



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 17: Inpatient Prospective Payment System (IPPS) Adjustment Factors

I. IPPS Payment Calculations

- A. Hospitals receive an MS-DRG payment under the IPPS, which is the sum of an “operating” portion (consisting of a labor and non-labor portion similar to the OPSS payment) and an additional “capital” portion.

As discussed later in this module, the operating portion of the DRG may be adjusted by the following, if applicable:

- Electronic Health Record (EHR) meaning user standards;
- The Inpatient Quality Reporting Program;
- The hospital’s wage index;
- The relative weight of the DRG;
- The Disproportionate Share Hospital (DSH);
- Indirect Medical Education (IME);
- Hospital Readmission Reduction Program (HRRP);
- Value Based Purchasing (VBP);
- New Technology Add-on payment; and
- Cost based outlier payment.

As discussed later in this module, the capital portion of the DRG may be adjusted by the following, if applicable:

- The geographic adjustment factor (GAF);
- The relative weight of the DRG;
- Capital DSH adjustment;
- Capital IME adjustment; and
- Cost based outlier payment.

As discussed later in this module, the hospital’s total payment may be adjusted by the Hospital Acquired Condition (HAC) Reduction Program adjustment if applicable

II. Inpatient Pricer

- A. CMS makes available a web based Pricer that can be used to calculate applicable inpatient payment amounts or look up inpatient adjustment factors on their website.

Link: IPPS - Pricer under Medicare-Related Sites - Hospital

- B. CMS updates the Pricer periodically with annual updates and hospital specific information from settled cost reports.

III. The Operating Portion of the DRG Payment

A. The Operating Payment Formula

1. Step 1: Determine the labor-related standardized amount

- a. The standardized amounts are set forth in Tables 1A (for hospitals with a wage index greater than 1) and 1B (for hospitals with a wage index equal to or less than 1)¹. Tables 1A and 1B are included in the materials behind the outline. <88 Fed. Reg. 59355-356>
 - i. The standardized amounts incorporate the “full update” of 3.1%. <88 Fed. Reg. 59356>
 - ii. The full updated standardized amount is published in the first column of Tables 1A and 1B. Three additional columns provide the standardized amounts for hospitals that receive reduced payments due to failure to meet quality reporting or meaningful electronic health record (EHR) user requirements.
 - iii. Inpatient Quality Reporting Program (IQRP)
 - a) Hospitals who do not meet IQRP requirements but are Electronic Health Record (EHR) meaningful users, will receive an update of 2.775%. This is equal to the full update of 3.8% minus 25% of the applicable market basket update (i.e., 25% of 4.1% or 1.025%). The updated standardized amount is published in the third column of Tables 1A and 1B. <88 Fed. Reg. 59356>

¹ Table 1C contains the standardized amounts for hospitals located in Puerto Rico.

- b) Hospitals can verify their status under the IQRP on the QualityNet website.

Link: QualityNet Main Page under Medicare-Related Sites - Hospital

iv. Electronic Health Record (EHR) Meaningful User

- a) Hospitals who do not qualify as meaningful users of EHR, but do meet IQRP requirements, will receive an update of 0.725%. This is equal to the full update of 3.8% minus 75% of the applicable market basket update (i.e., 75% of 4.1% or 3.075%). The updated standardized amount is published in the second column of Tables 1A and 1B. <88 Fed. Reg. 59356>

v. Failure to meet both IQR and EHR requirements

- a) Hospitals who fail to meet both the IQRP and the meaningful EHR user requirements will receive an update of -0.3%. This is equal to the full update of 3.8% minus the full market basket update of 4.1%. The updated standardized amount is published in the fourth column of Table 1A and 1B. <88 Fed. Reg. 59356>

2. Step 2: Multiply the applicable labor-related standardized amount (determined in Step 1 above) by the wage index for the hospital.
3. Step 3: Add the applicable non-labor-related standardized amount from Table 1A or 1B to the result from Step 2.
 - a. For hospitals located in Alaska and Hawaii, the non-labor-related standardized amount is multiplied by a “cost of living adjustment” (COLA) to account for the unique circumstances of those hospitals. <See 88 Fed. Reg. 59357>
 - i. The “cost of living” adjustment factors are published in a special table in the IPPS Final Rule. For Alaska, the adjustment is based on the distance from major cities within Alaska, and for Hawaii the adjustment is based on county. The current table is included in the materials behind the outline. <See 88 Fed. Reg. 59357>
4. Step 4: Multiply the result of Step 3 by the relative weight for the applicable MS-DRG from Table 5. Table 5 is included in the Supplement to these materials.

5. Step 5: Multiply the result of Step 4 by any hospital-specific operating adjustments, such as DSH or IME, to determine the amount of the add on payment. These amounts are set aside to be added back later.
 - a. These factors are not considered part of the “base operating payment” as defined for the HRRP or VBP adjustments. <42 CFR 412.152; 42 CFR 412.160>
 - b. Disproportionate Share Hospital (DSH) Adjustment
 - i. Hospitals that serve a “disproportionate share” of low-income patients (defined as Medicaid/non-Medicare patients and disabled Medicare patients) may receive a percentage increase in the DRG payment they receive for each IPPS case and a per case add-on amount for uncompensated care.
 - ii. For more information on the DSH Adjustment see the Disproportionate Share Hospital (DSH) website on the Acute Inpatient PPS page of the CMS website.

Link: Disproportionate Hospital Share (DSH) Information under Medicare-Related Sites - Hospital
 - c. Indirect Medical Education (IME) Adjustment
 - i. Hospitals that provide resident training may receive a percentage increase in the DRG payment they receive for each IPPS case based on the number of residents they host. This “Indirect Medical Education” or “IME” adjustment is intended to compensate teaching hospitals for the higher costs they incur relative to non-teaching hospitals (e.g., more lab tests).
 - ii. For more information on the IME Adjustment see the Indirect Medical Education (IME) website on the Acute Inpatient PPS page of the CMS website.

Link: Indirect Medical Education under Medicare-Related Sites - Hospital
6. Step 6: Add any applicable New Technology Payment to the result from Step 4 to determine the “base operating payment” as defined for the HRRP and VBP. <42 CFR 412.152, 412.160>
 - a. New Technology Add-On Payments

- i. Hospitals can receive an additional “add-on” payment for designated “new medical services and technology” if the hospital’s costs exceed a specified threshold. <42 CFR 412.87(a)>
 - a) This new technology add-on payment is conceptually similar to the outpatient “pass-through” payment concept.
 - b) CMS designates new technology services and devices if the prospective payment rate is determined to be inadequate and the technology is substantially new based on one of following:
 - 1) The new technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; or
 - 2) The new medical device has received Food and Drug Administration (FDA) marketing authorization and is part of the FDA’s Breakthrough Devices Program<42 CFR 412.87(c)(1)>; or
 - 3) The new medical product has received FDA marketing authorization and is designated as a Qualified Infectious Disease Product (QIDP) by the FDA. <42 CFR 412.87(d)(1)(i)>
 - (a) For more information on QIDPs and CMS initiatives to address antimicrobial resistance *MLN Matters SE20004*, available on the CMS website.
 - 4) The new medical device is approved under the FDA’s Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) and is used for indications approved under the LPAD pathway. <42 CFR 412.87(d)(1)(ii)>
- ii. Each year, CMS announces additions and deletions to the list of qualifying new technology in the IPPS Final Rule. The current list of designated new technologies is included on Attachment A behind the outline.
- iii. The new technology add-on payment is intended to be temporary. Once CMS has gathered enough data on the new technology to “recalibrate” the applicable weight of the DRG involving the new technology, the add-on payment will no longer be available. <42 CFR 412.87(b)(2)>
 - a) The regulations provide that a new technology should only be treated as “new” for 2 or 3 years from the time that product came on the market. <42 CFR 412.87(b)(2)>

- iv. CMS will extend new technology add-on payment to any substantially similar product, assigned to the same ICD-10-PCS code as the brand name specifically approved in the final rule, if it receives FDA approval before or during the applicable fiscal year. <70 Fed. Reg. 47357>
- v. Calculating the New Technology Add-On Payment
 - a) Qualifying for new technology add-on payment
 - 1) A case will qualify for new technology add-on payment if the hospital's operating costs (based on charges multiplied by the operating CCR) exceed the full DRG payment (including IME and DSH adjustments but excluding outlier payment) for a case that is billed with the qualifying new technology codes. <42 CFR 412.88>
 - b) Amount of new technology add-on payment
 - 1) For designated new technologies, other than QIDPs and LPADs, the add-on payment amount is the lesser of 65% of the cost of the new technology or 65% of the amount the hospital's costs exceed the full DRG payment (including IME and DSH but excluding outlier). <42 CFR 412.88>
 - 2) For designated QIDPs and LPADs, the add-on payment amount is the lesser of 75% of the cost of the new technology or 75% of the amount the hospital's operating costs exceed the full DRG payment for the case (including any IME and DSH but excluding any outlier payment). <42 CFR 412.88>

Case Study 1

Facts: A Medicare inpatient with osteomyelitis was taken to the OR for treatment with CERAMENT® G, an injectable bone-void filler made of calcium sulfate, hydroxyapatite, and gentamicin sulfate. The hospital submitted an inpatient claim and full payment (operating and capital) under MS-DRG 464 for the case was \$26,300, including all adjustments. The hospital has a combined operating cost-to-charge ratio of 0.40. The hospital's total charges for the case were \$93,800. The case did not qualify as an outlier. Assuming ICD-10-PCS code XW0V0P7 was reported on the claim for use of the CERAMENT® G, would this case qualify for a new technology add-on payment and, if so, how much?

7. Step 7: Multiply the result of Step 6, the “base operating payment”, by the adjustment factors for the HRRP and VBP.
- a. HRRP and VBP basics
 - i. The HRRP and VBP adjustments are made to the base operating portion of the DRG payment, which consists of the operating portion (i.e., the amount calculated through Step 4 above) plus any applicable new technology add-on. If applicable, the base operating amount used is based on the transfer amount or post-acute care transfer amount. <42 CFR 412.152; 42 CFR 412.160>
 - a) The base operating portion of the DRG does not include DSH, IME, Low Volume Hospital adjustments or applicable outlier. <42 CFR 412.152; 42 CFR 412.160>
 - b. The HRRP requires a reduction to a hospital’s base operating DRG payments for all discharges to account for excess readmissions for selected conditions. <77 Fed. Reg. 53374-53401, 88 Fed. Reg. 59412>
 - i. A hospital’s specific HRRP adjustment factor will be the **higher** of a hospital-specific ratio or a floor adjustment factor of .97 (maximum reduction in base operating DRG payments of 3%). The hospital-specific ratio will be rounded to the fourth decimal place, published in Table 15 of the FY2024 IPPS Final Rule. <88 Fed. Reg. 59380>
 - ii. The following conditions are included in the HRRP:
 - a) Acute Myocardial Infarction (AMI);
 - b) Heart Failure (HF);
 - c) Pneumonia;
 - d) Elective Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA) (added for FY2015);
 - e) Chronic Obstructive Pulmonary Disease (COPD) (added for FY2015);
and
 - f) Coronary Artery Bypass Graft (CABG) Surgery. <88 Fed. Reg. 59063>

- c. The VBP adjusts a hospital's base operating amount to account for their Total Performance Score (based on an achievement score and an improvement score) during a "Performance Period". The hospital's specific VBP adjustment factor may be a positive or negative adjustment. The hospital-specific adjustment factor is published in Table 16B of the IPPS Final Rule.
 - i. Four Quality Domains for the VBP:
 - a) Clinical Outcome Domain;
 - b) Person and Community Engagement Domain;
 - c) Safety Domain;
 - d) Efficiency and Cost Reduction Domain.

For more information, see the CMS.gov Quality Net page for Hospital VBP. Link: Quality Net Main Page under Medicare-Related Sites - Hospital

- 8. Step 8: Add any amounts from Step 5 (e.g., DSH, IME) to the result from Step 7 (i.e., base operating payment adjusted by the HRRP and VBP) to determine the combined operating amount.
- 9. Step 9: Add any applicable operating outlier payment (discussed below) to the result from Step 8 to determine the total operating amount.

IV. Adjustments to the Operating Portion for Special Hospitals

A. Sole Community Hospitals ("SCHs")

- 1. An SCH is located more than 35 miles from other like hospitals or meets certain other criteria, such as inaccessibility or travel time to other hospitals. <42 CFR 412.92(a)>
- 2. An SCH is required to notify the FI/MAC within 30 days of any change that could affect its classification as an SCH. <42 CFR 412.92(b)(3)>
- 3. A SCH is paid the same capital portion as other IPPS hospitals, and their operating amount is the greater of:
 - a. The applicable Federal IPPS operating amount; or

- b. A hospital specific rate determined under 42 C.F.R. 412.73, based on a Federal fiscal year 1982 base period (i.e., prior to implementation of the IPPS); or
- c. A hospital specific rate determined under 42 C.F.R. 412.75, based on a Federal fiscal year 1987 base period; or
- d. A hospital specific rate determined under 42 C.F.R. 412.77, based on a Federal fiscal year 1996 base period; or
- e. A hospital specific rate determined under 42 C.F.R. 412.78, based on a Federal fiscal year 2006 base period. <42 C.F.R. 412.92 (d)>

B. Low Volume Hospitals

- 1. A hospital qualifies for a low volume hospital payment adjustment if:
 - a. The hospital has fewer than 200 total Medicare and non-Medicare discharges; and
 - b. The hospital is located more than 25 road miles from another subsection (d) hospital. <87 Fed. Reg. 49060-61; 42 C.F.R. 412.101(b)(2)(i)>
- 2. The adjustment for low volume hospitals is an additional 25% for each Medicare discharge. <42 C.F.R. 412.101(c)(1)>

The Consolidated Appropriations Act of 2023 extended provisions that expired in FY2022 for hospitals with fewer than 3800 discharges and located more than 15 road miles from another subsection (d) hospital through FY2024. CMS published *One Time Notification Transmittal 11878* with instructions on the temporary extension.

C. Medicare Dependent Hospitals (MDH)

- 1. The program for Medicare Dependent Hospitals in rural areas, with 100 or fewer beds and at least 60% of inpatient days or discharges attributable to Medicare was set to expire at the end of FY2022. <87 Fed. Reg. 49064-65>

2. CMS allowed hospitals that were part of the MDH program to apply to be a SCH and if the MDH program is retroactively reinstated by Congress, CMS will allow them to cancel their SCH application/status and apply to reinstate their MDH status. <87 Fed. Reg. 49065>

The Consolidated Appropriations Act of 2023 extended the Medicare Dependent Hospital provisions through FY2024. CMS published *One Time Notification Transmittal 11848* with instructions on the temporary extension.

V. The Capital Portion of the DRG Payment

A. The Capital Payment Formula <42 CFR 412.312>

Capital Standard Federal Rate (Table 1D)	x	Geographic Adj. Factor (Table 4A-C)	x	Capital COLA (AK, HI only)	x	DRG Relative Weight (Table 5)
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B. The Capital Standard Federal Rate for FY 2024 is \$503.83. <88 Fed. Reg. 59363>

C. For hospitals located in Alaska and Hawaii, the capital “cost of living adjustment” (COLA) is equal to the operating COLA times 0.3152. <42 CFR 412.316(c)>

VI. The HAC Reduction Program

A. The HAC Reduction Program makes a 1% reduction to the total payment, include both the total operating and capital portion discusses above, for hospitals with HAC scores in the poorest performing quartile of all measured hospitals. <42 CFR 412.172, 79 Fed. Reg. 50088-89>

B. The HAC Reduction Program is based six measures:

1. CMS PSI-90 (a composite of several patient safety indicator measures);
2. CDC NHSN measures:
 - a. CAUTI (catheter associated urinary tract infection),
 - b. CDI (*Clostridium Difficile* Infection),
 - c. CLABSI (central line associated blood stream infection),
 - d. Colon and abdominal hysterectomy SSI (surgical site infection)
 - e. MRSA Bacteremia. <88 Fed. Reg. 59109>

VII. Transfer Payment for Discharges

A discharge will be paid as a transfer if:

- The patient is admitted to another hospital on the day of discharge; OR
- The patient is discharged with a qualifying MS-DRG to a post-acute care setting

A. CMS published *MLN Matters Article 21001*, available on the CMS website, with a review of Medicare’s transfer policy, including post-acute care transfers.

B. Patient admitted to another hospital on the day of discharge

1. A case will be treated as a transfer for payment purposes if a patient is admitted on the day of discharge to another acute IPPS hospital, critical access hospital, or a hospital eligible to be paid under IPPS but does not have a participation agreement with Medicare. <42 CFR 412.4(b); *Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A) and (B)>

a. Exception: The case will be treated as a discharge rather than a transfer if the readmission is unrelated to the discharge. <*Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A)>

Example: A patient is discharged from one hospital and later that is in an auto accident and is admitted to another hospital.

i. CMS has suggested that for the readmission to be considered unrelated “the hospital can present documentation showing that the patient’s care associated with the [first admission] was completed before discharge.” <68 *Fed. Reg.* 45405>

b. Patients who leave against medical advice and are admitted to another hospital on the same day are also treated as transfers. <*Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A)>

2. Patient readmitted on the day of discharge
 - a. If a patient is readmitted to the same hospital on the day of discharge for symptoms *related to*, the earlier stay's medical condition, the hospital must combine the original and subsequent stay onto a single claim. <Medicare Claims Processing Manual, Chapter 3 § 40.2.5>
 - b. If a patient is readmitted to the same hospital on the day of discharge for symptoms *unrelated to* the earlier stay's medical condition, the hospital should treat the readmission as a new admission and should report condition code "B4" on the claim for the second admission. <Medicare Claims Processing Manual, Chapter 3 § 40.2.5>
3. Patient readmitted after the day of discharge
 - a. If the patient is readmitted after the day of discharge for symptoms related to an earlier stay, the hospital should bill the new admission separately, unless the patient's readmission is expected (i.e., planned). <Medicare Claims Processing Manual, Chapter 3 §§ 40.2.5, 40.2.6>
 - b. An *expected* (i.e., planned) readmission may be billed separately or on a single claim with the original admission using leave of absence billing. <Medicare Claims Processing Manual, Chapter 3 §§ 40.2.5, 40.2.6>
 - i. If a single claim is submitted only one payment is made and occurrence span code 74 is used to indicate the days the patient is on leave of absence (i.e., between their initial discharge and the expected readmission). <Medicare Claims Processing Manual, Chapter 3 § 40.2.6>
 - ii. Separate readmission claims within 30 days of a prior discharge may be reviewed by the QIO to verify each stay was medically necessary, allowing payment for both stays. <Medicare Claims Processing Manual, Chapter 3 §§ 40.2.5>

Case Study 2

Facts: A patient was discharged from one acute care IPPS hospital (Hospital #1) and admitted to a different acute care IPPS hospital (Hospital #2) later that day. Under what circumstances should Hospital #1's claim be treated as a discharge rather than a transfer? How will Hospital #2 be paid?

C. Post-Acute Care Transfers

1. Post-Acute Care Transfer MS-DRGs

- a. For FY 2024, there are 282 designated post-acute care transfer MS-DRGs. The list of post-acute care transfer MS-DRGs is published in Table 5 of the IPPS Final Rule.

A post-acute care transfer payment is triggered when:

- The case is assigned to a designated post-acute care transfer MS-DRG; and
- The patient is discharged to a specific post-acute care setting.

2. The post-acute care settings, as indicated by the Patient Discharge Status code (see below) in Field 17 of the UB-04, which trigger the “post-acute care transfer” rule are:

- a. A non-IPPS hospital or a distinct part non-IPPS unit on the day of discharge. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>
- i. Inpatient rehabilitation facilities and units (Patient Discharge Status 62 or 90)
 - ii. Long-term care hospitals (Patient Discharge Status 63 or 91)
 - iii. Psychiatric hospitals and units (Patient Discharge Status 65 or 93)
 - iv. Children’s hospitals and cancer hospitals (Patient Discharge Status 05 or 85)
- b. A Medicare certified skilled nursing facility or SNF unit within a hospital, (Patient Discharge Status 03 or 83) on the day of discharge. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>
- i. A discharge to a SNF is considered a transfer under this policy if the patient is directly admitted to the SNF from the hospital. <63 Fed. Reg. 40978>
 - ii. Swing Beds (Patient Discharge Status 61 or 89)
 - a) A swing-bed is not a SNF for purposes of the post-acute care transfer provisions. <63 Fed. Reg. 40977>
 - iii. Non-covered SNF Admissions

- a) A discharge to a SNF bed is still considered to be a post-acute care transfer (assuming a qualifying DRG), regardless of whether or not the SNF admission was covered or paid by Medicare, as long as the patient qualified for skilled nursing care. <63 Fed. Reg. 40978, MedLearn Matters Article MM4046>
- b) The following discharges to a SNF are not considered post-acute care transfers:
 - 1) A patient discharged at a non-skilled level of care,
 - 2) A patient discharged to a non-Medicare certified bed, and
 - 3) A patient discharged to a non-skilled bed within a SNF. <MLN Matters Article MM4046>
- c. Home health care (Patient Discharge Status 06 or 86), beginning within 3 days of the discharge, including the resumption of home health services in place prior to the inpatient stay. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>
 - i. The hospital may add condition code 42 (“Continuing Care not Related to Inpatient Hospitalization”) to the claim if the patient’s continuing home health care is not related to the condition or diagnosis for which the patient received inpatient hospital services. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE1411; MLN Matters SE21001>
 - ii. The hospital may add condition code 43 (“Continuing Care not Provided Within Prescribed Post-Discharge Window”) to the claim if the patient’s continuing home health care is related, but no home health services are provided within 3 days of hospital discharge. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE1411; MLN Matters SE21001>
 - iii. If Patient Discharge Status code 06 or 86 is reported with condition code 42 or 43, full DRG payment is made, rather than post-acute care transfer payment. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE1411>
- d. Hospice care provided by a hospice program (Patient Discharge Status 50 – Discharged/Transferred to Hospice – Routine or Continuous Home Care; or Patient Discharge Status 51 – Discharged/Transferred to Hospice – General Inpatient Care or Inpatient Respite). <83 Fed. Reg. 41393-392; Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C)>

3. If a hospital submits a claim indicating the patient was discharged to home or another setting not included in the post-acute-care transfer policy and subsequently learns the patient went to a setting included in the post-acute-care transfer policy (e.g., home health), the hospital should submit an adjusted claim. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(C); MLN Matters SE20025>

D. Transfer Payment

1. Payment to the transferring hospital:
 - a. A “per diem” rate is determined by dividing the full payment for the discharge DRG by the geometric mean length of stay (“GMLOS”) for the discharge DRG.
 - i. The GMLOS for each DRG is listed in Table 5 of the IPPS final rule.
 - b. The first day of the admission is paid at twice the per diem rate in recognition of the extra expenses incurred on the day of admission.
 - c. All subsequent days are paid at the per diem, up to the full DRG amount.

Case Study 3

Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

2. For FY2024, special payment rules apply to 44 post-acute care transfer MS-DRGs identified on Table 5 of the IPPS Final Rule. <42 CFR 412.4(f)(6)>
 - a. The “special payment rules” only apply to post-acute care transfers and do not apply to other transfers. <42 CFR 412.4(f)(6)>
 - b. A “special pay” post-acute care transfer is paid:
 - i. 50% of the full DRG payment plus 50% of the calculated per diem for the first day.
 - ii. 50% of the calculated per diem for each subsequent day up to the full DRG payment.

3. The final discharging hospital” (i.e., the hospital to which the patient is considered to have been transferred) is paid at the full payment rate based on the final discharge DRG. <Medicare Claims Processing Manual, Chapter 3 § 40.2.4(A)>

Case Study 4

Modified Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated special pay post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

VIII. Outliers

A. Overview of inpatient outliers

1. Inpatient outliers are additional payments (above and beyond the standard DRG payment) designed to protect hospitals from large financial losses due to “unusually expensive cases.” <68 Fed. Reg. 34494>
 - a. The outlier payment, if any, for a particular case is based on the costs incurred by the hospital in connection with the case.
 - i. In previous years, outlier payments had also been available in certain cases where the length of stay was unusually long, however, these so-called “day outlier” payments have been eliminated.
2. Certification
 - a. For cost outlier cases, the physician must certify the need for the special and unusual services delivered. <42 CFR 424.13 (a)(2)(ii)>
 - b. The certification must be made no later than the day the hospital requests cost outlier payment or by day 20 of the hospitalization, whichever is earlier. <42 CFR 424.13 (f)(2)>
3. The National Fixed Loss Threshold
 - a. CMS publishes the “fixed loss threshold” in the final inpatient rule each year. For FY 2024, the fixed loss threshold is \$42,750. <88 Fed. Reg. 59354>

4. Reconciliation

- a. Under certain circumstances, as part of the cost report settlement process, the MAC will re-compute inpatient outlier payments using the hospital's actual CCR from the cost report for that year. <Medicare Claims Processing Manual, Chapter 3 § 20.1.2.5>
- b. Criteria for Reconciliation
 - i. The operating CCRs from the settled cost report varies by plus or minus 10% from the CCRs used to calculate the outlier payments for the year,
 - ii. Total inpatient outlier payments for the cost report period exceed \$500,000, and
 - iii. CMS central office approves the MACs determination that the hospital meets the criteria for reconciliation. <Medicare Claims Processing Manual, Chapter 3 § 20.1.2.5>
- c. Any underpayments/overpayments based on the subsequent reconciliation are subject to "interest" payments/charges. <42 CFR 412.84(m)>

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CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A Medicare inpatient with osteomyelitis was taken to the OR for treatment with CERAMENT® G, an injectable bone-void filler made of calcium sulfate, hydroxyapatite, and gentamicin sulfate. The hospital submitted an inpatient claim and full payment (operating and capital) under MS-DRG 464 for the case was \$26,300, including all adjustments. The hospital has a combined operating cost-to-charge ratio of 0.40. The hospital's total charges for the case were \$93,800. The case did not qualify as an outlier. Assuming ICD-10-PCS code XW0V0P7 was reported on the claim for use of the CERAMENT® G, would this case qualify for a new technology add-on payment and, if so, how much?

Analysis: This case would qualify for add on payment in the amount of \$4,918.55.

Total Operating Cost = $\$93,800 \times 0.40 = \$37,520$

Difference Between Operating Cost and Payment = $\$37,520 - \$26,300 = \$11,220$

Add-on payment = $65\% \times \$11,220 = \$7,293$

The add-on payment for CERAMENT® G is capped at \$4,918.55.

Case Study 2

Facts: A patient was discharged from one acute care IPPS hospital (Hospital #1) and admitted to a different acute care IPPS hospital (Hospital #2) later that day. Under what circumstances should Hospital #1's claim be treated as a discharge rather than a transfer? How will Hospital #2 be paid?

Analysis: The claim should be treated as a discharge rather than a transfer if Hospital #2's admission was unrelated to the discharge from Hospital #1. Regardless of whether Hospital #1 claim is paid as a discharge or transfer, Hospital #2 will be paid the full payment rate based on the patient's final discharge MS-DRG. <42 CFR 412.4(b); *Medicare Claims Processing Manual*, Chapter 3 § 40.2.4(A)>

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Case Study 3

Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

Analysis: The full payment rate of \$10,000 is divided by the GMLOS of 5 days to calculate a per diem of \$2000. The hospital receives \$4000 for day one, and \$2000 for days 2, 3 and 4 for a total of \$10,000. In this case, transfer payment was not less than the full discharge payment. <42 CFR 412.4(f)(1)>

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Case Study 4

Modified Facts: A patient is discharged from a hospital to a skilled nursing facility for skilled care following a stay assigned to a designated special pay post-acute care transfer MS-DRG. Full payment to the hospital for the MS-DRG would be \$10,000 and the GMLOS for the MS-DRG is 5 days. How much would the hospital be paid if the patient is discharged after four days in the hospital.

Analysis: The full payment rate of \$10,000 is divided by the GMLOS of 5 days to calculate a per diem of \$2000. The hospital receives \$6000 for day one (\$5000 + \$1000), and \$1000 for days 2, 3 and 4 for a total of \$9,000. <42 C.F.R.412.4(f)(6)>

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FY2024 IPPS New Technology Summary

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
GOSELA™ (trilaciclib, used to decrease the incidence of chemotherapy-induced myelosuppression in adult patients administered prior to a certain treatment for extensive-stage small cell lung cancer (ES-SCLC): Continued for FY2023 Discontinued	XW03377, or XW04377	\$5,526.30 (FY2022) \$5,612.10 (FY2023)	86 Fed. Reg. 45008-17; 87 Fed. Reg. 48912-913; 88 Fed. Reg. 58803
ABEGMA® (idecabtagene vicleucel, a B-cell maturation antigen (BCMA)-directed genetically modified autologous chimeric antigen receptor (CAR) T-cell immunotherapy for relapsed or refractory multiple myeloma and is a 5 th line plus treatment): Continued for FY2023 Discontinued	XW033K7, or XW043K7	\$272,675.00* (FY2022) \$289,532.75 (FY2023)	86 Fed. Reg. 45028-35; * as corrected in 86 Fed. Reg. 58032; 87 Fed. Reg. 48912-913; 88 Fed. Reg. 58803
TECARTUS® (brexucabtagene autoleucel, a CD19 directed genetically modifier autologous T-cell immunotherapy for relapsed and refractory mantle cell lymphoma, a form of CAR-T): Continued for FY2023 Discontinued	XW033M7, or XW043M7	\$259,350*	86 Fed. Reg. 45090-104; * as corrected in 86 Fed. Reg. 58033; 87 Fed. Reg. 48913; 88 Fed. Reg. 58803
VEKLURY® (remdesivir, a nucleotide analog that inhibits viral RNA-dependent RNA polymerases, demonstrating activity countering viral pathogens such as SARS-CoV-2 (COVID-19)): Continued for FY2023 Discontinued	XW033E5, or XW043E5	\$2,028.00	86 Fed. Reg. 45104-116; 87 Fed. Reg. 48913; 88 Fed. Reg. 58803
ZEPZELCA (turbinectedin, a marine derived, synthetic antineoplastic compound for treatment of metastatic small cell lung cancer (SCLC) with disease progression on chemotherapy): Continued for FY2023	XW03387, or XW04387	\$8,622.90 (FY2022) \$9,145.50 (FY2023)	86 Fed. Reg. 45116-126; 87 Fed. Reg. 48912-913; 88 Fed. Reg. 58803

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
Discontinued			
aScope Duodeno (a sterile, single-use endoscope for endoscopy and endoscopic treatment of the upper gastrointestinal tract): Continued for FY2023 Discontinued	XFJB8A7, or XFJD8A7	\$1,715.59 (FY2022) \$1,296.75 (FY2023)	86 Fed. Reg. 45133-135; 87 Fed. Reg. 48913; 48915; 88 Fed. Reg. 58803
Caption Guidance™ (an artificial intelligence (AI) guided medical imaging acquisition software system for cardiac ultrasound images, providing real-time guidance during transthoracic echocardiography): Continued for FY2023 Discontinued	X2JAX47	\$1,868.10	86 Fed. Reg. 45135-138; 87 Fed. Reg. 48913; 88 Fed. Reg. 58803
Harmony™ Transcatheter Pulmonary Valve System (a bioprosthetic heart valve from porcine pericardial tissue for treatment of congenital heart disease): Continued for FY2023 Discontinued	02RH38M	\$26,975.00	86 Fed. Reg. 45146-149; 87 Fed. Reg. 48913; 88 Fed. Reg. 58803
Shockwave G2 Intravascular Lithotripsy System (for lithotripsy-enabled, low-pressure dilation of calcified, stenotic de novo coronary arteries prior to stenting): Continued for FY2023 Discontinued	02F03ZZ, 02F13ZZ; 02F23ZZ, or 02F33ZZ	\$3,666.00	86 Fed. Reg. 45151-153; 87 Fed. Reg. 48913; 88 Fed. Reg. 58803
GARVYKTI™ (ciltacabtagene autoleucel) (an autologous chimeric antigen receptor (CAR) T-cell therapy directed against B cell maturation antigen (BCMA) for treatment of patients with multiple myeloma): New for FY2023 Discontinued	XW033A7, or XW043A7	\$289,532.75	87 Fed. Reg. 48920-925; 88 Fed. Reg. 58803
DARZALEX FASPRO® (a combination of daratumumab (a monoclonal CD38-directed cytolytic antibody) and hyaluronidase (an endoglycosidase) for the treatment of light chain amyloidosis in combination with bortezomib, cyclophosphamide and dexamethasone (CyBorD): New for FY2023 Discontinued	XW01318	\$5,159.41	87 Fed. Reg. 48925-937; 88 Fed. Reg. 58803

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
FETROJA [®] (cefiderocol) (an injectable siderophore cephalosporin for hospital-acquired bacterial pneumonia/ventilator-associated bacterial pneumonia). Continued for FY2023 Discontinued	XW033A6, or XW043A6 *reported with ICD-10-CM codes Y95 and J14, J15.0; J15.1, J15.5, J15.6, or J15.8; OR J95.851 and B96.1; B96.20, B96.21, B96.22, B96.23, B96.29, B96.3; B96.5, or B96.89	\$8,579.84** (75% add-on limit)	86 Fed. Reg. 45156-157; * as corrected in 86 Fed. Reg. 67875; ** as corrected in 86 Fed. Reg. 58032; 87 Fed. Reg. 48913-914; 88 Fed. Reg. 58803
RECARBRIO [™] (imipenem, cilastatin, and relebactam) (a novel beta-lactamase inhibitor for treatment of hospital acquired bacterial pneumonia/ventilator associated bacterial pneumonia caused by susceptible Gram-negative bacteria). Continued for FY2023 Discontinued	XW033U5, or XW043U5 *reported with ICD-10-CM codes Y95 and J14, J15.0; J15.1, J15.5, J15.6, or J15.8 for HABP; OR XW033A6 or XW043A6 reported with ICD-10-CM codes J95.851 and B96.1, B96.20, B96.21, B96.22, B96.23, B96.29, B96.3, B96.5, or B96.89 for VABP	\$9,576.51** (75% add-on limit)	86 Fed. Reg. 45157-159; * as corrected in 86 Fed. Reg. 58023; further corrected in 86 Fed. Reg. 67875; ** as corrected in 86 Fed. Reg. 58032; 87 Fed. Reg. 48913-914; 88 Fed. Reg. 58803
Hemolung Respiratory Assist System (Hemolung RAS) (for treatment of acute hypercapnic respiratory failure using extracorporeal circuit to remove CO ₂ directly from the blood). New for FY2023 Discontinued with Dx of U07.1 (COVID-19)	5A0920Z	\$6,500	87 Fed. Reg. 48937-948; 88 Fed. Reg. 58803
Hemolung Respiratory Assist System (Hemolung RAS) (for treatment of acute hypercapnic respiratory failure using extracorporeal circuit to remove CO ₂ directly from the blood). Continued for FY2024 without U07.1 (COVID-19)	5A0920Z without U07.1	\$6,500	87 Fed. Reg. 48937-948; 88 Fed. Reg. 58800-801
Aprevo [™] (an interbody fusion implant that stabilizes the lumbar spinal column and facilitates fusion during lumbar fusion procedures for spinal deformity, custom made from patient CT scans). Continued for FY2023	XRG(A,B,C,D)0R7 XRG(A,B,C,D)3R7 XRG(A,B,C,D)4R7	\$40,950.00*	86 Fed. Reg. 45127-133; * as corrected in 86 Fed. Reg. 67875; 87 Fed. Reg. 48913; 88 Fed. Reg. 58803

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
Discontinued for Anterior Lumbar Interbody Fusion (ALIF) and Lateral Lumbar Interbody Fusion (LLIF)			
Aprevo™ (an interbody fusion implant that stabilizes the lumbar spinal column and facilitates fusion during lumbar fusion procedures for spinal deformity, custom made from patient CT scans). Continued for FY2024 for Transforaminal Lumbar Interbody Fusion (TLIF)	XRG(A,B,C,D)0R7 XRG(A,B,C,D)3R7 XRG(A,B,C,D)4R7	\$40,950.00 *	86 Fed. Reg. 45127-133; * as corrected in 86 Fed. Reg. 67875; 87 Fed. Reg. 48913; 88 Fed. Reg. 58800
INTERCEPT Fibrinogen Complex (PRCFC) (a blood product for treatment of fibrinogen deficiency-related bleeding, including massive hemorrhage). Continued for FY2024	NDC 30233D1 or 30243D1 with ICD-10-CM codes D62*, D65, D68.2, D68.4*, or D68.9*	\$2,535.00	86 Fed. Reg. 45149-150; * as corrected in 86 Fed. Reg. 67875; 87 Fed. Reg. 48913; 88 Fed. Reg. 58800
RYBREVANT™ (amivantamab, for the treatment of metastatic non-small cell lung cancer (NSCLC)). Continued for FY2024	XW033B7, or XW043B7	\$6,405.89	86 Fed. Reg. 44988-996; 87 Fed. Reg. 48913; 88 Fed. Reg. 58800
StrataGraft™ Skin Tissue (a viable bioengineered, regenerative skin construct (BRSC) for treatment of severe thermal burns). Continued for FY2024	XHRPXF7	\$44,200.00	86 Fed. Reg. 45079-90; 87 Fed. Reg. 48913; 88 Fed. Reg. 58800
LIVTENCITY™ (maribavir) (a cytomegalovirus (CMV) pUL97 kinase inhibitor for treatment of post-transplant CMV infection/disease that is refractory to treatment (with or without genotypic resistance) to ganciclovir, valganciclovir, cidofovir, or foscarnet). Continued for FY2024	XW0DX38, XW0G738, or XW0H738	\$32,500	87 Fed. Reg. 48937-954; 88 Fed. Reg. 58800
CERAMENT® G (an injectable bone-void filler made of calcium sulfate, hydroxyapatite, and gentamicin sulfate for surgical treatment of osteomyelitis). Continued for FY2024	XW0V0P7	\$4,918.55	87 Fed. Reg. 48961-966; 88 Fed. Reg. 58800
GORE® TAG® Thoracic Branch Endoprosthesis (TBE) (a modular device consisting of three components, an Aortic Component, a Side Branch Component, and an optional Aortic Extender Component, each pre-mounted on a catheter delivery system for treatment of thoracic aortic aneurysms, traumatic aortic transection, and aortic dissection).	02VW3DZ in combination with 02VX3EZ	\$27,807.00	87 Fed. Reg. 48966-969; 88 Fed. Reg. 58800

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
Continued for FY2024			
iFuse Bedrock Granite Implant System (a sterile, single-use permanent implant intended to provide sacropelvic fusion of the sacroiliac joint and fixation to the pelvis when used in conjunction with commercially available pedicle screw fixation systems as a foundational element). Continued for FY2024	XNH6058, XNH6358, XNH7058, XNH7358, XRGE058, XRGE358, XRGF058, or XRGF358	\$9,828.00	87 Fed. Reg. 48969-974; 88 Fed. Reg. 58800
Thoraflex™ Hybrid Device (a sterile single-use, gelatin sealed Frozen Elephant Trunk (FET) surgical medical device, deployed through an opened aortic arch and positioned into the descending thoracic aorta for repair or replacement of damaged or diseased vessels of the aortic arch and descending aorta, with or without involvement of the ascending aorta, in cases of aneurysm and/or dissection). Continued for CY2024	X2RX0N7, in combination with X2VW0N7	\$22,750	87 Fed. Reg. 48974-975; 88 Fed. Reg. 58800
ViviStim® Paired VNS System (a paired vagus nerve stimulation therapy intended to stimulate the vagus nerve during rehabilitation therapy to reduce upper extremity motor deficits and improve motor function in chronic ischemic stroke patients with moderate to severe arm impairment). Continued for CY2024	X0HQ3R8	\$23,400.00	87 Fed. Reg. 48975-977; 88 Fed. Reg. 58800
Taurolidine/heparin (applied in FY2023 as DefenCath™ (solution of taurolidine (13.5 mg/mL) and heparin (1000 USP Units/ML))(a proprietary formulation of taurolidine, a thiadiazinane antimicrobial, and heparin, an anti-coagulant for use as catheter lock solution, to reduce the risk of catheter-related bloodstream infections (CRBI) from in-dwelling catheters in patients undergoing hemodialysis (HD) through a central venous catheter (CVC). Conditional approval, subject to receiving FDA marketing authorization by July 1, 2024	XY0YX28	\$17,111.25 (75% add-on limit)	87 Fed. Reg. 48978-82; 87 Fed. Reg. 66561; 88 Fed. Reg. 58942-944
Aveir™ AR Leadless Pacemaker (a programmable system comprised of a single leadless pacemaker implanted into the right atrium).	X2H63V9	\$10,725.00	88 Fed. Reg. 58919-923

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
<p>New for CY2024</p>			
<p>Aveir™ Leadless Pacemaker (Dual-Chamber) (a modular programmable system comprised of two implanted leadless pacemakers; a ventricular leadless pacemaker for direct implantation into the right ventricle, and an atrial leadless pacemaker for direct implantation into the right atrium).</p> <p>New for CY2024</p>	<p>X2H63V9 in combination with X2HK3V9</p>	<p>\$15,600</p>	<p>88 Fed. Reg. 58923-925</p>
<p>Canary Tibial Extension (CTE) with Canary Health Implanted Reporting Processor (CHIRP) System (a tibial extension implant containing electronics and software, used with the Zimmer Persona Personalized Knee System, collecting kinematic data pertaining to the patient’s gait and activity level following TKA using internal motion sensors (3-D accelerometers and 3-D gyroscopes)),</p> <p>New for CY2024</p>	<p>XNHG0F9 XNHH0F9</p>	<p>\$850.85 \$850.85 (each leg eligible for separate NTAP)</p>	<p>88 Fed. Reg. 58925-927</p>
<p>Ceribell Status Epilepticus Monitor (a medical device system comprised of proprietary software and two cleared proprietary products; a single-use signal acquisition headband (the Ceribell EEG Headband) and a recorder (the Ceribell Pocket EEG)).</p> <p>New for CY2024</p>	<p>XX20X89</p>	<p>\$913.90</p>	<p>88 Fed. Reg. 58927-930</p>
<p>CYTALUX® (pafolacianine) (lung indication) ((a targeted intraoperative molecular imaging agent that illuminates lung cancer in real time, enabling the detection of more cancer for resection, comprised of a folic acid analog conjugated with a fluorescent dye which binds to the folate receptor positive cancer cells and illuminates malignant lesions during surgery, used with a near-infrared imaging system).</p> <p>New for CY2024</p>	<p>8E0W0EN, 8E0W3EN, 8E0W4EN, 8E0W7EN, or 8E0W8EN</p>	<p>\$2,762.50</p>	<p>88 Fed. Reg. 58810-818</p>

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
<p>CYTALUX® (pafolacianine)(ovarian indication) (a targeted intraoperative molecular imaging agent that illuminates ovarian cancer in real time, enabling the detection of more cancer for resection, comprised of a folic acid analog conjugated with a fluorescent dye which binds to the folate receptor positive cancer cells and illuminates malignant lesions during surgery, used with a near-infrared imaging system).</p> <p>New for CY2024</p>	8E0W0EN, 8E0W3EN, 8E0W4EN, 8E0W7EN, or 8E0W8EN	\$2,762.50	88 Fed. Reg. 58804-810
<p>DETOUR System (a fully percutaneous approach to femoral-popliteal bypass under fluoroscopic guidance resulting in a large lumen endograft bypass delivering unobstructed, pulsatile flow from the superficial femoral artery ostium to the popliteal artery).</p> <p>New for CY2024</p>	X2KH3D9, X2KH3E9, X2KJ3D9, X2KJ3E9	\$16,250.00	88 Fed. Reg. 58930-932
<p>EchoGo Heart Failure 1.0 (an automated machine learning-based decision support system, as a diagnostic aid for patients undergoing routine functional cardiovascular assessment using echocardiography for detecting heart failure with preserved ejection fraction (HFpEF)).</p> <p>New for CY2024</p>	XXE2X19	\$1,023.75	88 Fed. Reg. 58932-935
<p>EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm) (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)).</p> <p>New for CY2024</p>	XW013S9, XW033P9, or XW043P9	\$6,504.07	88 Fed. Reg. 58818-835
<p>Lunsumio™ (mosunetuzumab) (a novel, full-length, humanized, immunoglobulin G1 (IgG1) bispecific antibody that is designed to concomitantly bind CD3 on T cells and CD20 on B cells, in the treatment of adults with relapsed/refractory (R/R) follicular lymphoma (FL) who have received at least 2 prior systemic therapies (also referred to herein as 3L+FL)).</p> <p>New for CY2024</p>	XW03358 or XW04358	\$17,492.10	88 Fed. Reg. 58835-845

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
Phagenyx® System (a system that treats neurogenic dysphagia using electrical pulses to stimulate sensory nerves in the oropharynx). New for CY2024	XWHD7Q7	\$3,250.00	88 Fed. Reg. 58935-937
REBYOTA™ (fecal microbiota, live-jslm) and VOWST™ (fecal microbiota spores, live-brpk)(microbiota-based treatments indicated for the reduction or prevention of recurrence of Clostridioides difficile infection (CDI) in individuals 18 years of age and older, following antibiotic treatment for recurrent CDI (rCDI). New for CY2024	XW0H7X8 or XW0DXN9	\$6,789.25	88 Fed. Reg. 58848-868
REZZAYO™ (rezafungin for injection) (an echinocandin antifungal drug for the treatment of candidemia and invasive candidiasis in patients 18 year of age and older). New for CY2024	XW033R9 or XW043R9	\$4,387.50 (75% add-on limit)	88 Fed. Reg. 58944-946
SAINT Neuromodulation System (a non-invasive repetitive transcranial magnetic stimulation (rTMS) system that identifies an individualized target and delivers navigationally directed repetitive magnetic pulses to targets within the left dorsolateral prefrontal cortex (L-DLPFC) to treat Major Depressive Disorder (MDD)). New for CY2024	X0Z0X18	\$12,675.00	88 Fed. Reg. 58937-939
SPEVIGO® (spesolimab) (a humanized antagonistic monoclonal immunoglobulin G1 antibody blocking human IL36R signaling for the treatment of flares in adult patients with generalized pustular psoriasis (GPP). New for CY2024	XW03308	\$33,236.45	88 Fed. Reg. 58879-885
TECVAYLI™ (teclistamab-cqyv)(a bispecific antibody approved for the treatment of multiple myeloma (MM), specifically adult patients with relapsed or refractory multiple myeloma (RRMM) who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-cluster of differentiation (CD)38 monoclonal antibody). New for CY2024	XW01348	\$8,940.54	88 Fed. Reg. 58885-891

Technology/Product	Qualifying Cases	Add-On Payment Limit	Source Authority
TERLIVAZ® (terlipressin) (a pharmacologic therapy administered via IV bolus for the treatment of hepatorenal syndrome (HRS) with rapid reduction in kidney function; a V1-receptor synthetic vasopressin analogue that acts as a pro-drug of lysine-vasopressin). New for CY2024	XW03367 or XW04367	\$16,672.50	88 Fed. Reg. 58891-906
TOPS™ System (a motion preserving device inserted and affixed during spinal surgery after open posterior decompression to preserve normal spinal motion and provide stabilization of the lumbar intervertebral segment). New for CY2024	XRHB018 in combination with M48.062	\$11,375.00	88 Fed. Reg. 58940-942
XACDURO® (sulbactam/durlobactam) (a penicillin derivative and classified as a beta-lactamase inhibitor with intrinsic antibacterial activity against Acinetobacter baumannii and other members of the Acineobacter baumannii-calcoaceticus complex (ABC)). New for CY2024	XW033K9 or XW043K9 in combination with Y95 and J15.61 ; OR J95.851 and B96.83	\$13,680.00 (75% add-on limit)	88 Fed. Reg. 58946 -948;

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FY 2024 FINAL Tables 1A-1E

TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 3.1 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.625 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.275)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.2 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
\$4,392.49	\$2,105.28	\$4,287.05	\$2,054.74	\$4,357.34	\$2,088.43	\$4,251.90	\$2,037.89

TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 3.1 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.625 Percent)		Submit Quality Data and is a Meaningful EHR User (Update = 2.275 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.2 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
\$4,028.62	\$2,469.15	\$3,931.91	\$2,409.88	\$3,996.38	\$2,449.39	\$3,899.67	\$2,390.12

TABLE 1D. - CAPITAL STANDARD FEDERAL PAYMENT RATE

	Rate
National	\$503.83

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B. Adjustments for Area Wage Levels and Cost-of-Living

Tables 1A through 1C, as published in section VI. of this Addendum (and available via the internet on the CMS website), contain the labor-related and nonlabor-related shares that we are using to calculate the prospective payment rates for hospitals located in the 50 States, the District of Columbia, and Puerto Rico for FY 2024. This section addresses two types of adjustments to the standardized amounts that are made in determining the prospective payment rates as described in this Addendum.

1. Adjustment for Area Wage Levels

Sections 1886(d)(3)(E) and 1886(d)(9)(C)(iv) of the Act require that we make an adjustment to the labor-related portion of the national prospective payment rate to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. For FY 2024, as discussed in section IV.B.3. of the preamble of this final rule, we are applying a labor-related share of 67.6

percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater than 1.0000. Consistent with section 1886(d)(3)(E) of the Act, we are applying the wage index to a labor-related share of 62 percent of the national standardized amount for all IPPS hospitals (including hospitals in Puerto Rico) whose wage index values are less than or equal to 1.0000. In section III. of the preamble of this final rule, we discuss the data and methodology for the FY 2024 wage index.

2. Adjustment for Cost-of-Living in Alaska and Hawaii

Section 1886(d)(5)(H) of the Act provides discretionary authority to the Secretary to make adjustments as the Secretary deems appropriate to take into account the unique circumstances of hospitals located in Alaska and Hawaii. Higher labor-related costs for these two States are taken into account in the adjustment for area wages described previously. To account for higher non-labor-related costs for these two States, we multiply the nonlabor-related portion of the standardized amount for hospitals in Alaska and Hawaii by an adjustment factor.

In the FY 2013 IPPS/LTCH PPS final rule, we established a methodology to update the cost of living adjustment (COLA) factors for Alaska and Hawaii that were published by the U.S. Office of Personnel Management (OPM) every 4 years (coinciding with the update to the labor related share of the IPPS market basket), beginning in FY 2014. We refer readers to the FY 2013 IPPS/LTCH PPS proposed and final rules for additional background and a detailed description of this methodology (77 FR 28145 through 28146 and 77 FR 53700 through 53701, respectively). For FY 2022, in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45546 through 45547), we updated the COLA factors published by OPM for 2009 (as these are the last COLA factors OPM published prior to transitioning from COLAs to locality pay) using the methodology that we finalized in the FY 2013 IPPS/LTCH PPS final rule. Based on the policy finalized in the FY 2013 IPPS/LTCH PPS final rule, we are continuing to use the same COLA factors in FY 2024 that were used in FY 2023 to adjust the nonlabor-related portion of the standardized amount for hospitals located in Alaska and Hawaii. The following table lists the COLA factors for FY 2024.

**FY 2024 Cost-of-Living Adjustment Factors (COLA):
Alaska and Hawaii Hospitals**

Area	FY 2022 through FY 2024
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22
City of Juneau and 80-kilometer (50-mile) radius by road	1.22
Rest of Alaska	1.24
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.22
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Lastly, as we finalized in the FY 2013 IPPS/LTCH PPS final rule (77 FR 53700 and 53701), we intend to update the COLA factors based on our methodology every 4 years, at the same time as the update to the labor-related share of the IPPS market basket.

C. Calculation of the Prospective Payment Rates

1. General Formula for Calculation of the Prospective Payment Rates for FY 2024

In general, the operating prospective payment rate for all hospitals (including hospitals in Puerto Rico) paid under the IPPS, except SCHs and MDHs, for FY

2024 equals the Federal rate (which includes uncompensated care payments). Under current law, the MDH program is effective for discharges on or before September 30, 2024.

SCHs are paid based on whichever of the following rates yields the greatest aggregate payment: the Federal national rate (which, as discussed in section VI.G. of the preamble of this final rule,