Unpack the 2024 IPPS Final Rule

A WEBINAR PRESENTED ON SEPTEMBER 27, 2023

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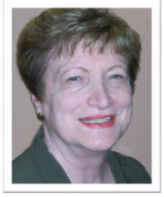

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Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Explain the most significant changes in the **2024 IPPS final rule**
  - Analyze the financial and operational impact of the changes
  - Discuss updates to quality programs

Agenda

- Key **FY 2024 IPPS final rule** priorities
- **FY 2024** payment factors and adjustments
- New technologies
- MS-DRG updates
- Meaningful quality measures

Source Authority

- The IPPS final rule is effective October 1 each year (beginning of the government's fiscal year)
  - Fiscal year (FY) 2023 IPPS final rule
    - *87 Fed. Reg. 48780–49499*
  - FY 2024 IPPS proposed rule
    - *88 Fed. Reg. 26658–27309*
  - **FY 2024 IPPS final rule**
    - ***88 Fed. Reg. 58640-59438***
      - The tables for this IPPS final rule are available on the CMS website at: **https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/AcuteInpatientPPS/index.html**
      - Click on the link on the left side of the screen titled **"FY 2024 IPPS Final Rule Home Page"** or **"Acute Inpatient—Files for Download"**

Key FY 2024 IPPS Final Rule Priorities

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- In addition to the payment changes discussed in Section II below, the **FY 2024 IPPS final rule** includes measures to address healthcare equity and assure Medicare beneficiaries' reasonable access to medically necessary inpatient hospital services, irrespective of geographic location, key demographics, or socio-economic factors
- These measures have been specifically designed to do the following:
  - Continue temporary policies finalized in the FY 2020 IPPS final rule that address wage index disparities affecting low-wage index hospitals, particularly those located in rural areas

Key FY 2024 IPPS Final Rule Priorities

  - Revise Graduate Medical Education (GME) payments for training in the new Medicare provider-type, Rural Emergency Hospital (REH), which was established by the Consolidated Appropriations Act, 2021 (CAA 2021) to address the growing concern over closures of rural hospitals
    - These changes will help support graduate medical training in rural areas by allowing these rural hospitals to serve as training sites for Medicare GME payment purposes after they become REHs
    - Effective for portions of cost reporting periods beginning **on or after October 1, 2023**, an REH may decide to be a nonprovider site and do one of the following:
      - Include the FTE resident training at the REH in its direct GME and IME FTE counts for Medicare payment purposes
      - Incur direct GME costs and be paid based on 100% of reasonable costs for those training costs

Key FY 2024 IPPS Final Rule Priorities

- REHs are a new provider type established by the CAA, 2021, to address the growing concern over rural hospital closures
- An REH must meet the following requirements:
  - Converted from either a critical access hospital (CAH) or a rural hospital (or one reclassified as rural) with 50 beds or less
  - **Does not** provide acute care inpatient services, except for post-hospital extended care services furnished in a distinct part unit licensed as a skilled nursing facility
- REH services include emergency department services, observation care, and, at the election of the REH, other outpatient medical and health services furnished on an outpatient basis

Key FY 2024 IPPS Final Rule Priorities

- Advance health equity through a focus on safety net hospitals
  - These hospitals play a crucial role in promoting health equity by making essential services available to populations that face barriers to accessing healthcare (e.g., uninsured, underinsured, racial and ethnic minority groups, the LGBTQ+ community, rural communities, etc.)
  - Safety net hospitals care for a disproportionate number of patients impacted by health-related social risk factors, including homelessness, as well as those listed above
  - CMS continues to seek public input on the following:
    - Collection of social determinants data by hospitals that could be used to identify safety net hospitals
    - Unique challenges faced by safety net hospitals and their patients
    - Current and potential approaches to help safety net hospitals meet those challenges, including both DSH empirically justified and uncompensated care payments

Key FY 2024 IPPS Final Rule Priorities

- Expand the collection, reporting, and analysis of standardized health equity data to measure the impact of current efforts to close gaps and support greater access to life-saving diagnostics and therapies beyond the COVID-19 public health emergency (PHE)
  - Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
    - The current subset of Z codes that describe SDOHs are found in categories Z55-Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances)
    - These codes describe a range of issues related—but not limited—to education, literacy, employment, housing, and the ability to obtain adequate amounts of food or safe drinking water, as well as occupational exposure to toxic agents, dust, or radiation
    - As additional data becomes available, CMS plans to incorporate it on an ongoing basis into its impact analyses

Key FY 2024 IPPS Final Rule Priorities

- Change the severity designation of certain Social Determinants of Health (SDOH) diagnosis codes to reflect the higher average resource costs of cases when they are present
  - Under the IPPS methodology, the more resources necessary to treat a diagnosis, the higher the severity level designation of that diagnosis, and the higher the payment to reflect the increased use of hospital resources
  - After review and analysis of applicable data, CMS is finalizing its proposal to change the severity level designation of the three ICD-10-CM diagnosis codes describing homelessness (e.g., unspecified, sheltered, and unsheltered) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without them

Key FY 2024 IPPS Final Rule Priorities

- Establish and maintain access to “essential medicines”
  - In the **CY 2024 OPPS proposed rule**, CMS included a request for public comments on potential payment under the IPPS for establishing and maintaining access to “essential medicines”
    - CMS is seeking comment on establishing and maintaining access to a buffer stock of essential medicines to foster a more reliable, resilient supply of these medicines, for which separate payment would be made under the IPPS
    - CMS will review and consider comments received through **September 11, 2023**
      - » If approved, separate payment for these medicines may begin as soon as cost reporting periods beginning **on or after January 1, 2024**

FY 2024 Payment Factors and Financial Changes

"Best Available Data" for Rate Setting

- CMS primarily uses two data sources for IPPS rate setting: claims data and cost report data
  - The claims data source is the Medicare Provider Analysis and Review (MedPAR) file, which includes fully coded diagnostic and procedure data for all Medicare inpatient hospital bills for discharges in a fiscal year
    - Ordinarily, the best available MedPAR data is the most recent MedPAR file that contains claims from discharges for the fiscal year that is two years prior to the one that is the subject of the rulemaking
  - The cost report data source is the Medicare hospital cost report data files from the most recent quarterly Healthcare Cost Report Information System (HCRIS) release
    - Ordinarily, the best available cost report data is based on the cost reports beginning three fiscal years prior to the fiscal year that is the subject of the rulemaking

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"Best Available Data" for Rate Setting

- Based on the information available at this time, CMS believes there will continue to be COVID-19 cases treated at IPPS hospitals in **FY 2024** at higher levels than those prior to the pandemic
- Therefore, CMS is finalizing its proposal to follow standard practice and use the FY 2022 MedPAR claims file and FY 2021 HCRIS dataset (which contains data from many cost reports ending in FY 2022 based on each hospital's cost reporting period) for purposes of **FY 2024 IPPS** rate setting

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Payment Factors: FY 2024 Operating Standardized Amount (OSA)

- 3.1% increase to IPPS operating standardized amount (OSA)

Summary:

+3.3%* – Market basket update (MBU)
-0.2% – Productivity adjustment
+3.1% – Percent update to the OSA

– *Hospitals not meeting IQRP requirements lose 25% of this update percent; hospitals not meeting meaningful EHR user requirements lose 75% of this update percent; these adjustments will be factored into the final OSAs listed in Tables 1A and 1B of the **FY 2024 IPPS final rule**

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Payment Factors: FY 2024 Operating Standardized Amount (OSA)

- For **FY 2024**, a hospital will only be eligible for the **full 3.1% update** to the OSA if it meets both the IQRP **and** EHR requirements.
  - If a hospital fails to meet both quality program requirements, it may be subject to the following additional payment adjustments:
    - A hospital that fails to meet EHR requirements but does meet IQRP requirements is subject to a 3/4 reduction to the full MBU (3.3 x 75%) or -2.475% in addition to the productivity adjustment (-0.2%), resulting in a **0.625% increase over FY 2023**
    - A hospital that fails to meet IQRP requirements but is a meaningful EHR user is subject to a 1/4 reduction to the full MBU (3.3% x 25%) or -0.825% in addition to the productivity adjustment (-0.2%), resulting in a **2.275% increase over FY 2023**
    - A hospital that fails to meet both IQRP and meaningful EHR user requirements is subject to a reduction of 3.3% from the full MBU (3.3%) in addition to the productivity adjustment (-0.2%), resulting in a **-0.2% increase over FY 2023**

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Payment Factors: FY 2024 Operating Standardized Amount (OSA)

FY 2024	Hospital DID submit quality data and IS a meaningful EHR user	Hospital DID submit quality data and IS NOT a meaningful EHR user	Hospital DID NOT submit quality data and IS a meaningful EHR user	Hospital DID NOT submit quality data and IS NOT a meaningful EHR user
MBU	3.3	3.3	3.3	3.3
Failed to submit quality data	0.0	0.0	-0.825	-0.825
Failed to meet EHR requirements	0.0	-2.475	0.0	-2.475
MFP adjustment	-0.2	-0.2	-0.2	-0.2
% increase to OSA	**3.1**	**0.625**	**2.275**	**-0.2**

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Payment Factors: Adjustments to Hospital-Specific Rates

- For **FY 2024**, the hospital-specific rate for sole community hospitals (SCH) is the higher of the federal rate (based on the standardized amount) or the highest hospital-specific rate from base years 1982, 1987, 1996, or 2006
  - CMS is finalizing its proposal that SCHs be subject to the same update factors as all other hospitals subject to the IPPS (depending upon their performance with respect to EHR and/or IQR requirements), consistent with the applicable percentage increases for the IPPS
- For **FY 2024**, the hospital-specific rate for Medicare-dependent hospitals (MDH) is the higher of the federal rate (based on the standardized amount) or the federal rate plus 75% of the amount by which the federal rate is exceeded by the highest hospital-specific rate from base years 1982,1987, or 2002
  - CMS is finalizing its proposal that MDHs also be subject to the same update factors as all other hospitals subject to the IPPS (depending upon their performance with respect to EHR and/or IQR requirements), consistent with the applicable percentage increases for the IPPS

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Payment Factors: Wage Index Adjustments

- Applicable wage indexes for all urban- and state-wide rural core-based statistical areas (CBSA) will be set out in **Table 3** to the **FY 2024 IPPS final rule**
  - Each year, CMS determines what the respective labor-related portion of the OSA will be for IPPS hospitals, depending upon whether the hospital's wage index is greater, less than, or equal to 1.
  - For **FY 2024**, CMS is continuing to determine the labor-related portion of a hospital's wage index as follows:
    - For hospitals with a wage index greater than 1, the labor-related portion will remain at **67.6%**,
    - For hospitals with a wage index of 1 or less, the labor-related portion will remain at **62%**
  - The labor-related portion of the operating standardized amount is that portion that will be subject to wage index adjustments

Payment Factors: Wage Index Adjustments

- For each FY, CMS determines the average hourly labor cost for all hospitals within a geographic region referred to as a core-based statistical area (CBSA) and compares that to the national average hourly labor cost (for **FY 2024**, **$50.39** unadjusted; **$50.34** adjusted for occupational mix) for all hospitals across the country
  - If labor costs in a CBSA exceed the national average, the WI will be greater than 1, resulting in an upward adjustment to the hospital's operating payments
  - If labor costs in a CBSA are less than the national average, the WI will be less than 1, resulting in a downward adjustment to the hospital's operating payments
  - Note that hospitals in "frontier areas" (Montana, Wyoming, North Dakota, South, Dakota and Nevada) have a wage index set at 1.0 unless calculated to be higher (currently Nevada)

Payment Factors: Wage Index Adjustments

- Beginning in FY 2020, CMS implemented an increase to the wage index for hospitals in the lowest quartile of wage indexes
  - The adjustment was adopted for at least four years (**FY 2020 - FY 2023**)
  - CMS increases the wage index of hospitals in the lowest quartile by ½ the difference between the otherwise final wage index value and the 25th percentile for that year (**FY 2024**: **0.8667**)
  - A budget neutrality adjustment to the operating standardized amount is applied across all IPPS hospitals
- For FY 2023 and subsequent years, CMS will apply a **5% cap** on any decrease in a hospital's wage index from the hospital's prior FY wage index regardless of the circumstances of the decrease
  - Previously, CMS only provided a cap for certain hospitals affected by the budget neutrality adjustment related to their increase in wage indexes lower than the 25th percentile

Payment Factors: Wage Index Adjustments

- For **FY 2024**, CMS is proposing to continue the low wage index hospital policy and the related budget neutrality adjustment, subject to the 5% cap on any decrease in the hospital's wage index from one year to the next
- Beginning in **FY 2024**, CMS is finalizing its proposal to include hospitals located in urban areas that reclassify to rural areas with geographically rural hospitals in rural wage index calculations
  - CMS will include the data of all such reclassified hospitals in the calculation of the wage index for the rural area of the state and the calculation of the wage index floor for urban hospitals in the state
    - Under existing law, the area wage index applicable for any hospital located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas of that state
    - This provision is referred to as the **"rural floor"**

Payment Factors: DSH Adjustments

- The DSH adjustment to the operating IPPS payment applies to hospitals with a significantly disproportionate share of low-income patients, including the following:
  - Patients entitled to Part A by reason of disability
    - FY 2020 SSI data was used to develop the final rule amounts
  - Patients not entitled to Part A but eligible for Medicaid
    - Information from the most recent available Provider Specific File was used

Payment Factors: DSH Adjustments

- In addition, CMS is finalizing changes to include in the Medicaid fraction those days for which patients receive benefits from Section 1115 demonstrations in one of the following forms:
  - Health insurance that covers inpatient hospital services
  - Premium assistance that covers 100% of the premium cost to the patient, which they use to buy health insurance that covers inpatient hospital services
    - » Note: Days of patients for which hospitals are paid from demonstration-authorized uncompensated/undercompensated care pools may **not** be included

Payment Factors: DSH Adjustments

- Total DSH payments are made up of two components: the empirically justified amount and the uncompensated care amount
  - Empirically justified amount
    - A per-discharge percentage add-on adjustment of 25% of what the DSH adjustment would have been under the prior calculation ("the empirically justified amount")
      - For **FY 2024**, the total empirically justified amount is approximately **$3.368 billion**

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Payment Factors: DSH Adjustments

- Uncompensated care amount
  - For **FY 2024**, CMS is approving a per-discharge set add-on payment to each MS-DRG discharge calculated based on three factors:
    - Factor 1: CMS' estimate of 75% of estimated DSH payments for **FY 2024**, determined to be **$10.015 billion** ($10.461 billion in FY 2023)
    - Factor 2: An adjustment of **59.29%** (1 minus the percent change in the percent of individuals who are uninsured), to account for changes in uninsured and under-insured patients,
      - Resulting in total uncompensated care payments of approximately **$5.938 billion** ($6.874 billion in FY 2023)
    - Factor 3: The hospital's **percentage** of uncompensated care compared to uncompensated care for all DSH hospitals
      - For **FY 2024**, CMS will use the three most recent years of audited data on uncompensated care costs from Worksheet S–10 of the FY 2018, FY 2019, and FY 2020 cost reports to calculate Factor 3 in the uncompensated care payment methodology for all eligible hospitals

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Payment Factors: DSH Adjustments

- Beginning with **FY 2023**, CMS set out special provisions relating to the calculation of Factor 3 for IHS, Tribal, and Puerto Rico hospitals
  - Beginning in FY 2023, CMS discontinued the use of low-income insured days as a proxy for the uncompensated care costs of IHS, Tribal, and Puerto Rico hospitals and began using data on uncompensated care costs from Worksheet S–10 to determine uncompensated care payments to those hospitals
  - CMS, however, also established a new supplemental payment for IHS, Tribal, and Puerto Rico hospitals beginning in FY 2023 to avoid undue long-term financial disruption to these hospitals as a result of discontinuing the use of low-income insured days as a proxy for uncompensated care
    - Eligible IHS/Tribal hospitals and hospitals located in Puerto Rico are estimated to receive approximately **$83.2** million in total supplemental payments in **FY 2024**
- For **FY 2024**, the total uncompensated care payments and supplemental payments for all hospitals equals approximately **$6.021 billion**

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Payment Factors: Capital Standard Federal Rate (CSFR)

- Overall: **3.8%** increase to **FY 2024** IPPS capital rate

Summary:

+2.9% – Capital input price index (CIPI)*
0.0% – Intensity
0.0% – Case-mix adjustment factors:
(Real across DRG change .5)
(Projected case-mix change -.5)
0.0% – Effect of FY 2022 reclassification and recalibration
0.9% – Forecast error correction
Total: **+3.8%**

- The CSFR for **FY 2024** will increase to **$503.83** ($483.79 in FY 2023)
  - *The CIPI represents the FY 2018-based CIPI

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Payment Factors: Outlier Calculation Factor Update

- For **FY 2024**, hospitals will only be eligible to receive an additional IPPS outlier payment for losses in **excess** of the outlier fixed-loss cost threshold
  - There will be no recovery for the **FY 2024** "fixed-loss amount" (**$42,750**), which is included in the calculation of the outlier fixed-loss cost threshold
  - The "outlier fixed-loss cost threshold" for **FY 2024** will be the sum of the following amounts:
    - IPPS rate for the MS–DRG
    - Any IME and empirically justified Medicare DSH payments
    - Any estimated uncompensated care payment
    - Supplemental payments to eligible IHS, Tribal, and Puerto Rico hospitals
    - Any add-on payments for new technology
    - The FY 2024 "fixed loss amount" (**$42,750**)

Payment Factors: Outlier Calculation Factor Update

- Costs of the case are determined by multiplying the total billed charges by the inpatient CCRs
- The marginal cost factor is the percentage of the excess of the costs of the case over the "fixed-loss cost threshold" that will determine the amount of outlier payment, if any
  - For **FY 2024**, CMS will continue to apply a marginal cost factor, in general, of 80%
    - 90% for burn MS-DRGs 927, 928, 929, 933, 934, and 935

New Technologies

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New Technology Add-on Payments

- Under the IPPS, as part of each FY final rule, certain new technologies are approved for new technology add-on payment (NTAP)
  - The NTAP is made in addition to the standard MS-DRG payment and is designed to cover the cost of new technologies that generally must meet the following three requirements:
    - The new technology must be new and not substantially similar to an existing technology
    - The cost of the new technology must be great enough that the otherwise applicable MS-DRG payment would be inadequate
    - The new technology must demonstrate substantial clinical improvement over existing technologies
  - In general, the NTAP is granted for a maximum of three years
  - NTAP cases are generally identified by ICD-10-PCS section "X" codes
  - For **FY 2024**, CMS is publicly posting new technology applications and supporting materials

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New Technology Add-on Payments

- For dates of service on or after October 1, 2019 (FY 2020):
  - CMS increased the NTAP payment generally to the **lesser** of the following:
    - 65% (rather than 50%) of the amount by which the costs of the case exceed the standard MS-DRG payment
    - 65% (rather than 50%) of the costs of the new medical service or technology
  - For certain new antimicrobial therapies, CMS increased the NTAP payment to the **lesser** of the following:
    - 75% of the amount by which the costs of the case exceed the standard MS-DRG payment
    - 75% of the costs of the new medical service or technology

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Alternative Pathway for Breakthrough Devices

- Beginning with NTAP applications for **FY 2021**, CMS implemented an alternative pathway for new medical devices that meet the following requirements:
  - Are part of the FDA's Breakthrough Devices Program (BDP)
  - Have received FDA marketing authorization **by July 1 preceding** the beginning of the FY (October 1) for which they seek NTAP
- Under this pathway, two current NTAP requirements would be effectively waived
  - Devices would be assumed to be new and not substantially similar to an existing technology and would not have to demonstrate substantial clinical improvement over existing technologies
  - The breakthrough devices would only need to meet the ***cost*** criterion to receive NTAP

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Alternative Pathway for Antimicrobial Products

- Beginning with NTAP applications for **FY 2021**, CMS also implemented an alternative pathway for new antimicrobial therapies that meet the following criteria:
  - Treat drug-resistant infections
  - Have received a Qualified Infectious Disease Products (QIDP) designation and marketing authorization from the FDA
- Under this pathway, the following rules apply:
  - As with breakthrough devices, QIDPs would only need to meet the ***cost*** criterion to receive NTAP
    - Their NTAP would continue to be based on a marginal cost factor of 75%
  - Antimicrobial drug-resistant ICD-10-CM diagnosis codes will continue to be designated as CCs, generally resulting in higher MS-DRG assignment and payment

Alternative Pathway for Limited Population Pathway for Antibacterial and Antifungal Drugs

- Beginning with NTAP applications for **FY 2022**, CMS expanded the alternative NTAP pathway for QIDPs to include products approved through the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD pathway).
  - NTAP applications received for FY 2022 and, subsequently, for antimicrobial products approved through the FDA's LPAD pathway will only need to meet the ***cost*** criterion to receive NTAP

FY IPPS Approval Date for QIDP and LPAD NTAP

- Beginning with FY 2021, CMS may grant ***conditional approval*** for otherwise qualifying products under the QIDP or LPAD, subject to the technology receiving FDA marketing authorization **by July 1 of the FY** for which the application was made
  - In this case, NTAP will only be paid for discharges beginning in the quarter following FDA authorization
    - For example: To receive NTAP during FY 2024, a qualifying product would have to receive FDA marketing authorization no later than July 1, 2024, and, in that case, NTAP would be paid only for discharges during the last quarter of FY 2024

New Technologies for FY 2024

- CMS finalized the following proposals:
  - To **discontinue** NTAP for **15** FY 2023 new technologies determined to no longer be new under the newness criteria
  - To **continue** NTAP for **11** FY 2023 new technologies still considered new for **FY 2024** (three-year anniversary date on/after 4/1/24), which are identified in the following slide

New Technologies Continued From FY 2023

Technology Name	FY 2024 NTAP (65% or 75%)
Intercept®	$2,535.00
Rvbrevant™	$6,405.89
StrataGraft®	$44,200.00
aprevo® Intervertebral Body Fusion Device	$40,950.00
Hemolung Respiratory Assist System (RAS)	$6,500.00
Livtencity™	$32,500.00
Thoraflex Hybrid Device	$22,750.00
ViviStim	$23,400.00
GORE TAG Thoracic Branch Endoprosthesis	$27,807.00
Cerament® G	$4,918.55
iFuse Bedrock Granite Implant System	$9,828.00

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New Technology Applications and Approvals for FY 2024

- In the **FY 2024 proposed rule**, CMS also sought input on a number of applications for new technology approval in **FY 2024**, including the following:
  - **10** new technologies for which CMS approved **8 NTAPs** under the **traditional pathway** in **FY 2024**
  - **9** new technologies with **Breakthrough Device designation** from the FDA for which CMS approved NTAP in **FY 2024**
  - **3** new technologies with **QIDP designation** for which CMS approved NTAP in **FY 2024**
- The approved new technologies are more fully described in the respective slides set out below

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New Technology Applications for FY 2024: Traditional Pathway

Technology	Medical Indication	FY 2024 NTAP (65%)
CYTALUX® (Pafolacianine), Indication 1	First targeted intraoperative molecular imaging agent that illuminates ovarian cancer in real time, enabling the detection of more cancer for resection	$2,762.50
CYTALUX® (Pafolacianine), Indication 2	First targeted intraoperative molecular imaging agent that illuminates lung cancer in real time, enabling the detection of more cancer for resection	$2,762.50
*EPKINLY™ and COLIMVI™	Bispecific antibodies used for the treatment of patients with relapsed/refractory (R/R) large B-cell lymphoma (LBCL) after two or more prior therapies, with COLUMVI™ specifically targeting the largest subset of LBCL, diffuse LBCL (DLBCL) *These two technologies were determined to be substantially similar and were therefore evaluated as one NTAP application	$6,504.07
Lunsumio™ (Mosunetuzumab)	Novel, full-length, humanized, immunoglobulin G1 (IgG1) bispecific antibody designed to bind CD3 on T cells and CD20 on B cells, in the treatment of adults with relapsed/refractory (R/R) follicular lymphoma	$17.492.10

New Technology Applications for FY 2024: Traditional Pathway

Technology	Medical Indication	FY 2024 NTAP (65%)
*REBYOTA™ (Fecal Microbiota, Live-jslm) and VOWST™	Microbiota-based live biotherapeutic suspension indicated for the prevention of recurrence of Clostridioides difficile infection *These two technologies were determined to be substantially similar and were therefore evaluated as one NTAP application	$6,789.25
SPEVIGO® (Spesolimab)	Humanized antagonistic monoclonal immunoglobulin G1 antibody under investigation for treatment of flares in adult patients with GPP	$33,236.45
TECVAYLI™ (Teclistamab-cqyv)	Bispecific antibody approved for treatment of MM, in certain adult patients with RRMM	$8,940.54
TERLIVAZ ® (Terlipressin)	Pharmacologic therapy administered via IV bolus for the treatment of hepatorenal syndrome (HRS) with rapid reduction in kidney function	$16,672.50

New Technology Applications for FY 2024: Breakthrough Devices Alternative Pathway

Technology	Medical Indication	FY 2024 NTAP (65%)
Aveir™ AR Leadless Pacemaker	Programmable system comprised of single leadless pacemaker implanted into right atrium and provides single-chamber pacing therapy	$10,725.00
Aveir™ Leadless Pacemaker (Dual-Chamber)	Modular programmable system comprised of two implanted leadless pacemakers that provide dual-chamber pacing therapy	$15,600.00
Canary Tibial Extension (CTE) With CHIRP System	CTE with CHIRP System collects kinematic data pertaining to a patient's gait and activity level following TKA	$850.85
Ceribell Status Epilepticus Monitor	Medical device system to analyze EEG signals to detect features indicative of electrographic status epilepticus (ESE)	$5913.90
EchoGo Heart Failure 1.0	Automated machine learning-based decision support system for patients undergoing routine functional cardiovascular assessment	$1,023.75

New Technology Applications for FY 2024: Breakthrough Devices Alternative Pathway

Technology	Medical Indication	FY 2024 NTAP (65%)
Phagenyx® System	Treatment of neurogenic dysphagia using electrical pulses to stimulate sensory nerves in the oropharynx	$3250.00
SAINT Neuromodulation System	Non-invasive repetitive transcranial magnetic stimulation (rTMS) system that identifies an individualized target to treat Major Depressive Disorder (MDD) in adult patients	$12,675.00
DETOUR System	Fully percutaneous approach to femoral-popliteal bypass	$16,250.00
TOPS™ System	Motion preserving device inserted and affixed during spinal surgery after open posterior decompression	$11,375.00

New Technology Applications for FY 2024: QIDP Alternative Pathway

Technology	Medical Indication	FY 2024 NTAP (75%)
Taurolidine/Heparin*	Proprietary formulation of taurolidine, a thiadiazinane antimicrobial, and heparin, an anti-coagulant, that is under development for use as catheter lock solution	$17,111.75
REZZAYO™ (Rezafungin for Injection)	Echinocandin antifungal drug for the treatment of candidemia and invasive candidiasis in patients 18 years and older	$4,387.50
XACDURO®	*Conditional approval; payments only made if technology receives FDA approval no later than July 1, 2024, beginning the quarter after approval	$13,680.00

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FY 2024 Changes to NTAP Process

- CMS also approved the following changes to the NTAP process:
  - Beginning in **FY 2025**, to be eligible for consideration for NTAP, an applicant must have already submitted an FDA market authorization request before applying
    - Submission would mean that the applicant has submitted a complete application to FDA and that the application has an active status
    - An applicant must provide documentation of the market authorization request at the time of their NTAP submission
      - FDA acceptance or filing letter would provide the clearest and most effective means of documentation
  - Beginning in **FY 2025**, applicants must receive FDA approval or clearance by **May 1 of the year before the FY for which NTAP application is made** in order to be eligible for payment in the upcoming fiscal year

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New COVID-19 Treatment Add-on Payments (NCTAP)

- **In October of FY 2021**, CMS established the NCTAP to cover the costs of cutting-edge COVID-19 therapies provided to hospital inpatients during the PHE
- Because CMS anticipated there will be inpatient cases of COVID-19 beyond the end of the PHE, CMS has extended the NCTAP for eligible COVID-19 products through the end of the FY in which the PHE ends, which is designed to do the following:
  - Mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments
  - Minimize any potential payment disruption immediately following the end of the PHE
- CMS made no additional changes to NCTAP
  - **The PHE ended on May 11, 2023, so NCTAP will continue only until 9/30/2023**

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New COVID-19 Treatment Add-on Payments (NCTAP)

- NCTAP payments are the **lesser** of the following:
  - (1) **65%** of the operating outlier threshold for the claim
  - (2) **65%** of the amount by which the costs of the case exceed the standard DRG payment, including the CARES Act 20% adjustment to the relative weight of the MS-DRG
- Beginning in FY 2022, hospitals can be eligible to receive both the NCTAP and the traditional NTAP for qualifying inpatient stays through the end of the FY in which the PHE ends **(September 30, 2023)**
  - The amount of the NCTAP, however, will be reduced by the amount of the NTAP
- Further information about NCTAP, including updates and a list of currently eligible drugs and biologicals, is available on the CMS website at **https://www.cms.gov/medicare/covid-19/newcovid-19-treatments-add-paymentnctap**

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MS-DRG Updates

MS-DRGs

- Payment under the IPPS is based upon the MS-DRG to which the case is assigned
  - The final list of approved MS-DRGs is published as **Table 5** to the **FY 2024 final rule**
  - MS-DRGs are grouped into one of 25 major diagnostic categories (MDC) based on organ/body system or nature of disease or injury
  - Every discharge is assigned to only one MS-DRG
    - Each MS-DRG is assigned a relative weight reflecting the "estimated relative cost of hospital resources" for cases assigned to that MS-DRG
- The best resource for MS-DRG assignment is the *MS-DRG Definitions Manual*
  - Available electronically on the CMS website: *https://www.cms.gov/icd10m/version39-fullcode-cms/fullcode_cms/P0001.html*

MS-DRGs

- The following factors drive MS-DRG assignment:
  - Principal DX (UB-04, FL 67)
  - Secondary DXs that rise to the level of CCs or MCCs (UB-04, FLs 67A-Q)
    - Some secondary DXs are considered CC exclusions when present with certain principal DXs and are **not** considered in MS-DRG assignment in those cases
    - Hospital-acquired conditions (HACs) that arise during that stay are **not** considered in MS-DRG assignment
  - Procedures performed during that stay (UB-04, FLs 74, 74a-e)
  - Gender and discharge status
- **Identification, documentation, and reporting of all relevant factors is essential for appropriate MS-DRG assignment and payment**

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MS-DRGs

- For cases with the same principal diagnosis and principal procedure, there may be as many as three separate payment groups:
  1. A base DRG with no additional secondary diagnosis that increases resource use
  2. A slightly higher paying DRG with at least one secondary diagnosis designated as a complication or comorbidity **(CC)** that increases resource use
  3. An even higher paying DRG with at least one secondary diagnosis designated as a major CC **(MCC)** that significantly increases resource use

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MS-DRGs

- CMS is required to annually update the MS-DRGs to which cases will be assigned, as well as their respective payment rates, to account for changes in the prices of goods and services used by hospitals to treat Medicare patients
  - **Beginning in FY 2024**
    - MS-DRG classification change requests must be submitted to CMS by October 20 of the **preceding FY**
      - For **FY 2024**, requests had to be submitted by October 20, 2022
    - To promote predictability and stability in hospital payments, as well as mitigate financial impact due to significant payment reductions, CMS will apply a permanent **10% cap** on the reduction in an MS-DRG's relative weight in a given fiscal year

MS-DRGs

- In the **FY 2024** IPPS proposed rule, CMS provided a test version of the ICD–10 MS–DRG GROUPER Software, Version 41
  - Version 41 reflects the proposed GROUPER logic for **FY 2024**, including the following:
    - **Table 6A.—New Diagnosis Codes—FY 2024**
    - **Table 6B.—New Procedure Codes—FY 2024**
    - **Table 6C.—Invalid Diagnosis Codes— FY 2024**
  - At the time of the publication of the FY 2024 IPPS proposed rule, there were no procedure codes designated as invalid for FY 2024, and, therefore, there was no Table 6D—Invalid Procedure Codes—FY 2024

MS-DRGs

- Because the diagnosis codes no longer valid for **FY 2024** were not reflected in the test software, Version 41, CMS made available an alternate test version of the ICD–10 MS–DRG GROUPER Software, Version 41.A, the draft version of the ICD–10 MS–DRG Definitions Manual, Version 41, and the supplemental mapping files in Table 6P.1a of the FY 2023 and FY 2024 ICD– 10–CM diagnosis codes on the following website:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MSDRG-Classifications-and-Software
    - Hospitals can use these alternative files for testing purposes with applicable available claims data

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Meaningful Quality Measures

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Meaningful Quality Measures

- In the **FY 2024 IPPS final rule**, CMS is making several changes to the following programs:
  - Medicare Promoting Interoperability Program (MPIP), formerly referred to as the Electronic Health Record (EHR) Program
  - Hospital Inpatient Quality Reporting Program (HIQRP)
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital Value-Based Purchasing Program (HVBPP)
  - Hospital-Acquired Condition (HAC) Reduction Program (HACRP)

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MPIP

- In **FY 2011**, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Medicare Promoting Interoperability Program and the Promoting Interoperability performance category in the Merit-based Incentive Payment System) to encourage eligible professionals, hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT)
  - **IPPS hospitals that fail to meet their MPIP/EHR requirements are subject to a three-fourths reduction in their IPPS market basket update**

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MPIP

- For **FY 2024**, CMS finalized its proposal to make the following changes to the MPIP program for eligible hospitals and CAHs:
  - Modify requirements for the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure to require eligible hospitals and CAHs to attest "yes" to having conducted an **annual self-assessment of all nine SAFER Guides at any point during the CY** in which the EHR reporting period occurs, beginning with the EHR reporting period in CY 2024, to satisfy the definition of a meaningful EHR user under 42 CFR 495.4
  - Amend the definition of "EHR reporting period for a payment adjustment year" for participating eligible hospitals and CAHs to define the EHR reporting period in **CY 2025** as a **minimum of any continuous 180-day period within CY 2025**
  - Amend the definition of "EHR reporting period for a payment adjustment year," for eligible hospitals that have not successfully demonstrated meaningful EHR use in a prior year, to **remove the requirement to attest to meaningful use by October 1 of the year prior to the payment adjustment year, beginning with the EHR reporting period in CY 2025**

MPIP

- Continued:
  - **Modify the response options** related to unique patients or actions, for objectives and measures for the Medicare Promoting Interoperability Program, **for which there is no numerator and denominator**, and for which unique patients or actions are not counted. The response option would read "**N/A (measure is Yes/No)**"
  - **Adopt the following three new eCQMs** for eligible hospitals and CAHs to select as one of their three self-selected eCQMs, in alignment with the Hospital IQR Program, **beginning with the CY 2025 reporting period**:
    - Hospital Harm — Pressure Injury eCQM
    - Hospital Harm — Acute Kidney Injury eCQM
    - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults (Hospital Level — Inpatient) eCQM

HIQRP

- The HIQRP is a pay-for-performance quality program that reduces payment to IPPS hospitals that fail to meet applicable requirements for timely and reliable reporting of key clinical measures
  - Hospitals that fail to meet HIQRP reporting requirements are subject to a one-fourth reduction in their market basket update under the IPPS
- For **FY 2024**, CMS is adopting three new quality measures, removing three existing quality measures, and modifying three current quality measures
  - CMS is also proposing two changes to current policies related to data submission, reporting, and validation, as well as requesting comment on the potential future inclusion of geriatric measures and a potential future public-facing geriatric hospital designation

HIQRP

- For **FY 2024**, CMS is **adopting three new electronic clinical quality measures (eCQMs)** to the list of eCQMs from which hospitals can self-select to meet the eCQM reporting requirements for a given year:
  - Hospital Harm — Pressure Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination
  - Hospital Harm — Acute Kidney Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination
  - Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level — Inpatient) eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination

HIQRP

- For **FY 2024**, CMS is also modifying the following three measures:
  - Hybrid hospital-wide **all-cause risk-standardized mortality measure** beginning with the **FY 2027** payment determination **to include Medicare Advantage (MA)** admissions
  - Hybrid **hospital-wide all-cause readmission measure** beginning with the **FY 2027 payment** determination **to include MA** admissions
  - **COVID-19 Vaccination** among Healthcare Personnel (HCP) measure, beginning with the **Quarter 4 CY 2023 reporting period/FY 2025 payment** determination
    - The prior version reported on the primary vaccination series only, but the proposed update would report the cumulative number of HCPs who are up to date with recommended COVID-19 vaccinations to align CMS programs with the Centers for Disease Control and Prevention's (CDC's) definition of "up to date" vaccination, keeping the measure relevant if future vaccination guidance evolves

HIQRP

- Finally, for **FY 2024**, CMS is removing the following three measures:
  - **Hospital-level risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty** measure beginning with the **FY 2030 payment determination** in conjunction with the proposal to adopt the updated measure in the HVBPP
  - **Medicare spending per beneficiary (MSPB)** hospital measure beginning with the **FY 2028 payment determination** in conjunction with the proposal to adopt the updated measure in the HVBPP
  - **Elective delivery prior to 39 completed weeks' gestation**: Percentage of babies electively delivered prior to 39 completed weeks' gestation measure (also known as PC-01) beginning with the **CY 2024 reporting period/FY 2026 payment determination**
    - CMS is removing this measure because measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made ("**topped out**")

HIQRP

- For **FY 2024**, CMS is also **modifying** the Hospital Consumer Assessment of Healthcare Providers and Systems (**HCAHPS**) survey measure beginning with the **CY 2025 reporting period/FY 2027 payment** determination.
  - These updates include removing the survey's prohibition on proxy respondents, extending the data collection period from 42 to 49 days, limiting the number of supplemental survey items to 12, requiring the official Spanish translation for Spanish language-preferring patients, and removing two administration methods that are not used by participating hospitals
- In addition, CMS has received feedback from stakeholders on the potential future inclusion of the following:
  - Two measures: geriatric hospital and geriatric surgical structural
  - Future establishment of a publicly reporting hospital designation to capture the quality and safety of patient-centered geriatric care

HRRP

- The HRRP is a value-based purchasing program that reduces payments to hospitals with excess readmissions while also supporting CMS' goal of improving healthcare for patients by linking payment to the quality of hospital care
- For purposes of the HRRP, a "readmission" occurs when a patient is discharged from an initial index hospital and admitted to the same or a different hospital within 30 days of discharge
  - Only one readmission is counted for purposes of calculating the excess readmission ratio
  - Certain patients (discharged AMA, under 65) as well as certain readmissions (transfers, planned readmissions) are not counted

HRRP

- For **FY 2024**, CMS is not making any changes to the HRRP
  - Therefore, for **FY 2024**, a hospital's **reduction will be based upon its excess readmissions during the applicable period for the following conditions:**
    - Acute Myocardial Infarction (AMI)
    - Heart Failure (HF)
    - Elective Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA)
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Hospital-Level, 30-Day, All-Cause, Unplanned Readmission Following Coronary Artery Bypass Graft (CABG) Surgery

HRRP

- The applicable period is the three-year period in which data is collected to calculate excess readmission ratios (ERRs) for payment in the program FY
  - The applicable period for HRRP adjustments in **FY 2024** is **July 1, 2019 - June 30, 2022**
- Hospitals are referred to the FY 2023 IPPS final rule (87 FR 49081 - 49094) for additional information on these policies

HVBPP

- The HVBPP is a budget-neutral program funded by reducing participating hospitals' base operating DRG payments each fiscal year by 2% and redistributing the entire amount back to the hospitals as value-based incentive payments
- Under the HVBPP, value-based incentive payments are made to eligible hospitals that meet or exceed certain performance standards, resulting in an increase to the hospital's base operating DRG payment
  - Eligibility for and amount of incentive payments is based on a hospital's FY Total Performance Score, which is the **higher** of two scores for the following measures:
    - Improvement: Comparing the hospital's base year performance to its performance during the performance period
    - Comparison to peers: Comparing the hospital's performance against that of its peers during the performance period

HVBPP

- For **FY 2024**, CMS is finalizing the following proposals:
  - Adopt the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning with the **FY 2026 program year**
  - Adopt substantive measure **modifications to the MSPB Hospital measure**, including allowing readmissions to trigger new episodes, beginning with the **FY 2028 program year**
  - Adopt substantive measure **modifications to the Hospital-level Risk-standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure**, including adding additional mechanical complication ICD-10 codes to the measure, beginning with the **FY 2030 program year**
  - Adopt changes to the **administration and submission requirements of the HCAHPS survey measure**, beginning with the **FY 2027 program year**

HVBPP

- Continued:
  - Adopt a **health equity scoring change for rewarding excellent care in underserved populations**, such that a health equity adjustment would be added to hospitals' Total Performance Scores (TPS) based on both a hospital's performance on existing HVBPP measures and the proportion of individuals with dual eligibility status that a hospital treats
    - As a result, CMS is also finalizing its proposal to **modify the TPS maximum to 110**, such that the numeric score range would be 0 to 110
  - Codify the measure removal factors, the health equity scoring change and modification of the TPS numeric score range, and the minimum number of cases

HACRP

- Under the HACRP, CMS reduces the sum of the total MS-DRG payment for each discharge from an "applicable hospital" by **1%**
  - An applicable hospital is a hospital in the top quartile of hospitals with the highest number of HACs reported during the "applicable periods"
  - HACs are specified high-cost and/or high-volume conditions CMS determines to be preventable
    - All HACs are designated as CCs or MCCs
    - CMS does not want to reward hospitals when HACs arise **after** admission and ignores them for purposes of MS-DRG assignment

HACRP

- For **FY 2024**, CMS will continue to determine a hospital's Total HAC Score based on its performance with respect to the **following six measures:**
  - Single claims-based composite measure (AHRQ PSI-90)
  - Five CDC NHSN (HAI) measures
    - CAUTI
    - CLABSI
    - Colon and Abdominal Hysterectomy SSI
    - C-Difficile
    - MRSA Bacteremia

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HACRP

- The applicable periods for **FY 2024** are set out below:
  - For **AHRQ PSI-90**, the 18-month performance period is **January 1, 2021 - June 30, 2022**
  - For the **five CDC NHSN** measures, the 12-month performance period is **January 1, 2022 - December 31, 2022**

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HACRP

- For **FY 2024**, CMS is also finalizing the following proposals:
  - Establish a **validation reconsideration process** for hospitals that failed to meet data validation requirements, beginning with the **FY 2025 program year**, affecting CY 2022 discharges
  - Modify the targeting criteria for data validation to include hospitals that received an Extraordinary Circumstances Exception (ECE) during the data periods validated beginning with the FY 2027 program year, affecting CY 2024 discharges
- In addition, CMS provided a summary of the comments received on its request for feedback on potential future measures and program modifications that would advance patient safety and reduce health disparities

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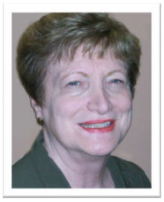
Questions & Answers



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