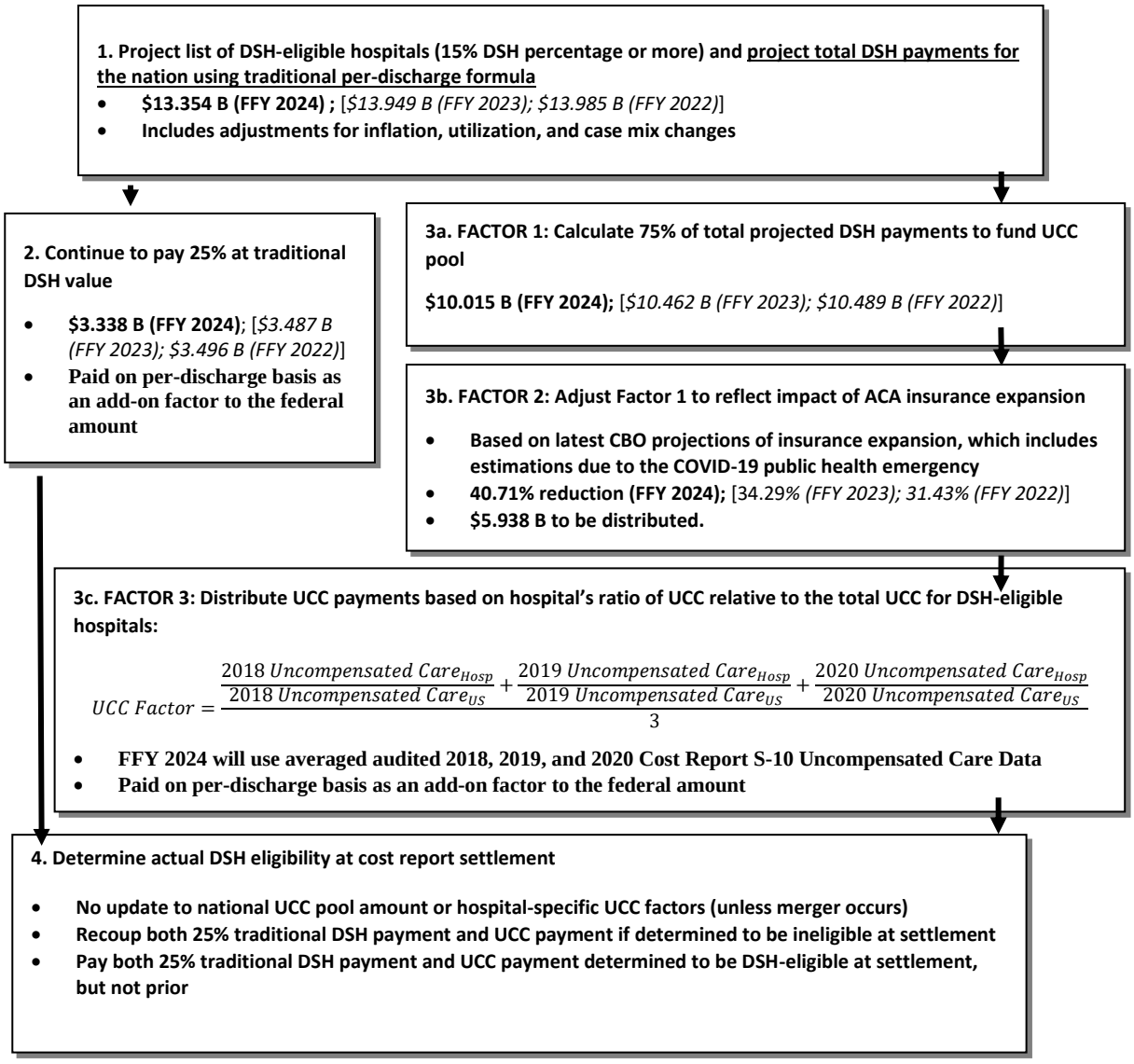
Prior to 2014, CMS made only DSH payments. Beginning in FFY 2014, the Affordable Care Act (ACA) required that DSH payments equal 25% of the statutory formula and UCC payments equal the product of three factors:

- Factor 1: 75% of aggregate DSH payments that would be made under Section 1886(d)(5)(F) without application of the ACA
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to ACA implementation
- Factor 3: A hospital's UCC costs for a given period relative to UCC costs over the same period for all hospitals that receive Medicare DSH payments

The statute precludes administrative or judicial review of the secretary's estimates of the factors used to determine and distribute UCC payments. UCC payments are made only to hospitals eligible to receive DSH payments that are paid using the national standardized amount.

Therefore, sole community hospitals (SCH) paid on the basis of hospital-specific rates and hospitals not paid under the IPPS are ineligible to receive UCC payments.

The schematic below describes the DSH payment methodology mandated by the ACA, along with the changes CMS finalizes for FFY 2024:



DSH dollars available to hospitals under the ACA's payment formula will decrease by $0.936 billion in FFY 2024 relative to FFY 2023 due to a decrease in the pool from projected DSH payments.

CMS projects 2,384 (proposed at 2,395) hospitals are eligible for DSH payments in FFY 2024. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology.

FFY 2024 Factor 1

CMS estimates this figure based on the most recent data available. It is not later adjusted based on actual data. CMS used the Office of the Actuary's (OACT) June 2023 Medicare DSH estimates, which were based on the March 2023 update of the HCRIS and the FFY 2024 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's June 2023 Medicare estimate of DSH payments for FFY 2024 is $13.354 billion (proposed $13.621 billion). The Factor 1 amount is 75% of this amount, or $10.015 billion (proposed $10.216 billion). The final Factor 1 for FFY 2024 is about $446 million (proposed $245 million) less than the final Factor 1 for FFY 2023.

FFY 2024 Factor 2

Factor 2 adjusts Factor 1 based on the percent change in the number of individuals who are uninsured from 2013 until the most recent period for which data are available. CMS uses uninsured estimates from the National Health Expenditure Accounts in place of Congressional Budget Office data as the source of change in the uninsured population.

For FFY 2024, CMS estimates that the uninsured rate for the historical baseline year of 2013 was 14%, and for calendar years (CYs) 2023 and 2024 is 7.7% and 8.5%, respectively (proposed at 9.3% and 9.2%). CMS calculates the Factor 2 for FFY 2024 (weighting the portion of CYs 2023 and 2024 included in FFY 2024) as follows:

- Percent of individuals without insurance for CY 2013: 14%
- Percent of individuals without insurance for CY 2023: 7.7%
- Percent of individuals without insurance for CY 2024: 8.5%
- Percent of individuals without insurance for FFY 2024 (0.25 times 0.077) + (0.75 times 0.085): 8.3%

Final Factor 2 = 1-|((0.14-0.083)/0.14)| = 1 - 0.4701 = 0.5929 (59.29%)

CMS calculated Factor 2 for the FFY 2024 rule to be 0.5929 or 59.29% (proposed at 65.71%), and the uncompensated care amount for FY 2024 to be $10.015 billion x 0.5929 = $5.938 billion (proposed at $6.713 billion) which is about $936 million less than the FFY 2023 UCP total of about $6.874 billion; the percentage decrease is 13.6%.

Factor 3 for FFY 2024

Factor 3 equals the proportion of hospitals' aggregate UCC attributable to each IPPS hospital. CMS continues to define UCC as the amount on line 30 of Worksheet S-10, which is the cost of charity care (line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29). The product of Factors 1 and 2 determines the total pool available for UCC

payments. This result multiplied by Factor 3 determines the amount of the UCC payment that each eligible hospital will receive.

CMS finalizes its proposal to determine Factor 3 for FFY 2024 using the average of the audited FFY 2018, FFY 2019, and FFY 2020 Worksheet S-10 reports.

Per Discharge Amount of Interim UCC Payments

Consistent with the approach adopted in FFY 2023, CMS proposed to calculate the average of FFYs 2019, 2021, and 2022 historical discharge data, rather than the average of the most recent three years of discharge data from FFYs 2020, 2021, and 2022. It is concerned about using FFY 2020 discharges that were significantly lower due to the COVID-19 pandemic and thus would potentially underestimate the number of discharges if used in the calculation for FFY 2024. In the final rule, CMS modified its policy and will calculate the per-discharge amount of UCC payments using two years of data from FFY 2021 and FFY 2022. CMS excludes the FFY 2020 discharge data as it believes that it would underestimate discharges due to the effects of the COVID-19 PHE in FFY 2020.

To reduce the risk of overpayments of interim UCC payments and the potential for unstable cash flows for hospitals, CMS continues its voluntary process through which a hospital may submit a request to its Medicare Administrative Coordinator (MAC) for a lower per-discharge interim UCC payment amount. It includes a reduction to zero, once before the beginning of the fiscal year and/or once during the fiscal year. The hospital would have to provide documentation to support a likely significant recoupment — for example, 10% or more of the hospital's total UCC payment, or at least $100,000. The only change that would be made would be to lower the per-discharge amount either to the amount requested by the hospital or another amount determined by the MAC. This does not change how the total UCC payment amount will be reconciled at cost report settlement.

Process for Notifying CMS of Merger Updates and to Report Upload Issues

CMS publishes a table on its website, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules. The table contains a list of the mergers known to CMS and the computed UCC payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies.

For FFY 2024 and subsequent years, CMS finalizes its proposal to eliminate the 15-business-day period after display of the final rule for hospitals to submit updated information on mergers and/or to report upload discrepancies. CMS believes there will be sufficient opportunity for hospitals to provide this information during the comment period for the proposed rule.

Treatment of Rural Reclassifications for Capital DSH payments

In the FFY 2007 IPPS final rule, CMS codified that urban hospitals that reclassified as rural are also considered rural when determining eligibility for capital DSH payments. On Sept. 30, 2021, in *Toledo Hospital v. Becerra*, it was ruled that this codification did not demonstrate that CMS took relative costs into account when considering the policy. As such, CMS revises this regulation so that, effective for discharges occurring on or after Oct. 1, 2023, hospitals reclassified as rural under §412.103 would no longer be considered rural for purposes of determining eligibility for capital DSH payments.

Counting Days Associated with Section 1115 Waivers

In February 2023, CMS proposed revisions to regulations on counting the 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). CMS is adopting the following in this final rule, effective Oct. 1, 2023:

- Days associated with section 1115 demonstrations will be counted in the DPP Medicaid fraction numerator only if the patient can be "regarded as" eligible for Medicaid for those days
- A patient would be "regarded as" eligible for Medicaid if they either receive health insurance authorized by a section 1115 demonstration or buy health insurance with premium assistance provided to them under a section 1115 demonstration.
- The additional days included in the numerator must only be made up of health insurance that covers inpatient hospital services, or premium assistance that covers 100% of premium costs to the patient which the patient uses to buy health insurance for inpatient hospital services, provided that the patient is not also entitled to Medicare Part A.

Patients whose hospital costs are paid with funds from a hospital's UCC pool authorized by a section 1115 demonstration are not "regarded as" eligible for Medicaid and would not be included in the DPP Medicaid fraction numerator.

Updates to MS-DRGs

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. For IPPS rate setting, CMS typically uses the MedPAR claims data file that contains claims from discharges two years prior to the fiscal year that is the subject of rulemaking. For Hospital Cost Report data, CMS traditionally uses the dataset containing cost reports beginning three years prior to the fiscal year under study. CMS finalizes its proposal to utilize FFY 2022 IPPS claims data and FFY 2021 HCRIS data, without modifications, to calculate FFY 2024 rates.

There will be 764 payable DRGs for FFY 2024 (compared to 765 for FFY 2023), with 70.0% of DRG weights changing by less than +/- 5%, 21.9% changing at least +/-5% but less than +/- 10%, 6.2% changing more than +/-10%, 4.5% that are affected by the relative weight cap on reductions, and 2.0% being new MS-DRGs. The five MS-DRGs with the greatest year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	Final FFY 2023 Weight	Final FFY 2024 Weight	Percent Change
MS-DRG 017: AUTOLOGOUS BONE MARROW TRANSPLANT WITHOUT CC/MCC	4.3701	6.1770	41.35%
MS-DRG 927: EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITH SKIN GRAFT	18.9822	26.3587	38.86%
MS-DRG 886: BEHAVIORAL AND DEVELOPMENTAL DISORDERS	1.365	1.6817	23.20%
MS-DRG 117: INTRAOCULAR PROCEDURES WITHOUT CC/MCC	0.9928	1.1984	20.71%
MS-DRG 592: SKIN ULCERS WITH MCC	1.754	2.0901	17.16%

The full list of the FFY 2024 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website. For comparison purposes, the final FFY 2023 DRGs are available in Table 5 on the CMS website.

MS-DRG Changes

CMS makes changes to a number of MS-DRGs effective for FFY 2024. CMS specifically:

- Reassigns procedures describing thrombolysis when performed for pulmonary embolism from MS-DRGs 166, 167, and 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) to new MS-DRG 173 (Ultrasound Accelerated and Other Thrombolysis for Pulmonary Embolism).
- Creates new base MS-DRG 212 (Concomitant Aortic and Mitral Valve Procedures) for cases reporting an aortic valve repair or replacement procedure and a mitral valve repair or replacement procedure in addition to another concomitant cardiovascular procedure.
- Reassigns the procedures involving cardiac defibrillator implants by deleting MSDRGs 222 through 227 (Cardiac Defibrillator Implant, with and without Cardiac Catheterization, with and without AMI/HF/shock, with and without MCC, respectively) and create new MS-DRG 275 (Cardiac Defibrillator Implant with Cardiac Catheterization and MCC) for cases reporting cardiac defibrillator implant with cardiac catheterization with MCC, and new MS-DRGs 276 and 277 (Cardiac Defibrillator Implant with MCC and without MCC, respectively) for cases reporting cardiac defibrillator implant.
- Reassigns procedures describing thrombolysis performed on peripheral vascular structures from MS-DRGs 252, 253, and 254 (Other Vascular Procedures with MCC, with CC, and without CC/MCC, respectively) to new MS-DRG 278 (Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures with MCC) and new MS-DRG 279 (Ultrasound Accelerated and Other Thrombolysis of Peripheral Vascular Structures without MCC).
- Creates new MS-DRGs 323 and 324 (Coronary Intravascular Lithotripsy with Intraluminal Device with MCC and without MCC, respectively) for cases reporting C-IVL with placement of an intraluminal device, create new base MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device) for cases reporting C-IVL without the placement of an intraluminal device, delete MS-DRG 246 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents), MS-DRG 247 (Percutaneous Cardiovascular Procedures with Drug-Eluting Stent without MCC), MS-DRG 248 (Percutaneous Cardiovascular Procedures with Non-Drug-Eluting Stent with MCC or 4+ Arteries or Stents) and MS-DRG 249 (Percutaneous Cardiovascular Procedures with Non-Drug- Eluting Stent without MCC) and create new MS-DRG 321(Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices) and new MS-DRG 322 (Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC).
- Deletes MS-DRGs 338 through 340 (Appendectomy with Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) and MS-DRGs 341 through 343 (Appendectomy without Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) describing appendectomy with and without a complicated principal diagnosis and create new MS-DRGs 397, 398, and 399 (Appendix Procedures with MCC, with CC, without CC/MCC, respectively)."

Social Determinants of Health (SDOH) Diagnosis Coding

In the FFY 2023 proposed rule, CMS requested information on the following topics that pertain to the 96 diagnosis codes relating to SDOH (Z codes found in categories Z55–Z65) to gauge whether a proposal to change severity level designations of these codes in future rulemaking would be appropriate.

As a result of feedback received in response to the FFY 2023 proposed rule, CMS finalizes its proposal in the FFY 2024 rule in the to change the severity level for the following diagnosis codes regarding homelessness from NonCC to CC effective for FFY 2024:

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

Cap for Relative MS-DRG Weight Reductions

Beginning in FFY 2023, CMS adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget-neutral manner. As such, CMS finalizes applying a budget-neutrality adjustment of 0.999928 (proposed at 0.999925) to the operating rate and 0.9999 (as proposed) to the capital rate for all hospitals in FFY 2024.

CAR-T Cell Therapies

In some cases, the CAR-T cell or other immunotherapy patients may be part of a clinical trial where the high-cost therapy product is furnished to the hospital at no cost. This may occur in "expanded access use" cases that are also known as compassionate use. There are also occasions where a CAR-T case is part of a clinical trial, but the hospital incurs the cost of the CAR-T product because another drug is under investigation. Beginning with FFY 2021, CMS adopted a differential payment for the first two of these three situations to recognize hospitals' lower costs.

To identify clinical trial cases, CMS excludes claims from the relative weight calculation with diagnosis codes Z00.6 or less than $373,000 in drug costs — the average sales price of the two CAR-T cell products approved to treat relapsed/refractory diffuse large B-cell lymphoma in drug costs. Until now, there have been no indicators on the claims to identify expanded access use cases that should also be excluded from the relative weight calculation. There have also been no indicators on the claims to identify when a case is part of a clinical trial but a different drug is under investigation and the hospital has a cost for the CAR-T product.

For FFY 2024, CMS is adopting two changes in the methodology for identifying clinical trial claims and expanded access use claims in MS-DRG 018. First, CMS will exclude claims with the presence of condition codes 90 or ZB and claims that contain ICD-10-CM diagnosis code Z00.6 without payer-only code ZC when calculating the average cost. Second, CMS will no longer use the proxy of standardized drug charges of less than $373,000 to identify clinical trial claims and expanded access use cases when calculating the average cost of this MS-DRG.

For FY 2024, CMS finalized an adjustor of 0.27 to MS-DRG 018 in the scenarios where the hospital does have a cost for the CAR-T or other immunotherapy product.

Post-Acute Transfer Policy

CMS finalizes changes to a number of MS-DRGs effective for FFY 2024. As a result of its review, CMS finalizes adding two new MS-DRGs to the post-acute care transfer MS-DRG list (MS-DRGs 276 and 277, Cardiac Defibrillator Implant with and without MCC, respectively). CMS also makes these MS-DRGs subject to the special payment methodology.

New Technology Payments

The final rule states that many new medical services or technologies are eligible for add-on payments outside the PPS. The table below shows the 11 technologies that are eligible for continued add-on payments for FFY 2024, since their three-year anniversary date will occur on or after April 1, 2024.

Continuation of Technologies Approved for FY 2023 New Technology Add-On Payments Still Considered New for FY 2024 Because 3-Year Anniversary Date Occurs on or After April 1, 2024*

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto US. Market
1	Intercept® (PRCFC)	05/05/2021	10/1/2021	5/05/2024
2	Rybrevant™	05/21/2021	10/1/2021	05/21/2024
3	StrataGraft®	06/15/2021	10/1/2021	06/15/2024
4	aprevo® Intervertebral Body Fusion Device	6/30/2021 (TLIF)	10/1/2021	6/30/2024 (TLIF)
5	Hemolung Respiratory Assist System (RAS)	11/15/2021 (other)	10/1/2022	11/15/2024 (other)
6	Livtencity™	12/2/2021	10/1/2022	12/2/2024
7	Thoraflex Hybrid Device	04/19/2022	10/1/2022	04/19/2025
8	ViviStim	04/29/2022	10/1/2022	04/29/2025
9	GORE TAG Thoracic Branch Endoprosthesis	05/13/2022	10/1/2022	05/13/2025
10	Cerament® G	05/17/2022	10/1/2022	05/17/2025
11	iFuse Bedrock Granite Implant System	05/26/2022	10/1/2022	05/26/2025

*As discussed in the following section, CMS finalizes its proposal to discontinue new technology add-on payments for COVID-19 Hemolung RAS cases.

The table below shows the 15 technologies that will no longer receive add-on payments for FFY 2024 since their three-year anniversary date will occur prior to April 1, 2024.

Technologies Approved for FY 2023 New Technology Add-On Payments But No Longer Considered New for FY 2024 Because 3-Year Anniversary Date Occurs Prior to April 1, 2024				
	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market
1	TECARTUS®*	7/4/2020	10/1/2021	7/4/2023
2	VEKLURY®**	7/1/2020*	10/1/2021	7/1/2023*
3	Zepzelca™	6/15/2020	10/1/2021	6/15/2023
4	aScope® Duodeno	7/17/2020	10/1/2021	7/17/2023
5	Caption Guidance™	9/15/2020	10/1/2021	9/15/2023
6	aprevo® Intervertebral Body Fusion Device	12/3/2020 (ALIF and LLIF)	10/1/2021	12/3/2023 (ALIF and LLIF)
7	Cosela™	2/12/2021	10/1/2021	2/12/2024
8	ShockWave C2 Intravascular Lithotripsy (IVL) System	2/12/2021	10/1/2021	2/12/2024
9	ABECMA®	3/26/2021	10/1/2021	3/26/2024
10	Harmony™ Transcatheter Pulmonary Valve (TPV) System	03/26/2021	10/1/2021	3/26/2024
11	Recarbrio™ (HABP/VABP)	6/4/2020	10/1/2021	6/4/2023
12	Fetroja® (HABP/VABP)	9/25/2020	10/1/2021	9/25/2023
13	DARZALEX FASPRO®	01/15/2021	10/1/2022	01/15/2024
14	CARVYKTI™	03/26/2021**	10/1/2022	03/26/2024
15	Hemolung Respiratory Assist System (RAS)	04/22/2020 (COVID-19)	10/1/2022	04/22/2023 (COVID-19)

*See discussion in the FY 2023 IPPS/LTCH PPS final rule (87 FR 48909 through 48914).

** As discussed in the FY 2023 IPPS/LTCH PPS final rule, because CMS determined that CARVYKTI™ is substantially similar to ABECMA®, it considers the beginning of the newness period for CARVYKTI™ to be March 26, 2021, which is the date that ABECMA® received FDA marketing authorization (87 FR 48925).

CMS approved new technology add-on payments for 8 technologies under the traditional pathway[1] and 11 under alternative pathways.[2] CMS is also conditionally approving one new technology (taurolidine/heparin) under the alternate pathway.

New COVID-19 Treatment Add-On Payments Extend Through Sept 30, 2023

Eligible products will continue to receive the New COVID-19 Treatment Add-On Payment (NCTAP) through Sept. 30, 2023. CMS previously established the NCTAP to increase the current IPPS payment amount for drugs and biologicals authorized for emergency use for the treatment of COVID-19 in the inpatient setting. Specifically, beginning for discharges on or after Nov. 2, 2020, through the end of the PHE, hospitals will be paid the lesser of 65% of the operating outlier threshold for the claim or 65% of the amount for which the cost of the case exceeds the standard DRG payment. More information about NCTAP can be found on the CMS website.

FFY 2024 Wage Index

CMS adjusts a portion of IPPS payments to account for area differences in the cost of hospital labor, an adjustment known as the area wage index. Additional details about this methodology can be found in the regulation. A complete list of the final wage indexes for payments in FFY 2024 is available on the CMS website.

Core-Based Statistical Areas (CBSAs) for the FFY 2024 Hospital Wage Index

Hospitals are assigned to labor market areas and the wage index reflects the weighted (by hours) average hourly wage reported on Medicare cost reports. CMS uses Office of Management and Budget (OMB) CBSA delineations as labor market areas. CMS is currently using OMB delineations from 2015 (based on the 2010 census) updated by OMB Bulletin numbers 13-01, 15-01, 17-01, 18-04, and 20-01.

Worksheet S-3 Wage Data

CMS calculates the FFY 2024 wage index using data from FFY 2020 submitted cost reports. CMS does not make any changes to the categories of included and excluded costs for FFY 2024 relative to prior years. CMS' calculations of the FFY 2024 wage index are based on wage data of 3,129 hospitals. The data file used to construct the wage index includes FFY 2020 data submitted to CMS as of June 2023.

The final rule notes the wage index data CMS is using for the FFY 2024 wage index spans the COVID-19 PHE. The proposed rule presented summary data showing that a higher proportion of hospitals had an increase in their average hourly wage using the FFY 2020 data than in prior years. However, CMS indicates that it is not apparent whether any changes due to the COVID-19 PHE differentially impacted the wages paid by individual hospitals and therefore proposed no changes related to COVID-19.

1 CYTALUX® for ovarian cancer; CYTALUX® for lung cancer; EPKINLY™ and COLUMVI™; Lunsumio™; REBYOTA™ and VOWST™; SPEVIGO®; TECVAYLI™; and TERLIVAZ®.
2 Aveir™ AR Leadless Pacemaker; Aveir™ Dual-Chamber Leadless Pacemaker; Canary Tibial Extension with Canary Health Implanted Reporting Processor System; Ceribell Status Epilepticus Monitor; DETOUR System; EchoGo Heart Failure 1.0; Phagenyx® System; SAINT Neuromodulation System; TOPS™ System; REZZAYO™; and XACDURO®.

General wage index policies are unchanged from prior years. CMS notes that it excluded 61 providers (down from 81 in the proposed rule) due to aberrant wage data that failed edits for accuracy from the final rule wage index calculation. CMS calculates an unadjusted national average hourly wage of $50.39.

Occupational Mix Adjustment

CMS is required to collect data every three years on the occupational mix of employees for each short-term, acute care hospital that participates in Medicare. This is done to construct an occupational mix adjustment to the wage index. Data from the 2019 occupational mix survey are used for the mix adjustment applied to the FFY 2024 wage index. CMS reports having used occupational mix data for 97% of hospitals (3,007 of 3,103) to determine the wage index. Consistent with the statute, CMS will apply the 2019 occupational mix survey data to the FFY 2024 wage index. The FFY 2024 national average hourly wage, adjusted for occupational mix, is $50.34.

For FFY 2025, a new occupational mix will be required and will be based on a new CY 2022 survey. The survey can be found on the CMS website. Hospitals were required to submit their CY 2022 surveys to their MACs by June 30, 2023. The preliminary, unaudited CY 2022 survey data was posted on the CMS website in mid-July 2023. Hospitals had until Sept. 1, 2023, to request revisions to their Worksheet S-3 wage data and CY 2022 occupational mix data as included in the wage and occupational mix preliminary public use files.

Rural Floor

The rural floor is a provision of statute that prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS indicates that the rural floor will increase the FFY 2024 wage index for 646 urban hospitals (compared to 275 in FFY 2023) requiring a budget-neutrality adjustment factor 0.978183 (-2.18%) applied to hospital wage indexes. This compares to an adjustment of 0.991909 (-0.81%) in FFY 2023.

In the FFY 2020 IPPS final rule, CMS adopted a policy where hospitals that reclassified from urban to rural had their wage data removed from the rural floor calculation to prevent inappropriate payment increases under the rural floor. The wage data were also removed from the calculation to determine the wage index for rural areas of each state. This rural floor policy and the related budget-neutrality adjustment were subject to litigation (*Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*) in which it was determined that the secretary does not have the authority to establish a rural floor lower than the rural wage index for a state. In the FFY 2023 IPPS final rule, CMS adopted the removal of that policy that began in FFY 2020. Upon further review of this case law, prior public comments, and relevant statutes, CMS now fully agrees with the courts' decisions on this and will treat §412.103 (redesignated rural) hospitals the same as geographically rural hospitals for the wage index calculation.

CMS has a longstanding hold harmless policy to prevent the rural wage index of a state from being lowered by hospitals that reclassify to a state rural area. Due to the adopted policy above, the rural wage index will no longer be held harmless from in-state hospitals reclassifying as rural under §412.103. However, for hospitals who have a state-to-state MGCRB reclassification, CMS

will continue this hold harmless policy to exclude the data of hospitals reclassifying into another state's rural area if doing so would reduce that state's rural wage index.
Similarly, CMS' current policy is to exclude a dually reclassified hospital — an urban hospital that reclassified into the rural area and obtained an MGCRB reclassification out of the rural area — from the calculation of the rural wage index. Under the final rule, the urban to rural reclassified hospital with an MGCRB reclassification will be included in the group of hospitals reclassifying out of the rural area to determine whether the hold harmless policy applies with respect to including or excluding these hospitals from the rural wage index.

Another provision of the statute provides hold harmless protection to hospitals remaining in an urban county if an MGCRB reclassification or a Lugar reclassification results in the urban county having a wage index below the rural area of its state. In that event, hospitals remaining in that county receive the rural floor wage index of the state in which it is located. CMS will continue this policy. CMS also finalized that hospitals that reclassify across state lines to use the rural wage index in a different state would receive the combined wage index that includes the wage data for geographically rural hospitals and all hospitals reclassified into the rural area.

Imputed Floor

The rural floor cannot apply in all urban states, as there is no rural area wage index upon which to determine the floor. CMS adopted an imputed floor for all urban states beginning in FFY 2005 (benefiting only New Jersey hospitals) and in FFY 2013, adopted an alternative methodology benefiting hospitals in all urban states (i.e., Delaware and Rhode Island) that did not benefit from the original methodology. Both methodologies were applied in a budget-neutral manner — necessitating a reduction in payments to all hospitals to offset the cost. CMS allowed both imputed floor methodologies to expire after FFY 2018.

Section 9831 of the American Rescue Plan Act (ARPA), enacted by Congress on March 11, 2021, re-established the imputed floor. However, the provision was exempted from IPPS budget-neutrality requirements, eliminating the need for a reduction in payment to hospitals to offset its cost. In addition to states that previously benefited from the imputed floor, the ARPA provision applies in Washington, D.C., Puerto Rico, and in one state (Connecticut) that has rural areas but no hospitals that are being paid using a rural wage index. In the final rule impact analysis, CMS indicates that the imputed floor will increase payment to 65 hospitals by $230million.

Frontier Floor Wage Index

The ACA requires a wage index floor for hospitals in the low-population-density states of Montana, Nevada, North Dakota, South Dakota, and Wyoming. As all hospitals in Nevada have a wage index of over 1.0, the provision will have no effect on Nevada hospitals. This provision is not budget neutral, and CMS estimates an increase of approximately $60 million in IPPS operating payments to 42 hospitals in Montana, North Dakota, South Dakota, and Wyoming due to the frontier floor.

Revisions to FFY 2024 Wage Index Based on Geographic Reclassifications

There are 466 hospitals approved for wage index reclassifications starting in FFY 2024. Because reclassifications are effective for three years, there are a total of 1,062 hospitals in MGCRB reclassification status for FFY 2024.

The deadline for withdrawing or terminating a wage index reclassification approved by the MGCRB was 45 days from publication of the FFY 2024 proposed rule in the *Federal Register* (June 15, 2023). Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process were incorporated into the final FFY 2024 wage index values.

Lugar Hospitals and Counties
A "Lugar" hospital is located in a rural county adjacent to one or more urban areas that is automatically reclassified to the urban area from which the highest number of its workers commute. The out-migration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Out-migration adjustments are fixed for three years. A hospital can either be reclassified or receive the out-migration adjustment, but not both. Lugar status is automatic. A Lugar hospital must decline its reclassification using the same process as other hospitals to receive the out-migration adjustment (e.g., notify CMS within 45 days of the proposed rule publication that it is declining its Lugar reclassification).

The final rule restates the following policies with respect to how Lugar hospitals may decline their urban status to receive the out-migration adjustment:

- Waiving deemed urban status results in the Lugar hospital being treated as rural for all IPPS purposes.
- Waiving deemed urban status can be done once for the three-year period that the outmigration adjustment is effective.
- If a Lugar hospital waives its reclassification for three years, it must notify CMS to reinstate its Lugar status within 45 days of the IPPS proposed rule publication for the following fiscal year.
- In some circumstances, a Lugar hospital may decline its urban reclassification to receive an out-migration adjustment that it would no longer qualify for once it is reclassified as rural. In these circumstances, CMS will decline the Lugar hospital's request and continue to assign it a higher urban wage index (which itself could result in the county requalifying for the out-migration adjustment based on data in the final rule).

Out-migration Adjustment

CMS applies the same policies for the FFY 2024 out-migration adjustment that it has been using since FFY 2012. CMS estimates the out-migration adjustment will increase IPPS payments by $52 million to 173 hospitals in FFY 2024. This provision is not budget neutral.

Reclassification from Urban to Rural

A qualifying IPPS hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Not later than 60 days after the receipt of an application from an IPPS hospital that satisfies the statutory criteria, CMS must treat the hospital as being located in the rural area of the state in which the hospital is located.

CMS restates policies adopted in earlier years regarding urban to rural reclassifications. It also notes that it is adopting a new policy with respect to the effective date for hospitals that qualify

for urban-to-rural reclassification to become SCHs. This change is discussed below in the SCH section.

Process for Requests for Wage Index Data Corrections

CMS details its established multistep, 15-month process for the review and correction of the hospital wage data used to create the IPPS wage index for the upcoming fiscal year. A hospital that fails to meet the procedural deadlines does not have a later opportunity to submit wage index data corrections or to dispute CMS' decision on requested changes.

The FY 2025 wage index process has already begun. For the FY 2025 wage index timetable go to the CMS website. It includes all the public use files made available during the wage index development process.

Labor-Related Share

CMS updates the labor-related share every four years. The labor-related share was last updated in the FFY 2022 final rule. CMS is currently using a national labor-related share of 67.6%. If a hospital has a wage index of less than 1.0, its IPPS payments will be higher with a labor-related share of 62%. If a hospital has a wage index that is higher than 1.0, its IPPS payments will be higher using the national labor-related share of 67.6%. Consistent with the statute, CMS is not applying budget neutrality when using the lower 62% labor share when a hospital has a wage index less than 1.0.

Permanent Cap on Wage Index Decreases

CMS adopted a policy to apply a 5% cap on any decrease of the FFY 2023 IPPS wage index, and all future IPPS wage indexes, compared with the previous year's final wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner.

This also means that if an IPPS provider's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. If a hospital reclassifies as rural under 42 CFR §412.103 with an effective date after this day, the policy will apply to the reclassified wage index instead. Additionally, a new IPPS hospital will be paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS will not have a wage index in the prior FFY.

This policy is implemented in a budget-neutral manner with a net budget-neutrality factor of 0.99996 (proposed at 0.99687), after backing out the effects of the FFY 2023 adjustment.

Continuation of the Low-Wage Index Hospital Policy

Despite opposition from CHA and other stakeholders, in the FFY 2020 IPPS final rule, CMS adopted a policy intended to address concerns that the current wage index system perpetuates and exacerbates the disparities between high- and low-wage index hospitals. CMS finalized the policies to be effective for a minimum of four years and be reflected in the Medicare cost report for future years. Therefore, for FFY 2024, CMS continues the following specific policies:

- Hospitals with a wage index value in the bottom quartile of the nation would have that wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals. For FFY 2024, the 25th percentile wage index value across all hospitals is 0.8667 (proposed at 0.8615).
- CMS applies a budget-neutrality adjustment of 0.99925 (proposed at 0.99922) after backing out the effects of the FFY 2023 adjustment.

This policy is subject to pending litigation (*Bridgeport Hospital, et al., v. Becerra; Kaweah Delta Medical Center v. Becerra)* in which the court found that the secretary did not have the authority to adopt this low-wage index policy and has ordered additional briefing on an appropriate remedy. These decisions involve only FFY 2020, are not final, and have been appealed by CMS. Given there is only one year of relevant data (FFY 2020) that CMS could use to evaluate any potential impacts of the policy on hospital wages, CMS believes it necessary to wait until usable data from additional fiscal years are available before making a decision to modify or discontinue the policy for additional years.

In addition to the 2020 litigation (*Kaweah Delta Medical Center v. Becerra*), CHA is currently pursuing similar, separate litigation on behalf of its members for FFYs 2021, 2022, and 2023.

Rural Referral Center: Annual Updates to Case-Mix Index and Discharge Criteria

CMS provides updated criteria for determining Rural Referral Center (RRC) status, including updated minimum national and regional case-mix index (CMI) values, and updated minimum national and regional numbers of discharges. For FFY 2024, CMS uses FFY 2022 data to set the CMI criteria.
To qualify for initial RRC status for cost reporting periods beginning on or after Oct. 1, 2023, a rural hospital must have 275 or more beds. Those with fewer than 275 beds available for use can obtain RRC status if they meet specific geographic criteria, and have:

- More than 5,000 discharges (3,000 for an osteopathic hospital) in their cost reporting period that began during FFY 2021
- A CMI greater than or equal to the lower of 1.80655 (national urban hospital CMI excluding teaching hospitals) or the CMI for the hospital's census region (Pacific Census Region, 1.8094)

The median regional CMIs in the final rule reflect the March 2023 update of the FFY 2022 MedPAR, which contains data from claims received through March 2023. A hospital seeking to qualify as an RRC should get its hospital-specific CMI value (not transfer-adjusted) from its MAC.

Low-Volume Hospital Adjustment

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modify the amount of the adjustments. The Bipartisan Budget Act of 2018 had extended the relaxed low-volume adjustment criteria through the end of FFY 2018. In addition, the Act included a further

extension of the adjustment for FFYs 2019-22 with a change to the discharge criteria by requiring that a hospital have fewer than 3,800 total discharges (rather than 1,600 Medicare discharges). The Consolidated Appropriations Act (CAA) of 2023 extended these criteria through FFY 2024.

In FFY 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 both the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital
- Have fewer than 200 total discharges (all payer) during the fiscal year

Consistent with historical practice, for a hospital to receive low-volume status for FFY 2024 it must submit a written request to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for FFY 2024. The MAC must have received the request by Sept. 1, 2023, for the adjustment to be applied to payments for its discharges beginning on or after Oct. 1, 2023. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

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

Medicare-Dependent Small Rural Hospitals (MDH)

The MDH program was most recently extended through FFY 2024 by the CAA of 2023. As a result of this extension, any hospital classified as an MDH as of Dec. 23, 2022, was reinstated as an MDH effective Dec. 24, 2022, without the need to reapply. Due to the retroactive nature of these extensions, hospitals classified as MDHs as of Sept. 30, 2022, would generally be classified as MDHs as of Oct. 1, 2022. CMS is not adopting any other changes in the regulations regarding eligibility or payments for the MDH program through FFY 2024. CMS also recommends that any provider who is unsure of their MDH status should contact their MAC.

Sole Community Hospital (SCH) Status

CMS modifies the effective date for SCH status in the case where there is a merger that allows two hospitals operating 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 is adopting that the SCH and payment adjustment would be effective as of the approved merger effective date if the 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. The effective date of the rural reclassification of these hospitals be effective on the same day as the SCH classification.

Indirect and Direct Graduate Medical Education Costs

The indirect medical education (IME) adjustment factor remains at 1.35 for FFY 2024. Below is an overview of several IME/graduate medical education (GME) policies discussed in the FFY 2024 IPPS final rule.

Cost Report Instructions Clarification

The final rule responds to questions it has received regarding the application of the affiliated group provisions to the interns and residents to bed (IRB) ratio. The rule indicates how the cost reporting instructions are being revised to clarify the complex calculations involved in determining a hospital's IME payments inclusive of the rules related to the three-year rolling average count of residents and the IRB cap.

Training in a Rural Emergency Hospital (REH)

In response to comments submitted on the 2023 outpatient prospective payment system (OPPS) final rule related to the REH model, CMS finalizes 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 IME FTE counts. This could be done as long as a hospital meets the non-provider setting requirements and other regulations that would be applicable to critical access hospitals.

Reasonable Cost Payment for Nursing and Allied Health Education Programs

Medicare pays for provider-operated nursing and allied health education programs on a reasonable-cost basis. CMS is required to include Medicare Advantage (MA) utilization in determining the Medicare share of reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to MA utilization were funded through a reduction to analogous payments made to teaching hospitals for direct GME and limited to $60 million per year.

CMS uses cost reporting periods ending in the fiscal year that is two years prior to the current CY to determine each eligible hospital's share of the $60 million pool in a given year. Each hospital's payment is based on its relative share of national nursing and allied health education payments and MA utilization.

CMS released change request 2692 on May 23, 2003. This change request included a pool of $43.7 million for nursing and allied health education MA payments that required a 14.13% reduction to MA direct GME payments. The next change request was released on Dec. 14, 2020. It provided the amounts for the nursing and allied health education MA pool for the years 2002 to 2018 that ranged from $8.7 million to $60 million and reductions to MA direct GME payments ranging from 4.58% to 9.88%.

This 17-year delay in updating the figures for nursing and allied health education MA payments resulted in overpayments of hundreds of millions of dollars to hospitals with provider-operated schools of nursing and allied health education and underpayment of MA direct GME payments.

For 2020 and 2021, CMS used the FFY 2023 IPPS rule to furnish the nursing and allied health MA add-on payment rates and the MA direct GME offset. For 2022, CMS proposed to use data from

cost reports ending in FY 2020 (the fiscal year that is two years prior to CY 2022) to notify the public of key statistics regarding nursing and allied health education MA payments.

For the final rule, CMS is using the first quarter 2023 update of the 2020 HCRIS. For 2022, CMS will be distributing $60 million in nursing and allied health education MA payments with an offset of 3.27% to MA DGME payments. These figures are the result of applying the statutory formula, which leads to capped payments of $60 million for nursing and allied health education MA payments.

While CMS did not update the data used to determine nursing and allied health GME payments from 2003 until 2020, the MACs continued to make them using data that were in the May 23, 2003, change request that included an offset to MA direct GME payments of 14.13%. This exceeds the amounts that would have been applied if CMS had annually updated the calculations. During this period, nursing and allied health education payments exceeded the $60 million cap and resulted in CMS seeking refunds of hundreds of millions of dollars from hospitals in Medicare reasonable cost payments for the period 2010 through 2019. CMS also repaid hospitals for the underpayment of MA direct GME payments.

Section 4143 of the CAA of 2023 provides relief for hospitals subjected to recoupment of overpayments for 2010 through 2019. It does this by not applying the $60 million payment limit to nursing and allied health education MA payments during these years. This relief only applies to hospitals that, as of the date of enactment of the CAA of 2023, were continuing to operate a school of nursing or allied health entitled to receive reasonable cost education payments. Section 4143 also provides that CMS shall not reduce a hospital's MA direct GME payments to offset the increase in nursing and allied health MA education payments.

The proposed rule detailed CMS' instructions to the MACs to implement section 4143. In summary, CMS instructed the MACs to recalculate a hospital's total nursing and allied health education MA payment for 2010 through 2019 using information in the table reproduced below. Each hospital would receive a share of payments in the column labeled "Section 4143 CAA POOL" based on the ratio of its own MA days compared to national aggregate MA days. To be eligible to receive these payments, the hospital must have been receiving nursing and allied health MA payments on an interim basis as of Dec. 29, 2022.

The MAC will then compare the hospital's share of nursing and allied health MA payments from these calculations and reconcile them with any prior amounts already paid or recouped from the hospital. Amounts previously recouped will be returned to hospitals, and recoupments that would have occurred if not for the enactment of Section 4143 of the CAA of 2023 will not occur.

CALCULATION TABLE FOR SECTION 4143 OF CAA OF 2023						
YEAR	Section 4143 CAA POOL	FFS NURSING AND ALLIED HEALTH (NAH) PAYMENTS	FFS INPATIENT DAYS	MA INPATIENT DAYS	(FFS NAH/FFS INPT DAYS) X MA INPT DAYS	PERCENT REDUCTION TO MA DGME PAYMENTS
CY 2010	$62,997,033	$213,862,393	45,409,814	3,114,194	$14,666,631	9.77%
CY 2011	$66,438,422	$226,645,225	49,217,935	3,825,354	$17,615,494	7.85%
CY 2012	$76,035,672	$240,958,503	55,551,047	4,376,532	$18,983,667	7.16%
CY 2013	$84,753,118	$245,304,017	54,965,956	4,945,724	$22,071,952	6.41%
CY 2014	$93,598,893	$248,506,989	54,405,730	5,360,315	$24,484,107	5.86%
CY 2015	$102,448,386	$247,076,161	55,223,064	5,907,933	$26,432,967	5.32%
CY 2016	$110,412,962	$253,272,740	55,717,901	6,376,818	$28,986,630	4.99%
CY 2017	$119,165,456	$249,546,528	58,599,068	7,241,576	$30,838,548	4.44%
CY 2018	$130,335,289	$267,714,849	61,066,487	7,888,809	$34,584,457	4.12%
CY 2019	$140,589,366	$262,043,840	62,649,285	8,481,459	$35,475,490	4.07%

Commenters objected to CMS requiring that the hospital must be receiving nursing and allied health MA payments on an interim basis as of Dec. 29, 2022 to be eligible for relief under section 4143 of the CAA, 2023. These commenters indicated that such a requirement was not specified in statute and will deny relief to hospitals that have nursing and allied health education programs where the MAC denied payment but the issue is under appeal.

In the final rule, CMS clarifies that in these cases, it believes the normal appeals process should be followed. If the hospitals prevail in their appeal, and the MAC restores nursing and allied education payments, CMS would treat the hospitals as though they were receiving interim nursing and allied health MA payments as of December 29, 2022. This policy would not apply to hospitals that closed a nursing and allied education program because of denial of payment before December 29, 2022, even if that denial of payment is under appeal.

Rate-of-Increase for TEFRA Hospitals

Hospitals subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) continue to be paid based on reasonable costs subject to a per-discharge limit updated annually. These hospitals include 11 cancer hospitals, children's hospitals, and hospitals located in the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Religious non-medical health care institutions are also paid reasonable costs subject to a limit. The FFY 2024 annual update to the TEFRA limit is 3.3%.

Disclosures of Ownership and Additional Disclosable Parties Information

Under the authority of section 6101 of the ACA, CMS requires disclosure of certain ownership, managerial, and other information regarding Medicare skilled-nursing facilities (SNFs) and Medicaid nursing facilities (NFs). In a *Federal Register* notice published on Feb. 15, 2023 (88 FR 9820), CMS proposed a definition of "private equity company" (PEC) and "real estate investment trust" (REIT) for purposes of ownership disclosure on the CMS-855A Medicare enrollment form.

The proposed rule indicates that these types of ownership arrangements are associated with declining nursing home quality. CMS does not believe these quality issues are limited to SNFs and NFs. Rather, these quality issues could be associated with other providers and suppliers that also enroll using the CMS-855A. CMS proposed that all providers and suppliers that enroll in Medicare using the form CMS-855A disclose PEC and REIT ownership information. CMS further requests comments on whether the definitions of PEC and REIT should be modified from the definition that applies to SNFs and NFs for other provider or supplier types.

CMS received 10 comments on these proposals. These comments closely aligned with those received on the Feb. 15, 2023, proposed rule, *Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities* (88 FR 9820). CMS will address the comments it received in response to the IPPS proposed rule when it finalizes the Feb. 15, 2023, rule.

Physician Self-Referral Law and Physician-Owned Hospitals

Section 1877(i) of the Act prohibits hospitals subject to the rural exception and the whole hospital exception from increasing the number of operating rooms, procedure rooms, and beds beyond that for which the hospital was licensed (referred to as its "baseline number") on specific dates. The secretary is permitted to provide exceptions to the limits on facility expansion to an "applicable hospital" or "high Medicaid facility."

Some of the statutory provisions regarding expansion of facility capacity apply only to applicable hospitals, not to high Medicaid facilities. For instance, the statute explicitly limits applications for an exception to the expansion limit up to once every two years to an applicable hospital. Further, the statute only explicitly requires CMS to provide an opportunity for public input on the exception from applicable hospitals. However, CMS extended these provisions to high Medicaid facilities under its regulatory authority, citing program integrity concerns and the desirability of having a uniform set of requirements apply to both facility types. If granted an exception, CMS' regulations, as finalized in 2012, limit the increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital or high Medicaid facility is licensed — to the extent such increase does not exceed 200% of its baseline number. By regulation, the increases may only occur on the hospital's main campus.

In the CY 2021 OPPS/ambulatory surgery center rulemaking cycle, CMS reconsidered these policies as applied to high Medicaid facilities as part of the Patients Over Paperwork initiative. Citing burden, the final rule removed a number of these restrictions on expansion requests for these facilities. Thus, as of Jan. 1, 2021, a high Medicaid facility may request an exception to the prohibition on expansion of facility capacity more frequently than once every two years. It may also request to expand its facility capacity beyond 200% of the hospital's baseline number of operating rooms, procedure rooms, and beds. If its request is granted, it is not restricted to locating approved expansion facility capacity on the hospital's main campus.

Revisions to the Process for Requesting an Exception from the Prohibition on Expansion of Facility Capacity

CMS finalizes a number of changes, with some modifications from the proposed rule, to the existing regulations that implement the statutory requirement for that process.

Eligibility: CMS clarifies the applicant must first demonstrate it meets the criteria for an applicable hospital or high Medicaid facility before CMS will consider an expansion exception request. Hospitals that satisfy those criteria must also demonstrate the following:

- The hospital has not already been approved by CMS for an expansion exception that would allow the hospital to reach 200% of its baseline facility capacity; and
- It has been at least 2 calendar years from the date of the most recent decision by CMS approving or denying the hospital's most recent expansion exception.

Decisions to Approve or Deny an Application: CMS finalizes its proposals, with modifications, for the process it will use to approve or deny an application for an expansion request.

First, CMS will determine whether the hospital meets the criteria for an applicable hospital or a high Medicaid facility. This will be based on the information submitted in the application as well as on community input.

Then, in reviewing a request, the agency will consider the information submitted by the hospital in the application, community input, and information provided by the applicant hospital in its rebuttal statement, if any. In its review, CMS could also consider other data and information relevant to its decision, which could include publicly available data and information, information provided by interested parties, and information from government agencies.

CMS will consider the following factors in making decisions on applications and could also consider other factors:

- The specialty (e.g., maternity, psychiatric, or substance use disorder care) of the hospital or the services furnished by, or to be furnished by, the hospital if CMS approves the request
- Program integrity or quality of care concerns related to the hospital
- Whether the hospital needs additional operating rooms, procedure rooms, or beds
- Whether there is a need for additional operating rooms, procedure rooms, or beds in
    - the county in which the main campus of the hospital is located, or
    - any county in which the hospital provides inpatient or outpatient hospital services as of the date the hospital submits the expansion exception request.

Hospital Performance-Based Quality Programs

For FFYs 2022 and 2023, CMS applied measure suppression policies and established special scoring methodologies to account for the impact of COVID-19 hospital performance under its performance-based quality programs: the Hospital Readmissions Reduction Program (HRRP), the hospital Value-Based Purchasing (VBP) Program, and the Hospital-Acquired Conditions (HAC) Reduction Program. Under these policies, the agency did not apply payment penalties for any hospitals in the hospital VBP (FFY 2022 and 2023) or HAC Reduction programs (FFY 2023) and suppressed certain HRRP measures and modified other HRRP measure specifications. CMS also finalized measure modifications under the HAC and hospital VBP programs to address the ongoing impacts of COVID-19 in future program years. For more detailed discussion of its previous modifications to measure specifications, see CHA's summary of the FFY 2023 IPPS proposed rule.

For FFY 2024, CMS will return to each program's typical scoring methodology, resuming positive and negative payment adjustments under the hospital VBP Program and a 1% reduction in IPPS

payments to hospitals in the worst-performing quartile of the HAC Reduction Program. Specific policies related to each program are discussed below. Notably, CMS finalized no changes to the HRRP in the final rule.

Hospital Readmissions Reduction Program

The HRRP reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital subject to the HRRP receives an adjustment factor between 1 (no reduction) and 0.9700, for the greatest possible reduction of 3% of base operating diagnosis-related group (DRG) payments. As adopted in the FFY 2018 IPPS final rule, and as required by the 21st Century Cures Act, hospitals are assigned to one of five peer groups based on the proportion of Medicare inpatients who are dually eligible for full-benefit Medicare and Medicaid; the HRRP formula compares a hospital's performance to the median for its peer group.

The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio (ERR) to the median ERR for the hospital's peer group. "Payment" refers to base operating DRG payments, "dx" refers to an HRRP condition (i.e., acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA), chronic obstructive pulmonary disease (COPD), and coronary artery bypass grafting (CABG)), and "NMM" is a budget-neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions. For additional information on the methodology, see CHA's FFY 2018 IPPS final rule summary.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}),0\})}{All\ payments}\}$$

CMS retains the six previously adopted readmissions measures: AMI, HF, PN, THA/TKA, COPD, and CABG. As noted earlier, CMS previously adopted technical changes to measure specifications to address the impact of COVID-19, including the removal of patients with a primary or secondary diagnosis of COVID-19 from measure denominators and including a covariate adjustment for patients with a history of COVID-19 in the 12 months prior to admission for each program measure. CMS does not adopt any changes to the HRRP in this final rule.

Hospital VBP Program

As required by law, the available funding pool for the hospital VBP Program is equal to 2% of the base operating DRG payments to all participating hospitals. CMS calculates a VBP incentive payment percentage for a hospital based on its Total Performance Score (TPS) for a specified performance period. The adjustment factor may be positive, negative, or result in no change in the payment rate that would apply absent the program.

CMS finalizes several changes to the program, including modified versions of two existing measures, one new measure under the safety domain, and technical changes to the administration of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. In addition, CMS adopts changes to the scoring methodology to include a health equity adjustment and to increase the TPS maximum to 110 points. However, in general, other scoring methodology policies — including domain weights at 25% each and payment

adjustment methodologies — are continued. Table 2 in the appendix of this summary lists previously adopted measures for the program.

Codification of Current VBP Program Measure Removal Factors
CMS codifies the program's eight measure removal factors — established in the FFY 2019 IPPS final rule — into regulation at 42 CFR §412.164(c). The current measure removal factors are:

1. Measure performance among hospitals is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("topped out" measures)
2. Measure does not align with current clinical guidelines or practice
3. Measure can be replaced by a more broadly applicable measure (across settings or populations) or a measure that is more proximal in time to desired patient outcomes for the particular topic
4. Measure performance or improvement does not result in better patient outcomes
5. Measure can be replaced by a measure more strongly associated with desired patient outcomes for the particular topic
6. Measure collection or public reporting leads to negative intended consequences other than patient harm
7. Measure is not feasible to implement as specified
8. Costs associated with a measure outweigh the benefit of its continued use in the program

Proposed Updates to Existing Program Measures
CMS finalizes its proposal to adopt substantive measure changes to two existing program measures: Medicare Spending per Beneficiary (#2158) and Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (#1550) Measure (THA/TKA Complication Measure). The modifications align with updates adopted for the measures in the hospital IQR Program in the FFY 2023 IPPS final rule.

Medicare Spending per Beneficiary (MSPB): CMS adopts a refined version of the MSPB hospital claims-based measure beginning with the FFY 2028 program year. CMS will begin publicly reporting the updated version of the measure under the IQR Program beginning in January 2024.

The refined MSPB hospital measure differs from the original version by (1) including new service inclusion and exclusion rules that reduce the capture of services outside of the control of providers, (2) allowing readmissions to trigger new episodes, and (3) modifying the measure calculation from the sum of observed costs divided by the sum of expected costs to the mean of observed costs divided by expected costs. The changes are believed to measure costs for which hospitals should be held accountable more accurately while reducing the effects of outliers on final measure scores. Consideration was given to adjusting the measure for beneficiary social risk factors, but no adjustments were made after extensive analyses showed the impacts of social risk factors on the measure to be inconsistent and limited. The refined methodology is available on QualityNet.

THA/TKA Complication Measure: CMS adopts a refined version of the claims-based THA/TKA Complication measure beginning with the FFY 2030 program year, with an initial performance

period of April 1, 2025, through March 31, 2028. CMS began publicly reporting updated measure data under the IQR Program beginning in July 2023.

The refined THA/TKA Complication measure differs from the original version by the addition of 26 ICD-10 diagnostic codes for mechanical complications in the outcome (numerator) specifications. The data source for the codes is Part A claims.

New Measure: Severe Sepsis and Septic Shock: Management Bundle (SEP-1) (#0500)
CMS finalizes its proposal to add a new measure under the Safety Domain — Severe Sepsis and Septic Shock: Management Bundle (#0500) — beginning with the FFY 2026 program year. CMS notes the measure was initially adopted in the hospital IQR Program beginning with the FFY 2017 payment determination, and that technical updates to address hospital abstractor and clinician feedback have been adopted since the measure was first introduced. The measure specifications are below.

Numerator: The number of patients who received all the following interventions for which they qualify:

Time frame	Intervention
Within 3 hours of presentation of severe sepsis	• Initial lactate level measurement • Broad spectrum or other antibiotics administered • Blood cultures drawn prior to antibiotics
AND	
Within 6 hours of presentation of severe sepsis, only if the initial lactate is elevated	• Repeat lactate level measurement
AND	
Within 3 hours of initial hypotension, OR within 3 hours of septic shock	• Resuscitation with 30 mL/kg crystalloid fluids
AND	
Within 6 hours of septic shock presentation, only if hypotension persists after fluid administration	• Vasopressors are administered
AND	
Within 6 hours of septic shock presentation, if hypertension persists after fluid administration, or initial lactate >=4mmol/L	• Repeat volume status and tissue perfusion assessment is performed

Denominator: The number of patients with an ICD-10-CM Principal or Other Diagnosis Code for sepsis, severe sepsis without septic shock, or severe sepsis with septic shock.

Exclusions: Patients under 18 years of age; patients admitted as a transfer from an inpatient, outpatient, or emergency/observation department of another hospital or an ambulatory surgical

center, or who are enrolled in a clinical trial associated with treatment of patients with sepsis; patients with advanced directives for comfort care or palliative care; patients who decline or are unwilling to consent to interventions; patients with severe sepsis or septic shock who are discharged within six hours of presentation; patients who received IV antibiotics for more than 24 hours before severe sepsis presentation; and patients with an ICD-10-CM Principal or Other Diagnosis Code of U07.1 (COVID-19).

Updates to Data Collection and Submission Requirements for HCAHPS Survey Measure (#0166)
CMS finalizes its proposal to update the form and manner of administration of the HCAHPS Survey measure under the hospital VBP Program, beginning with the FFY 2027 program year (for discharges beginning January 2025). The changes are consistent with updates adopted for the measure under the hospital IQR Program.

Specifically, CMS adopts the following changes:

- The addition of three new modes of survey administration (Web-Mail mode, Web-Phone mode, and Web-Mail-Phone mode) in addition to the current Mail Only, Telephone Only, and Mail-Phone modes
- Removal of the requirement that only the patient may respond to the survey (allowing a proxy to respond)
- Extension of the data collection period for the HCAHPS Survey from 42 to 49 days
- Limiting the number of supplemental items to 12
- Requiring hospitals to collect information about the language that the patient speaks while in the hospital and requiring the official CMS Spanish translation of the HCAHPS Survey be administered to all patients who prefer Spanish
- Removal of two options for administration of the HCAHPS Survey (Active Interactive Voice Response (IVR) survey mode and the "Hospitals Administering HCAHPS for Multiple Sites" option), both of which are not currently used by participating hospitals.

Performance and Baseline Periods
The table shows the baseline and performance periods previously updated for FFY 2025 and FFY 2026, as well as newly established periods for the SEP-1 measure in italics:

Program Year FFY 2025 and FFY 2026 Baseline and Performance Periods Updates by Measure

Measure	Baseline Period FFY 2025	Performance Period FFY 2025	Baseline Period FFY 2026	Performance Period FFY 2026
Person and Community Engagement Domain				
HCAHPS	1/1/19 – 12/31/19	1/1/23 – 12/31/23	1/1/22-12/31/22	1/1/24-12/31/24
Safety Domain				
CAUTI	1/1/19 – 12/31/19	1/1/23 – 12/31/23	1/1/22-12/31/22	1/1/24-12/31/24
CLABSI	1/1/19 – 12/31/19	1/1/23 – 12/31/23	1/1/22-12/31/22	1/1/24-12/31/24
SSI	1/1/19 – 12/31/19	1/1/23 – 12/31/23	1/1/22-12/31/22	1/1/24-12/31/24
CDI	1/1/19 – 12/31/19	1/1/23 – 12/31/23	1/1/22-12/31/22	1/1/24-12/31/24
MRSA	1/1/19 – 12/31/19	1/1/23 – 12/31/23	1/1/22-12/31/22	1/1/24-12/31/24
SEP-1			*1/1/22-12/31/22*	*1/1/24-12/31/24*
Clinical Outcomes Domain				
MORT-30-AMI	7/1/15 – 6/3/18	7/1/20-6/30/23	7/1/16-6/30/19	7/1/21-6/30/24

Program Year FFY 2025 and FFY 2026 Baseline and Performance Periods Updates by Measure				
Measure	**Baseline Period FFY 2025**	**Performance Period FFY 2025**	**Baseline Period FFY 2026**	**Performance Period FFY 2026**
MORT-30-HF	7/1/15 – 6/3/18	7/1/20-6/30/23	7/1/16-6/30/19	7/1/21-6/30/24
MORT-30-COPD	7/1/15 – 6/3/18	7/1/20-6/30/23	7/1/16-6/30/19	7/1/21-6/30/24
MORT-30-CABG	7/1/15 – 6/3/18	7/1/20-6/30/23	7/1/16-6/30/19	7/1/21-6/30/24
MORT-30-PN	7/1/15 – 6/3/18	7/1/20-6/30/23	7/1/16-6/30/19	7/1/21-6/30/24
COMP-HIP-KNEE	4/1/15-3/31/18	7/1/20-3/31/23	4/1/16-3/31/19	4/1/21-3/31/24
Efficiency and Cost Reduction Domain				
MSPB	1/1/21-12/31/21	1/1/23-12/31/23	1/1/22-12/31-22	1/1/24-12/31/24
Source: Tables V.K.-03 through V.K.-04 in the rule.				

Performance Standards

CMS updates the performance standards for the measures in the FFY 2025 program year in Table V.K.-08 of the final rule to reflect a correction to display the correct performance standards using CY 2019 data for the FFY 2025 program year. The five hospital-associated infection measures had incorrectly displayed performance standards using CY 2021 data. The previously established and estimated performance standards for the measures in the FFY 2026 program year have been updated and shown on Tables V.K.-09, V.K.-10, V.K.-11, and V.K.-12 of the final rule.

Changes to the Hospital VBP Program Scoring Methodology: Health Equity Adjustment

CMS finalizes its proposal to revise the hospital VBP Program scoring methodology to reward hospitals for providing excellent care to underserved populations. Specifically, beginning with the FFY 2026 program year, CMS will add health equity adjustment (HEA) bonus points to a hospital's TPS, calculated using a methodology that incorporates a hospitals performance across all four domains and the hospital's proportion of dually eligible patients. CMS notes that dually eligible status (DES) is a strong predictor of poorer health outcomes even when other social and functional risk factors are accounted for and is a way to capture common socioeconomic challenges.

The bonus points will be calculated and added to the total of weighted domain scores to determine the TPS as follows:

1. Calculate the measure performance scaler. The scaler is the sum of all points awarded to a hospital for each domain based on the hospital's performance. For each domain, a hospital would earn 4 points if its performance falls in the top third, 2 points if its performance falls in the middle third, or 0 points if its performance falls in the bottom third of performance of all hospitals for the domain (with a maximum of 16 performance scaler points across the 4 domains).
2. Calculate (using a logistic exchange function) the underserved multiplier, which is the number of inpatient stays for patients with DES out of the total number of inpatient Medicare fee-for-service (FFS) and MA stays during the calendar year two years before the start of the respective program year.
    - The calculation would be a logistic exchange function such that hospitals that care for the highest proportions of patients with DES would have the opportunity for the most HEA bonus points.

- A stay is identified as being dually eligible if it is for a patient with Medicare and full Medicaid benefits for the month the patient was discharged from the hospital.
- CMS is not requiring a minimum percent of patients with DES that a hospital must treat, meaning a hospital serving any percent of patients with DES will be eligible for bonus points.
- CMS notes that the adjustment uses DES data since the data are readily available and already used in the HRRP.

3. Calculate the HEA bonus points, which is the product of the measure performance scaler points multiplied by the underserved multiplier proportion, capped at 10 points (allowing for a maximum final TPS of 110).
4. Add the calculated HEA bonus points for a hospital to the total of the weighted domain scores to calculate the hospital's TPS for the program year.

CMS updates its regulations to codify a new maximum TPS of 110 points.

Minimum Number of Cases for Hospital VBP Program Measures
The previously adopted minimum numbers of cases for hospital VBP Program measures, as well as the minimum number of cases for the newly adopted Severe Sepsis and Septic Shock: Management Bundle measure beginning with the FFY 2026 program year, are shown in Table V.K.-18 of the final rule. For HCAHPS measures, there are a minimum number of 100 completed HCAHPS surveys required. For each measure in the clinical outcome's domain, there is a minimum of 25 cases required to be reported. For each measure in the safety domain (other than SEP-1), there is a minimum of 1,000 predicted infections as calculated by the CDC; and for the measure MSPB in the efficiency and cost reduction domain, there is a minimum number of 25 cases required to be reported. For the SEP-1 measure, hospitals will be required to report a minimum number of 25 cases.

Hospital-Acquired Conditions (HAC) Reduction Program

Under the HAC Reduction Program, which was implemented in FFY 2015, hospitals that fall in the worst-performing quartile are subject to a 1% reduction in IPPS payments. While CMS did not make any changes to the measure set, CMS sought comments on the addition of new measures in the future, such as the patient safety-related electronic clinical quality measures (eCQMs) that are used in the hospital IQR Program. CMS also finalized its proposals to establish a validation program reconsideration process and updates to validation targeting criteria, consistent with the IQR Program. Table 3 in the appendix of this summary lists previously adopted measures for the HAC Reduction Program.

Validation of Program Data
Beginning with FFY 2025 (CY 2022 discharges), CMS finalizes its proposal to establish a validation reconsideration process for hospitals that fail data validation. Specifically, hospitals that fail the confidence interval calculation validation can request reconsideration of their results before use in the HAC scoring calculations. This will be conducted once per program year after the validation of hospital-acquired infections for all four quarters of data and after the confidence interval has been calculated.

Similar to the IQR reconsideration process, hospitals that fail to meet the validation requirements will be notified by CMS with instructions on how to submit a request for reconsideration using a reconsideration request form. This must be done within 30 days from the date stated on the notification letter. This form can be found on the QualityNet website along with a detailed description of the reconsideration process. CMS will email hospitals an acknowledgment after receiving the form using the contact information provided on the request. CMS will also provide written notification of the final decision in approximately 90 days.

CMS will limit the scope of reconsideration reviews to information already submitted by the hospital during the initial validation process. In addition, CMS will modify the validation targeting criteria for extraordinary circumstances exceptions (ECE) beginning FFY 2027 and impacting CY 2024 discharges, to include a new criterion beyond the five established targeting criteria used to select up to 200 additional hospitals for validation. Specifically, CMS will include any hospital with an estimated reliability upper bound of the two-tailed confidence interval that is less than 75% and received an ECE for one or more quarters. These hospitals will be targeted for validation in the subsequent validation year and would not fail data validation in the program.

Hospital IQR Program

The hospital IQR Program is a pay-for-reporting program under which hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update. Additional information on the IQR measures and reporting processes is available online.

CMS adopts several changes to the IQR Program, including the addition of three new eCQMs, the removal of three measures, and refinements to existing measures. Table 1 in the appendix to this summary shows the IQR Program measure sets for FFY 2024 through FFY 2027.

New Measures in the Hospital IQR Measure Set

CMS finalizes its proposal to adopt three eCQMs to the IQR Program that are focused on patient safety. The eCQMs will be added to the list of available eCQMs that hospitals can self-select to meet reporting requirements, beginning with the FFY 2027 payment determination. The measure specifications and policies are described in detail below.

Hospital Harm – Pressure Injury eCQM

The Hospital Harm – Pressure Injury measure is an outcome eCQM that assesses the proportion of inpatient hospitalizations for patients 18 years and older who suffer the harm of developing a new stage 2, stage 3, stage 4, deep tissue, or unstageable pressure injury. The measure is intended to provide hospitals with a reliable and timely measurement of harm reduction efforts and the ability to modify their improvement efforts in near real-time.

Numerator: Inpatient hospitalizations for patients with a new deep tissue pressure injury (DTPI) or stage 2, 3, 4, or unstageable pressure injury, as evidenced by:

- A diagnosis of DTPI with the DTPI not present on admission
- A diagnosis of stage 2, 3, 4 or unstageable pressure injury with the pressure injury diagnosis not present on admission
- A DTPI found on exam greater than 72 hours after the start of the encounter; or

- A stage 2, 3, 4 or unstageable pressure injury found on exam greater than 24 hours after the start of the encounter

Denominator: Inpatient hospitalizations for patients 18 years and older
Exclusions: (1) Inpatient hospitalizations for patients with a DTPI or stage 2, 3, 4 or unstageable pressure injury diagnosis present on admission; (2) inpatient hospitalizations for patients with a DTPI found on exam within 72 hours of the encounter start; (3) inpatient hospitalizations for patients with a stage 2, 3, 4, or unstageable pressure injury found on exam within 24 hours of the encounter start; and (4) inpatient hospitalizations for patients with diagnosis of a COVID-19 infection during the encounter
Data Submission and Reporting: The measure will be calculated by the hospital's certified electronic health record (EHR) technology using the patient-level data collected through hospitals' EHRs and then submitted by hospitals to CMS. CMS s adds the measure to the available eCQM measure set from which hospitals can self-select to report beginning with the CY 2025 reporting period/FFY 2027 payment determination.

Hospital Harm – Acute Kidney Injury eCQM
The Hospital Harm – Acute Kidney Injury (AKI) measure is an outcome eCQM that assesses the proportion of inpatient hospitalizations for patients 18 years and older who have a stage 2 or greater AKI (i.e., moderate-to-severe AKI) that occurred during the encounter. It is intended to improve patient safety and prevent patients from developing stage 2 or greater AKI during hospitalization.

Numerator: Inpatient hospitalizations for patients who develop AKI (stage 2 or greater) during the encounter, as evidenced by:

- A subsequent increase in the serum creatinine value at least 2 times higher than the lowest serum creatinine value, and the increased value is greater than the highest sex-specific normal value for serum creatinine; or
- Kidney dialysis (hemodialysis or peritoneal dialysis) initiated 48 hours or more after the start of the encounter

Denominator: Inpatient hospitalizations for patients without a diagnosis of obstetrics, with a length of stay of 48 hours or longer, and who had at least one serum creatinine value after 48 hours from the start of the encounter
Exclusion: Inpatient hospitalizations for patients who (1) are younger than 18 years; (2) are already in AKI at the start of the encounter; (3) have chronic kidney disease stage 3A or greater; (4) have fewer than two serum creatinine results within 48 hours of the encounter start; (5) have kidney dialysis initiated within 48 hours of the encounter start; (6) have at least one specified diagnosis present on admission that puts them at extremely high risk for AKI, or (7) have at least one specified procedure during the encounter that puts them at extremely high risk for AKI
Data Submission and Reporting: The measure will be calculated by the hospital's certified EHR technology using the patient-level data collected through hospitals' EHRs and then submitted by hospitals to CMS. CMS adds the measure to the available eCQM measure set from which hospitals can self-select to report beginning with the CY 2025 reporting period/FFY 2027 payment determination.

Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography in Adults (Hospital Level – Inpatient) eCQM (Excessive Radiation eCQM) (#3663e)
The Excessive Radiation eCQM provides a standardized method for monitoring the performance of diagnostic CT. The measure is not risk-adjusted and is expressed as a percentage of eligible CT scans that are out-of-range based on having either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam.

> Numerator: The number of diagnostic CT scans that have a size-adjusted radiation dose greater than the threshold defined for the specific CT category and diagnostic CT scans with a noise value greater than a threshold specific to the CT category
> Denominator: The number of all diagnostic CT scans performed on patients 18 years and older during the one-year measurement period which have an assigned CT category, a size-adjusted radiation dose value, and a global noise value
> Exclusions: CT scans that cannot be categorized by the area of the body being imaged, or reason for imaging, and CT scans missing information on the patient's age, Calculated CT Size-Adjusted Dose, or Calculated CT Global Noise
> Data Submission and Reporting: The measure uses hospitals' EHR data and radiology electronic clinical data systems, including the Radiology Information System and the Picture Archiving and Communication System. Since eCQMs cannot access and process data elements in the Digital Imaging and Communications in Medicine (DICOM) standard format, and medical imaging information is stored according to that format, the measure developer created translation software (Alara Imaging Software for CMS Measure Compliance), which will be made available to all reporting entities for free. The software links primary data elements, assesses CT scans for eligibility for inclusion in the measure, and generates three data elements to calculate the eCQM: CT Dose and Image Quality Category, Calculated CT Size-Adjusted Dose, and Calculated CT Global Noise. CMS adds the measure to the available eCQM measure set from which hospitals can self-select to report beginning with the CY 2025 reporting period/FFY 2027 payment determination.

Refinements to Current IQR Program Measures

CMS finalizes refinements to three current IQR Program measures: the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure, the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure, and the Hybrid Hospital-Wide All-Cause Readmission (HWR) measure.

COVID-19 Vaccination Coverage Among HCP
Beginning with the FFY 2025 IQR (Fourth Quarter of 2023 data collection), CMS finalizes its proposal to modify the COVID-19 Vaccination Coverage Among HCP measure to replace the term "complete vaccination course" with the term "up to date" in the HCP vaccination definition, to account for additional doses and boosters that have been made available since the measure was initially adopted. The modified measure will be calculated as follows:

> Numerator: The number of HCP in the denominator population who are considered up to date with CDC-recommended COVID-19 vaccines
> Denominator: The number of HCP eligible to work in the facility for at least one day during the reporting period, excluding persons with contraindications to COVID-19 vaccination that are described by the CDC. HCPs include employees of the facility,

licensed independent practitioners, and adult students/trainees and volunteers. There are no proposed changes to the denominator from that of the current measure.
Data Submission and Reporting: For the FFY 2025 payment determination for the hospital IQR Program, the reporting period for the modified measure will begin with the fourth quarter of 2023. Providers will collect the numerator and denominator for the modified measure for at least one self-selected week during each month of the reporting quarter, and submit the data to the NHSN Healthcare Personnel Safety Component before the quarterly deadline.

Each quarter, the CDC will calculate a single quarterly COVID-19 HCP vaccination coverage rate for each provider, by taking the average of the data from the 3 weekly rates submitted by the provider for that quarter.

CMS will publicly report the COVID-19 HCP vaccination coverage rate as calculated by the CDC. CMS estimates that public reporting on the modified measure will begin with the October 2024 *Care Compare* refresh.

Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measure
CMS modifies the measure beginning for the FFY 2027 payment determination (discharge data from July 1, 2024, through June 30, 2025) by expanding the cohort of the measure from only Medicare FFS patients to a cohort that includes both FFS and MA patients. All other specifications for the measure would remain the same.

Hybrid Hospital-Wide All-Cause Readmission (HWR) Measure
CMS modifies the adopted measure beginning for the FFY 2027 payment determination (discharge data from July 1, 2024, through June 30, 2025) by expanding the cohort of the measure from only Medicare FFS patients to a cohort that includes both FFS and MA patients. All other specifications for the measure would remain the same.

Measure Removals for the IQR Program

CMS finalizes its proposal to remove the following three measures from the IQR Program. In addition, CMS codifies its eight measure removal factors (described in the hospital VBP section of this summary) in regulation.

Hospital Level RSCR Following Elective Primary THA and/or TKA Measure (THA/TKA Complication Measure)
In the FFY 2023 IPPS final rule, CMS adopted a modified version of this measure. It was revised to include 26 additional mechanical complication ICD-10 codes. CMS announced that it intended to propose the updated measure for inclusion in the hospital VBP Program after the required one-year period of public reporting under the hospital IQR Program.

CMS will remove this measure from the hospital IQR Program beginning with the April 1, 2025-March 31, 2028, reporting period associated with the FFY 2030 payment determination. This removal coincides with the addition of the revised measure to the hospital VBP Program to avoid duplicative reporting requirements.

Medicare Spending Per Beneficiary
In the FFY 2023 IPPS final rule, CMS adopted a modified version of this measure and announced that it intended to propose the updated measure for inclusion in the hospital VBP after the required one-year period of public reporting under the hospital IQR Program. The modifications are described in more detail in the hospital VBP Program section of this summary.

CMS will remove the updated MSPB measure from the hospital IQR Program beginning with the FFY 2028 payment determination, coinciding with the adoption of the updated measure under the hospital VBP Program beginning with the FFY 2028 program year.

Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (PC–01) Measure
CMS finalizes its proposal to remove the Elective Delivery measure beginning with the CY 2024 reporting period/FFY 2026 payment determination because data indicate that measure performance has topped out. CMS notes that it has recently adopted several new measures to prioritize maternal health, including the Maternal Morbidity Structural measure beginning with the FFY 2023 payment determination, the adoption of the Severe Obstetric Complications eCQM and the Cesarean Birth eCQM as two of the eCQMs in the hospital IQR Program measure set, as well as the adoption of the Birthing-Friendly Hospital designation.

Form, Manner, and Timing of Quality Data Submission

CMS did not adopt changes to its policies related to quality data submission, collection, and reporting requirements, including certification requirements for eCQM reporting for the hospital IQR Program, the requirement that EHRs be certified to all available eCQMs, the file format for EHR data, the submission deadlines for eCQM data, submission and reporting requirements for hybrid measures, sampling and case thresholds for chart-abstracted measures, and data submission and reporting requirements for CDC NHSN measures, structural measures, and PRO-PMs. CMS did adopt changes to the administration of the HCAHPS survey data, described in more detail below.

Updates to the HCAHPS Survey Measure
The HCAHPS Survey was adopted into the hospital IQR Program beginning with the FFY 2008 payment determination. The measure is a national, standardized, publicly reported survey of patients' experiences of hospital care, and asks a random sample of eligible discharged adult patients (who received medical, surgical, or maternity care between 48 hours and six weeks after discharge, and who are not limited to Medicare beneficiaries) 29 questions about their recent hospital stay. In 2021, CMS conducted a large-scale mode experiment to test improvements to the survey, including the addition of web-based survey modes. After reviewing the results of the experiment, CMS finalizes the following changes to HCAHPS survey administration:

- Addition of Three New Modes of Survey Implementation: Based on the mode experiment finding that the addition of the three modes resulted in increased response rates, CMS will add the new modes of survey administration (Web-Mail mode, Web-Phone mode, and Web-Mail-Phone mode) in addition to the current Mail Only, Phone Only, and Mail-Phone modes, beginning with January 2025 discharges.
- Removal of Prohibition of Proxy Respondents to HCAHPS Survey: CMS removes the requirement that only the patient may respond to the survey and thus allows a patient's proxy to respond to the survey, beginning with January 2025 discharges.

- Extension of Data Collection Period: Based on the mode experiment finding that showed an increased rate of completion of the survey — including from patients typically under-represented in HCAHPS — when the data collection period is extended, CMS extends the period from 42 to 49 days, beginning with January 2025 discharges.
- Limit on Number of Supplemental HCAHPS Survey Items: CMS limits the number of supplemental items permitted to be added to the survey to 12 items, which aligns with other CMS Consumer Assessment of Healthcare Providers and Systems surveys.
- Requirement to Use Official Spanish Translation for Spanish Language-Preferring Patients: CMS will require hospitals to collect information about the language that the patient speaks while in the hospital and that the official CMS Spanish translation of the HCAHPS survey be administered to all patients who prefer Spanish, beginning with January 2025 discharges.
- Removal of Two Administration Methods: CMS removes the Active IVR survey mode and the Hospitals Administering HCAHPS for Multiple Sites option, beginning in January 2025 discharges. CMS notes that neither method is currently used by participating hospitals.

Targeting Criteria for Validation of Hospital IQR Program Data

CMS modifies the targeting criteria for validation of hospitals granted an ECE. Beginning with validations of CY 2024 reporting period data for the FFY 2027 payment determination, CMS adds a targeting criterion for any hospital with a two-tailed confidence interval that is less than 75% and which submitted less than four quarters of data due to receiving an ECE for one or more quarters.

Hospitals would not fail the validation-related requirements for the annual payment update determination for the payment year for which an ECE provides hospitals with an exception from data reporting or validation requirements. These hospitals could be selected for validation in the following year.

PPS-Exempt Cancer Hospital Quality Reporting Program

In the FFY 2013 IPPS final rule, CMS established a Quality Reporting Program beginning in FFY 2014 for PPS-exempt cancer hospitals (PCHs). The PCH Quality Reporting (PCHQR) Program follows many of the policies established for the hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation. No policy was adopted to address the consequences for a PCH that fails to meet the quality reporting requirements; CMS has indicated its intention to discuss the issue in future rulemaking.

CMS finalizes its proposals to adopt four new measures for the PCHQR Program, including three health equity-focused measures and a patient preference-focused measure. CMS also modifies the COVID-19 HCP Vaccination measure in the PCHQR and the administration of the HCAHPS survey measure in alignment with its policies for the hospital IQR Program. In addition, CMS will publicly report the Surgical Treatment Complications for Localized Prostate Cancer measure beginning with data from the FFY 2025 program year. Table 4 of the Appendix of this summary lists the measure set for the program.

New Measures

CMS adopts the following new measures for the PCHQR Program: the Facility Commitment to Health Equity measure, the Screening for Social Drivers of Health measure, the Screen Positive Rate for Social Drivers of Health measure, and the Documentation of Goals of Care Discussions Among Cancer Patients measure.

Facility Commitment to Health Equity Measure

CMS adopts an attestation-based structural measure, the Facility Commitment to Health Equity, to address health equity beginning with the FFY 2026 program year. The measure is consistent with the "Hospital Commitment to Health Equity measure" adopted in the hospital IQR Program, beginning with FFY 2023.

The measure is intended to assess PCH commitment to health equity across five domains (equity in a strategic priority, data collection, data analysis, quality improvement, and leadership engagement), some of which have multiple elements. A point is awarded for each domain to which a PCH attests affirmatively. For a PCH to attest "yes" to a domain and receive credit for that domain, the PCH would evaluate and determine whether it engages in each of the elements that comprise that domain. A complete list of domains and elements is provided in the table below:

Attestation Statement	Elements (Affirmative attestation of all elements within a domain would be required for the hospital to receive a point for the domain in the numerator)
Domain 1: Equity is a Strategic Priority	
Hospital commitment to reducing healthcare disparities is strengthened when equity is a key organizational priority. Please attest that your hospital has a strategic plan for advancing healthcare equity and that it includes all the following elements.	(A) Our hospital strategic plan identifies priority populations who currently experience health disparities. (B) Our hospital strategic plan identifies healthcare equity goals and discrete action steps to achieving these goals. (C) Our hospital strategic plan outlines specific resources which have been dedicated to achieving our equity goals. (D) Our hospital strategic plan describes our approach for engaging key stakeholders, such as community-based organizations.
Domain 2: Data Collection	
Collecting valid and reliable demographic and social determinant of health data on patients served in a hospital is an important step in identifying and eliminating health disparities. Please attest that your hospital engages in the following activities.	(A) Our hospital collects demographic information, including self-reported race and ethnicity and/or social determinant of health information on the majority of our patients. (B) Our hospital has training for staff in culturally sensitive collection of demographic and/or social determinant of health information. (C) Our hospital inputs demographic and/or social determinant of health information collected from patients into structured, interoperable data elements using a certified EHR technology.

Domain 3: Data Analysis	
Effective data analysis can provide insights into which factors contribute to health disparities and how to respond. Please attest that your hospital engages in the following activities.	(A) Our hospital stratifies key performance indicators by demographic and/or social determinants of health variables to identify equity gaps and includes this information on hospital performance dashboards.
Domain 4: Quality Improvement	
Health disparities are evidence that high-quality care has not been delivered equitably to all patients. Engagement in quality improvement activities can improve quality of care for all patients.	(A) Our hospital participates in local, regional, or national quality improvement activities focused on reducing health disparities.
Domain 5: Leadership Engagement	
Leaders and staff can improve their capacity to address disparities by demonstrating routine and thorough attention to equity and setting an organizational culture of equity. Please attest that your hospital engages in the following activities.	(A) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews our strategic plan for achieving health equity. (B) Our hospital senior leadership, including chief executives and the entire hospital board of trustees, annually reviews key performance indicators stratified by demographic and/or social factors.

Numerator: Number of domains for which a PCH attests to completing all of the required elements
Denominator: Five points (one for each domain available for attestation)
Calculation: A point is awarded for each domain to which a PCH attests affirmatively. No partial credit is awarded; all elements within a domain must be completed to attest affirmatively and receive a point for that domain.
Data Submission and Reporting: PCHs will be required to submit information for the measure once annually using a CMS-approved web-based data collection tool available within the HQR System beginning with the 2026 program year.

Screening for Social Drivers of Health Measure
CMS adopts the Screening for Social Drivers of Health measure as voluntary, beginning with the FFY 2026 program year, and mandatory beginning with the FFY 2027 program year. The measure is intended to promote adoption of screening for health-related social needs (HRSNs) by hospitals across five domains: food security, housing instability, transportation needs, utility difficulties, and interpersonal safety.

Numerator: Number of patients admitted to the PCH who are screened for all five HRSNs
Denominator: Number of patients admitted to the PCH
Exclusion: Patients younger than 18 years of age at the time of admission, patients who opt out of screening, and patients who are unable to complete the screening themselves and without a caregiver available to do so on the patient's behalf
Data Submission and Reporting: PCHs will report on the measure once annually, using a CMS-approved web-based data collection tool available within the HQR System. This will begin with voluntary reporting in the FFY 2026 program year and be followed by required reporting beginning in the FFY 2027 program year. CMS does not require a specific,

standardized screening tool, and readers are referred to the Social Interventions Research and Evaluation Network (SIREN) website for comprehensive information about the most widely used HRSN screening tools.

Screen Positive Rate for Social Drivers of Health

CMS adopts the Screen Positive Rate for Social Drivers of Health as voluntary beginning with the FFY 2026 program year, and mandatory beginning with the FFY 2027 program year. This structural measure is a companion measure to the Screening for Social Drivers of Health measure. It is intended to enhance standardized data collection for identifying high-risk individuals who could benefit from connection via the hospital to community-based services relevant to their HRSNs. CMS notes that the measure is not intended for comparing PCHs.

Numerator: For each HRSN, the number of patients who screen positive (calculated separately for each of the five HRSNs). A patient who screens positive for more than one HRSN would be included in the numerator for each of such HRSNs.
Denominator: For each HRSN, the number of patients screened
Exclusion: Patients younger than 18 years at the time of admission, patients who opt out of screening, and patients who are unable to complete the screening themselves and lack a guardian or caregiver available do so on the patient's behalf
Calculation: A separate rate is calculated for each screening domain, so that five rates are calculated by each PCH for screen-positive patients divided by screened patients.
Data Submission and Reporting: PCHs will report on the measure once annually, using a CMS-approved web-based data collection tool available within the HQR System. This would begin with voluntary reporting in the FFY 2026 program year and be followed by required reporting beginning in the FFY 2027 program year.

Documentation of Goals of Care Discussions Among Cancer Patients Measure

CMS finalizes its proposal to add a process measure — the Documentation of Goals of Care Discussions Among Cancer Patients measure — beginning with the FFY 2026 program year. The measure assesses the percentage of cancer patients who died during the PCHQR reporting period and had their goals of care documented before death.

Numerator: The number of patients included in the denominator for whom a Goals of Care conversation was documented in a structured field in the medical record. To meet the requirements for inclusion in the numerator, the documentation in the EHR would need to include either of the following:

- Any documentation in one or more patient goals fields in the EHR
- Documentation that the patient opted not to have a goals of care discussion

Denominator: The number of patients meeting the following criteria in the reporting period:

- Died at the PCH in the measurement period
- Had a diagnosis of cancer
- Had at least two eligible contacts (inpatient admissions and hematology or oncology ambulatory visits) at the PCH within the six months prior to death

Calculation: Performance is reported as a percentage determined by calculating (numerator ÷ denominator) x 100; a higher score is better.

Data Submission and Reporting: PCHs will submit information for the measure once annually using a CMS-approved web-based data collection tool available within the HQR System, beginning with the FFY 2026 program year.

Public Reporting of Measure Results

Public reporting of PCHQR Program measure data is proposed through rulemaking and generally follows a period of confidential reporting to hospitals. Data are posted to the Provider Data Catalog website.

CMS finalized the inclusion of the Surgical Treatment Complications for Localized Prostate Cancer (PCH-37) measure in the PCHQR measure set beginning with the FFY 2022 program year. CMS finalizes its proposal to begin public reporting of the PCH-specific results for the PCH-37 measure, beginning with the FFY 2025 program year data in the summer of 2024. It will reflect PCH performance for the July 1, 2021, through June 30, 2022, reporting period.

Updates to the Administration of the HCAHPS Survey Measure

CMS finalizes updates to the administration of the HCAHPS survey measure beginning with the FFY 2027 program (2025 discharges). These changes are consistent with the policies in the hospital IQR and VBP programs, including the addition of three new web-based survey modes, allowing proxy survey responses, extending the data collection period, limiting supplemental survey questions, and requiring the official CMS Spanish translation of the HCAHPS survey be administered to all patients who prefer Spanish. For more details on the changes, refer to the hospital IQR Program section of this summary.

Medicare Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program — previously the EHR incentive program — hospitals that are not identified as meaningful EHR users are subject to a reduction equal to three quarters of the market basket.

CMS establishes a reporting period for CY 2025, adopts a modification of reporting requirements for an existing measure, and adds new eCQMs in alignment with the policies for the hospital IQR Program eCQM measure set. CMS does not adopt any changes to the program's scoring methodology.

Reporting Period for 2025

CMS previously adopted a continuous 90-day reporting period for the Medicare Promoting Interoperability Program through CY 2023, and an increase to a minimum of any continuous 180-day period beginning with CY 2024. CMS finalizes its proposal to maintain a reporting period of any continuous 180 days for CY 2025. CMS notes that it is considering increasing the reporting period in CY 2026 but will address that year in future rulemaking.

In addition, beginning with the CY 2025 reporting period, CMS finalizes its proposal that hospitals that have not successfully demonstrated they are a meaningful EHR user in the prior year will no longer be differentiated for the purposes of a payment adjustment from those that did successfully demonstrate they are meaningful EHR users in a prior year. Those hospitals that have not demonstrated they are meaningful EHR users in a prior year will no longer have to attest to meaningful use for the next payment adjustment year beginning with Oct. 1, 2025. Those that

wish to attest by Oct. 1, 2023, or Oct. 1, 2024, will need to email CMS through the QualityNet helpdesk (QnetSupport@cms.hhs.gov) due to technological modifications made by CMS to the data submission process.

Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

CMS adopted the SAFER Guides measure under the Protect Patient Health Information Objective, beginning with the EHR reporting period in CY 2022. Eligible hospitals and critical access hospitals (CAHs) must attest to whether they have conducted an annual self-assessment using all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs. Beginning in CY 2022, the attestation of this measure was required, but eligible hospitals and CAHs were not scored, and an attestation of "yes" or "no" were both acceptable answers without penalty.

Beginning with the CY 2024 EHR reporting period, CMS will require a "yes" attestation to satisfy this measure; attesting "no" would mean that the eligible hospital or CAH had not met the measure and thus is not a meaningful EHR user for the reporting period, subjecting the facility to a downward payment adjustment.

Scoring Methodology for the EHR Reporting Period in 2024

CMS adopts no changes to the scoring methodology for the CY 2024 EHR reporting period. To be considered a meaningful user of EHR technology, an eligible hospital or CAH will be required to:

- Report on all the required measures across all four objectives, unless an exclusion applies
- Report "yes" on all required yes/no measures, unless an exclusion applies
- Attest to completing the actions included in the Security Risk Analysis measure
- Achieve a total score of at least 60 points, based on the methodology in the table below

Failure to meet any of the first three requirements results in an automatic score of zero.

Performance-Based Scoring Methodology Beginning with the CY 2024 EHR Reporting Period

Objectives	Measures	Maximum Points	Redistribution if Exclusion Claimed
Electronic Prescribing	e-Prescribing	10 points	10 points to HIE Objective
	Query of PDMP	10 points	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information	15 points	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	15 points	No exclusion
	OR		
	HIE Bi-Directional Exchange Measure	30 points	No exclusion
	OR		
	Enabling Exchange under TEFCA	30 points	No exclusion

Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	No exclusion
Public Health and Clinical Data Exchange	Required with yes/no response • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AUR Surveillance Reporting ***(Required beginning CY 2024)***	25 points	If an exclusion is claimed for all 5 measures, 25 points redistributed to provide patients electronic access to their health information
	Optional to report one of the following • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (bonus)	

Note: The Security Risk Analysis measure, SAFER Guides measure, and information blocking attestations required by section 106(b)(2)(B) of MACRA are required but will not be scored. eCQM measures are required but will not be scored.

Proposed eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

In alignment with the hospital IQR Program, CMS adopts the following new eCQMs available for the Promoting Interoperability Program eCQM measure set from which hospitals may self-select, beginning with the CY 2025 EHR reporting period:

- Hospital Harm – Pressure Injury eCQM
- Hospital Harm – Acute Kidney Injury eCQM
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient) eCQM

CHA refers readers to the IQR Program section of this summary for a full discussion of the new eCQMs. CMS is not adopting any changes to its previously finalized eCQM reporting requirements. As a reminder, beginning with CY 2024, hospitals and CAHs must report four calendar quarters of data for each required eCQM: (i) three self-selected eCQMs; (ii) the Safe Use of Opioids-Concurrent Prescribing eCQM; (iii) the Severe Obstetric Complications eCQM; and (iv) the Cesarean Birth eCQM. The total number of required eCQMs is six for the 2024 reporting period and subsequent years.

Appendix — Quality Reporting Program Tables

Table 1

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure	2024	2025	2026	2027
Chart-Abstracted Process of Care Measures				
Severe sepsis and septic shock: management bundle (NQF #500)	X	X	X	X
PC-01 Elective delivery < 39 weeks gestation (NQF#0469)	X	X	Remove	
Electronic Clinical Quality Measures				
ED-2 Time from admit decision to ED departure for admitted patients (NQF #0497) PC-05 Exclusive breast milk feeding (NQF #0480) STK-02 Antithrombotic therapy for ischemic stroke (NQF #0435) STK-03 Anticoagulation therapy for Afib/flutter (NQF #0436) STK-05 Antithrombotic therapy by end of hospital day 2 (NQF #0438) STK-06 Discharged on statin (NQF #0439) VTE-1 VTE prophylaxis (NQF #0371) VTE-2 ICU VTE prophylaxis (NQF #0372) Safe Use of Opioids – Concurrent Prescribing (NQF #3316c) HH-01 Hospital Harm-Severe Hypoglycemia (NQF #3503e) HH-02 Hospital Harm-Severe Hyperglycemia (NQF #3533e) Hospital Harm Opioid Related Adverse Events HH-ORAE ePC-02 Cesarean Birth ePC-07/SMM Sever Obstetric Complications Global Malnutrition Composite Score GMCS (NQF #3592e) *HH-PI Hospital Harm-Pressure Injury (CBE 3498e)** *HH-AKI Hospital Harm-Acute Kidney Injury (CBE 3713e)** *Excessive Radiation Does or Inadequate Image Quality for Diagnostic CT in Adults (ExRad)**	Report Safe Use of Opioids AND 3 of the following 8 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2	Report Safe Use of Opioids 3 of the following 12 eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 HH-01 HH-02 ePC-02 ePC-07	Report Safe Use of Opioids AND Cesarean Birth AND Severe Obstetric Complications AND 3 of the following 9 eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS	Report Safe Use of Opioids AND Cesarean Birth AND Severe Obstetric Complications AND 3 of the following 12* eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS *HH-PI** *HH-AKI** *ExRad**
Healthcare-Associated Infection Measures				
Healthcare Personnel Influenza Vaccination (NQF #0431)	X	X	X	X
Healthcare Personnel COVID-19 Vaccination	X	X	X	X
Mortality				
Stroke 30-day mortality rate	X	X	X	X
Readmission/Coordination of Care				

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure				
	2024	**2025**	**2026**	**2027**
Hospital-wide all-cause unplanned readmission (NQF #1789)	X	X	Removed	
Excess days in acute care after hospitalization for AMI (NQF #2881)	X	X	X	X
Excess days in acute care after hospitalization for HF (NQF #2880)	X	X	X	X
Excess days in acute care after hospitalization for PN (NQF #2882)	X	X	X	X
Claims and Electronic Data Measures (Hybrid)				
Hybrid HWR (all-cause readmission) (NQF #2879)	Voluntary		X	X
Hybrid HWM (all-cause mortality)		Voluntary	X	X
Patient Safety				
PSI-04 Death among surgical inpatients with serious, treatable complications (NQF #0351)	X	X	X	X
THA/TKA complications	Removed	Refine*	Refine*	Refine*
Efficiency/Payment				
AMI payment per 30-day episode of care (NQF #2431)	X	X	X	X
Heart Failure payment per 30-day episode of care (NQF # 2436)	X	X	X	X
Pneumonia payment per 30-day episode of care (NQF #2579)	X	X	X	X
THA/TKA payment per 30-day episode of care	X	X	X	X (Remove FFY 2030)
MSPB-Hospital	X	X	X	X (Remove FFY 2028)
Patient Experience of Care				
HCAHPS survey (NQF #0166)	X	X	X	X
Patient-Reported Outcome-Based Performance Measure (PRO-PM)				
Hospital-Level THA/TKA PRO-PM			Voluntary	X
Structural Measures				
Maternal Morbidity	X	X	X	X
Hospital Commitment to Health Equity (HCHE)		X	X	X
Process Measures				
SDOH-1 Screening for Social Drivers of Health		Voluntary	X	X
SDOH-2 Screen Positive Rate for Social Drivers of Health		Voluntary	X	X

*Proposed measure

Table 2

Summary Table VBP-1: Measures and Domains by Payment Year				
Measure	**NQF #**	**2024-2025**	**2026-2029**	**2030+**
Clinical Outcomes Domain				
Acute Myocardial Infarction (AMI) 30-day mortality rate	0230	X	X	X
Heart Failure (HF) 30-day mortality rate	0229	X	X	X
Pneumonia (PN) 30-day mortality rate	0468	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty	1550	X	X	X**
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate	1893	X	X	X
CABG 30-day mortality rate	2558	X	X	X
Safety Domain				
Central Line Associated Blood Stream Infection (CLABSI)	0139	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	0138	X	X	X
Colon and Abdominal Hysterectomy Surgical Site Infections (SSI)	0753	X	X	X
Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Bacteremia	1716	X	X	X
Clostridium Difficile Infection (CDI)	1717	X	X	X
Severe Sepsis and Septic Shock: Management Bundle (Sep-1)	0500		X	X
Person and Community Engagement Domain				
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff Communication About Medicines Cleanliness and Quietness of Hospital Environment Discharge Information Overall Rating of Hospital 3-Item Care Transition measure (CTM)	0166 0228	X	X	X
Efficiency and Cost Reduction Domain				
Medicare Spending per Beneficiary*	2158	X	X*	X

* Substantive updates proposed to the MSPB measure beginning with FFY 2028 program year
**Substantive updated proposed to the THA/TKA Complications measure beginning with the FFY 2030 program year

Table 3

HAC Reduction Program Measures for FFY 2024 and Subsequent Years		
	NQF #	**FFY 2024+**
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531	X
CDC NSHN Measures		
Central Line-associated Blood Stream Infection (CLABSI)	0139	X
Catheter-associated Urinary Tract Infection (CAUTI)	0138	X
Colon and Abdominal Hysterectomy Surgical Site Infections	0753	X
Methicillin-resistant staphylococcus aureus (MRSA)	1716	X
Clostridium difficile (CDI)	1717	X

Table 4

PCHQR Program Measures and Public Display Requirements	
Measure	**Public Reporting**
Safety and Healthcare Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	2019 and subsequent years
NHSN CDI (NQF #1717)	2019 and subsequent years
NHSN MRSA bacteremia (NQF #1716)	2019 and subsequent years
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	2019 and subsequent years
NHSN COVID-19 vaccination coverage among health care personnel	October 2022 and subsequent years
NHSN CLABSI (NQF #0139)	October 2022 and subsequent years
NHSN CAUTI (NQF #0138)	October 2022 and subsequent years
Clinical Process/Oncology Care	
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (NQF #0210)	July 2024 or as soon as feasible thereafter
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	July 2024 or as soon as feasible thereafter
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	July 2024 or as soon as feasible thereafter
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	July 2024 or as soon as feasible thereafter
Patient Experience of Care	
HCAHPS (NQF #0166)	2016 and subsequent years
Documentation of Goals of Care Discussions Among Cancer Patients	July 2026 or as soon as feasible thereafter
Claims-Based Outcomes	
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	October 2023 or as soon as feasible thereafter
Surgical Treatment Complications for Localized Prostate Cancer	July 2024 or as soon as feasible thereafter
Health Equity Measures	
Facility Commitment to Health Equity	July 2026 or as soon as feasible thereafter
Screening for Social Drivers of Health	July 2027 or as soon as feasible thereafter
Screen Positive Rate for Social Drivers of Health	July 2027 or as soon as feasible thereafter