

# IPPS FY 2024 Proposed Rule

May 17, 2023

# Welcome to AHPA's webinar on the FY 2024 IPPS proposed rule.

Thank you for joining us! We ask that you please:



**Keep your  
microphone  
muted until the  
end.**



**Share  
questions in  
the chat box at  
any time.**



**Reach out to our  
team to get  
involved in  
comment  
submission.**

# Adventist Health Policy Association (AHPA)



LOMA LINDA  
UNIVERSITY

# Policy Team



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# What is IPPS?

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**Comments due June 9<sup>th</sup>**

**The IPPS rule sets the reimbursement rate for Medicare Inpatient payments.**

It includes updates to Medicare quality programs.

- Inpatient Quality Reporting (IQR) Program  
*Incentive program to report quality measures*
- Hospital-Acquired Conditions (HAC) Program  
*Penalty program based on performance*
- Hospital Readmissions Reduction Program (HRRP)  
*Penalty program based on performance*
- Value-Based Purchasing (VBP) Program  
*Budget-neutral incentive program based on performance and improvement*
- Promoting Interoperability (PI) Program  
*Measures interoperability and the exchange of information*

# Overview

- **Inpatient Payment Changes**
- **Health Equity**
- **Disproportionate Share Hospitals (DSH)**
- **Safety Net Hospitals**
- **Wage Index**
- **CMS' Quality Programs**
  - Inpatient Quality Reporting
  - Hospital-Acquired Conditions Program
  - Hospital Readmissions Reduction Program
  - Value-Based Purchasing Program
  - Promoting Interoperability Program



# Key Issues in IPPS

## Inpatient Payments

- Net 2.8% payment increase.
- 2.4% decrease in uncompensated care payments.

## Quality Highlights

- **IQR** – 3 new eCQM measures (CY 2025 reporting); 3 adjustments and 3 removals.
- **Readmissions** – no proposals.
- **Promoting Interoperability** – 3 new eCQMs to choose from (CY 2025 reporting).
- **VBP** – one proposed measure and health equity payment adjustment.

## COVID-19

- Add-on payment expires at the end of FY 2023.
- End of suppression policy.
- Modification of COVID-19 health care personnel vaccination measure.

## Health Equity

- New health equity payment adjustment in VBP.
- Potential geriatric hospital designation in the future.
- Adjustment for Homelessness to account for higher utilization.
- What measures should be introduced in the IQR, HAC and LTCH quality reporting programs to address equity gaps?

# Payment Changes

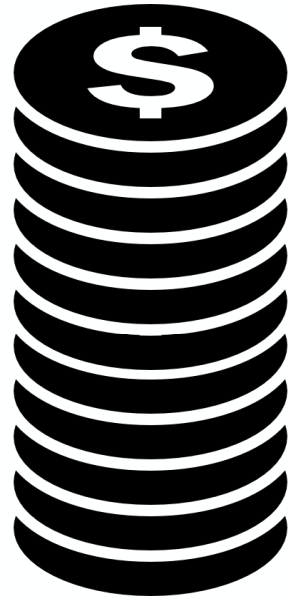


# Inpatient Payments

Contributing Factor	Change
IPPS Net Payments	+ \$3.3 billion (+2.8%) – In FY 2023, CMS increased payments by 4.3%.
Uncompensated Care	- \$167 million (-2.4%)
Technology Add-On Payments	- \$466 million
Capital Payment Update	+ \$505.54 million (+4.5%)
LTCHs IPPS Payments	- \$24 million (-0.9%)

# Disproportionate Share Hospital Payments (DSH)

# Disproportionate Share Hospital Payments



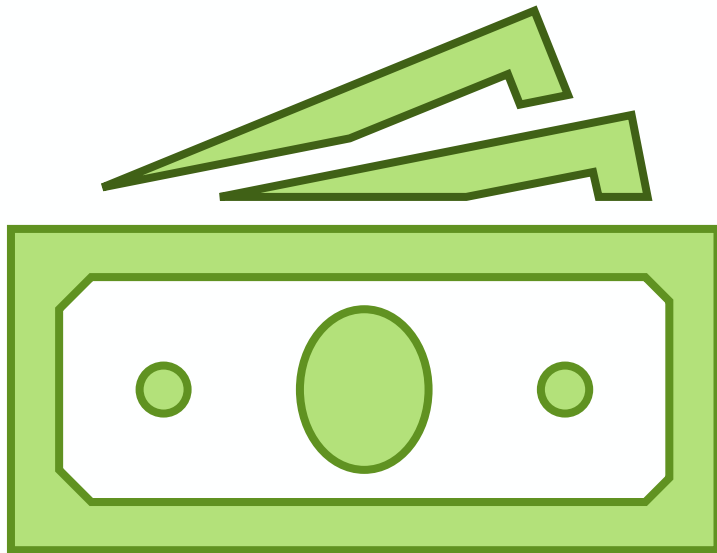
**Base Payment**



**DSH Supplemental Payment**

- Percentage add-on to basic DRG payment.
- Worksheet S-10 data.

# FY 2024 Medicare DSH Payments



**\$167 million decrease (-2.4%) relative to FY 2023.**

- Based on 3-year average from Worksheet S-10 of the Medicare cost report (FYs 2018, 2019, 2020).

# FY 2024 Medicaid DSH Payments

- \$8 billion cut in Medicaid DSH payments in FY 2024 and three years thereafter.
- Advocate for passage of the *Supporting Safety Net Hospitals Act* (H.R. 2665) to delay the cuts.

# RFI: Safety Net Hospitals

- No specific proposal; potential change in the future.
- How should CMS better identify and pay safety-net hospitals?
- Two options on the table:

MedPAC's Safety Net Index (SNI)	HRSA's Area Deprivation Index (ADI)
<p>Calculated as the sum of:</p> <ul style="list-style-type: none"><li>• Hospital's share of Medicare volume associated with low-income beneficiaries (proportion of dual-eligibles or those who receive Part D low-income subsidy).</li><li>• The share of hospital revenue spent on uncompensated care; and</li><li>• How dependent the hospital is on Medicare (50% of Medicare share of total inpatient days on worksheet S-3 of cost report).</li></ul>	<p>Ranks neighborhoods by socioeconomic disadvantage.</p> <ul style="list-style-type: none"><li>• Composite measure of 17 census variables designed to describe income, education, household characteristics, and housing.</li><li>• Five years average of data.</li><li>• The higher the ADI, the higher the disadvantage.</li></ul>

# Health Equity

# Health Equity

**Health equity is achieved when every person in every community is able to attain their full health potential, without being disadvantaged because of their:**

Race Ethnicity Language Ability Age

Gender Social Class Religion Housing Access

Sexual Orientation Socio-economic Status

Education Community

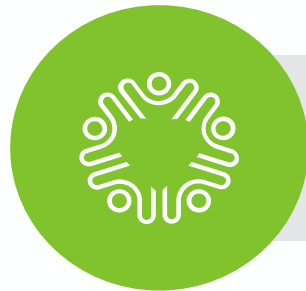
**“At HHS, we’re centering equity in all that we do—whether it’s our work to address maternal health disparities, remove language barriers to care, or protect the rights of those with disabilities to access services.”**

*HHS Secretary X. Becerra*



# Health Equity

Across health care payment rules this regulatory season, expect to see policy proposals focused on addressing health differences between groups that are systematic, avoidable and unfair.



*Policy Idea: CMS proposes...*

# Health Equity Policy Examples

Proposed

Finalized

## Commitment to Health Equity and SDOH Screening Measures

**Inpatient Quality Reporting Program (IQR)**  
FY2023



**PPS-Exempt Cancer Hospital Quality Reporting Program (PCQHR)**  
FY2026



**Inpatient Psychiatric Facility Quality Reporting Program (IPF QRP)**  
FY2026



## Health Equity Reimbursement Adjustment

**Medicare Shared Savings Program (MSSP)**  
FY2023



**Hospital Value-Based Purchasing Program (HVBP)**  
FY2026



**Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)**  
FY2026



# Health Equity: Z-Codes, Homelessness

Z-Codes are the ICD-10 codes used to document the social and economic circumstances impacting our patients' health.

CMS has found that the resources involved in caring for a patient experiencing homelessness support a greater severity level than currently assigned.

***CMS proposes increasing the severity levels for Z 59.00, Z59.01, and Z59.02 from “NonCC” to “CC”.***



# Requests for Information: Health Equity

# Requests for Information (RFIs)

RFIs give us a **preview** into regulatory priority areas.  
Participation gives us the opportunity to **influence**.

Agency solicits  
industry feedback on  
general subject/topic.



Agency solicits  
industry feedback on  
specific proposals.



**Agency finalizes  
policy change.**

# RFI: Health Equity for Geriatric Care

**CMS wants to ensure the health care ecosystem is ready to serve the one-in-five Americans expected to be over 65 years old within the next 10 years.**

**In the future, should CMS adopt attestation-based structural measures specifically designed to capture excellence in geriatric care?**

- Geriatric Hospital Structural Measure (printed [page 27106](#))
- Geriatric Surgical Structural Measure (printed [page 27108](#))

# RFI: Health Equity for Geriatric Care

## **Should CMS design a public-facing geriatric hospital designation?**

What are best practices and barriers for hospitals actively engaging with post-acute care facilities?

How should hospitals best educate and interact with patients in underserved communities to increase access to timely geriatric care?

What specific challenges to rural providers face in providing geriatric care?

Are there barriers to implementing protocols for delirium and cognition screenings to flag high-risk geriatric patients?

How can CMS best consider the critical role family caregivers play in any potential geriatric hospital designation?

# Low Wage Index Hospital

- Maintains low wage index hospital policy through FY 2024 despite March 2022 court decision in Bridgeport Hospital v. Becerra.
- DC District Court found in favor of hospitals, but CMS has appealed that decision.
- Benefits hospitals with wage index below 25<sup>th</sup> percentile (0.8615).
- Increases wage index to half the difference between otherwise applicable hospital-specific wage index value and 25<sup>th</sup> percentile for all hospitals.
- Policy applied in budget-neutral manner by adjusting standardized amounts (winners and losers).



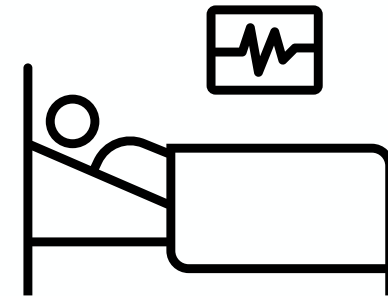
# Rural Wage Index Calculation

## Continue:

- To include urban to rural reclassified hospitals in *rural floor* wage index.

## Proposal:

- Treat a hospital that reclassifies to a rural area the same as a hospital that is physically located in a rural area in calculating the *wage index*.
  - In FY2023, these hospitals were included in calculating the rural floor but not the wage index.
  - Likely to bump the wage index in rural areas.



# New Technology Add-On Payments (NTAP)

- **Require applicants to have a complete and active FDA market authorization request at time of NTAP application submission.**
  - Applicable for technologies that have not already received FDA market authorization.
  - Must provide documentation of FDA acceptance or filing at the time of application submission.
- **Modify deadline by which technologies must receive FDA approval or clearance.**
  - Technologies must receive approval/clearance by May 1 of year prior to the FY for which application is being considered (current deadline is July 1).
  - Not applicable to applications submitted under the alternative pathway for certain antimicrobial products.
- **CMS established team to help navigate Medicare coverage, coding, and payment – intended to:**
  - Provide information and resources on process, requirements and timelines.
  - Coordinate engagements with other CMS components.
  - Serve as primary point of contact for updates or developments.

# NTAP Updates

- **NCTAP Expiration**

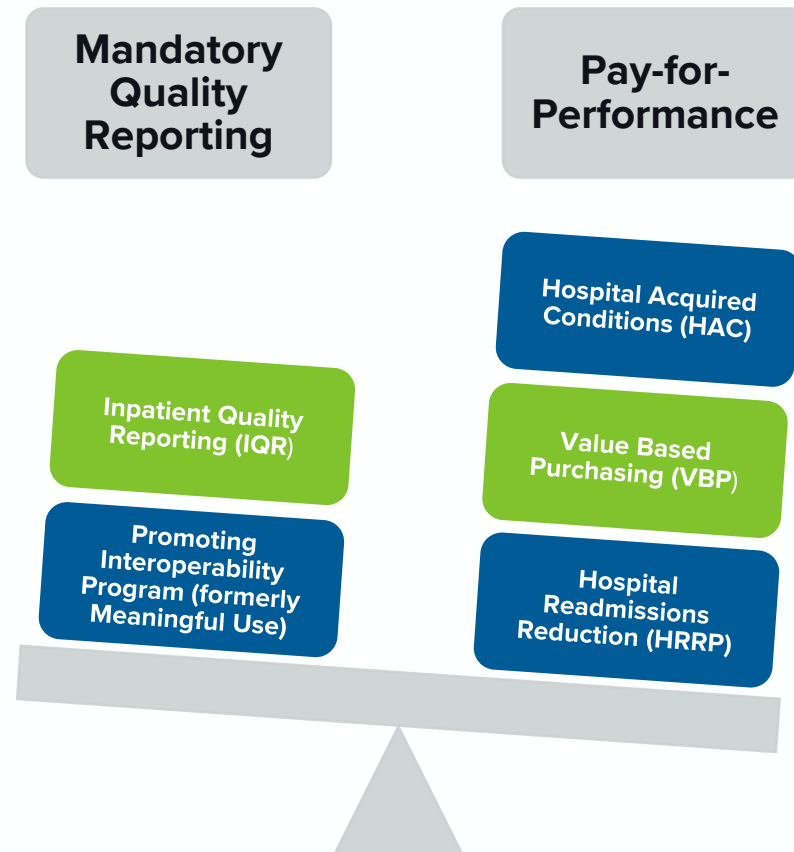
- New COVID-19 Treatment Add-on Payments (NCTAP) expiration.
  - Add-on payment expires at the end of FY2023; no payment for discharges on or after 10/1/23.

- **NTAP FY 2024 Changes**

- Continuing NTAPs for 11 products that continue to meet newness criterion.
- Discontinuing NTAPs for 15 products because no longer meet newness criterion.
- Proposes approving 19 products through the alternative NTAP pathway.
- Considers 19 new applications under the traditional NTAP pathway.

# Quality Programs

# Hospital Quality Programs



# Hospital Inpatient Quality Reporting (IQR) Program

# Overview

## **The IQR program collects quality data.**

- This data is made available to providers and consumers on the *Hospital Compare* website.
- Hospitals that fail to submit data are subject to a one-fourth reduction in annual payment update.

## **FY 2024 Proposed Update:**

- Adopt, Modify and Remove measures
- Update the HCAPHS Survey
- Request for Information on the potential inclusion of future geriatric measures

# New: IQR Measures

Measure	Reporting Pd./ Payment Determination	More Information
Hospital Harm — Pressure Injury eCQM	CY 2025/FY 2027	Assess the proportion of inpatient hospitalizations for patients 18 years and older who suffer the harm of developing a new stage 2 - 4, deep tissue, or unstageable pressure injury.
Hospital Harm — Acute Kidney Injury eCQM	CY 2025/FY 2027	Assess the proportion of inpatient hospitalizations for patients 18 years and older who have an AKI (stage 2 or greater) that occurred during the encounter.
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level — Inpatient) eCQM	CY 2025/FY 2027	<p>Evaluates performance diagnostic CT to discourage unnecessarily high radiation doses while preserving image quality.</p> <p>The percentage of eligible CT scans that are out-of-range on either excessive radiation dose or inadequate image quality, relative to evidence-based thresholds based on the clinical indication for the exam.</p>



# Modify: IQR Measures

Measure	Reporting Pd. / Payment Determination	More Information
Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM)	Admissions data from July 1, 2024 – June 30, 2025 / FY 2027	Modify measure to expand patient population to include Medicare Advantage (MA) patients 65-94 years of age.
Hybrid Hospital-Wide All-Cause Readmission (HWR)	Admissions data from July 1, 2024 – June 30, 2025 / FY 2027	Modify measure to expand patient population to include Medicare Advantage (MA) patients 65 years and older.
COVID-19 Vaccination among Healthcare Personnel (HCP)	Quarter 4, CY 2023 / FY 2025	<p>Process measure tracking percentage of health care workers receiving complete COVID-19 vaccination course.</p> <p>Modify the measure to align with CDC changes regarding whether an individual is considered <u>up-to-date with COVID-19 vaccinations</u>.</p>

# Removal: IQR Measures

Measure	Reporting Pd./ Payment Determination	More Information
Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	April 1, 2025 – March 31, 2028 / FY 2030	<p>Both measures were readopted into the Hospital IQR Program last year following substantive updates to measure specifications.</p> <p>Statute requires at least one year of public reporting prior to adoption in the Hospital Value-Based Purchasing (VBP) Program.</p> <p>Proposes to remove both measures from Hospital IQR program contingent on the revised measures being adopted into the Hospital VBP Program.</p>
Medicare Spending Per Beneficiary (MSPB) Hospital	CY 2026 / FY 2028	
Percentage of Babies Electively Delivered Prior to 39 Completed Weeks' Gestation (PC-01)	CY 2024 / FY 2026	Measure is topped out.

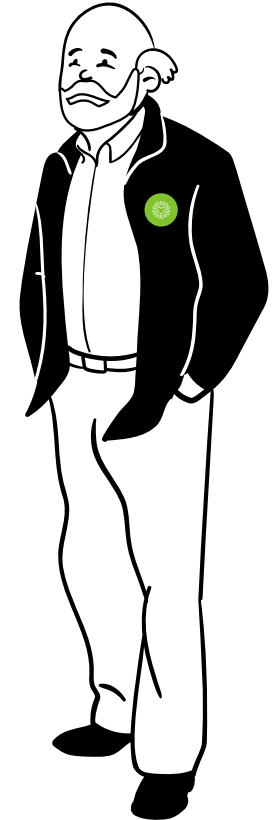
# HCAHPS Modifications

## **Modifications of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey:**

- Three new online-first modes of survey implementation.
- Allowing for a patient's proxy to respond.
- Extension to the data collection period from 42 to 49 days.
- Limit to the number of supplemental survey items to 12.
- Requiring official Spanish translation.
- Removal of two administration methods that are not used by participating hospitals.

# Spotlighting Geriatric Care in IQR

Measure	More Information	Domains
Geriatric Hospital Measure	Assesses hospital commitment to improving outcomes for patients 65 years or older through eight Domain Attestations	<ol style="list-style-type: none"> <li>1. Identifying goals of Care</li> <li>2. Medication Management</li> <li>3. Cognition and Delirium</li> <li>4. Preventing Delirium Related Events</li> <li>5. Function and Mobility</li> <li>6. SDOH</li> <li>7. Care Transition</li> <li>8. Ensuring Quality Care for High-Risk Patients</li> </ol>
Geriatric Surgical Structural Measure	Assesses hospital commitment to improving surgical outcomes for patients 65 years or older through seven domain attestations patient-centered competencies	<ol style="list-style-type: none"> <li>1. Identifying goals of Care</li> <li>2. Medication Management</li> <li>3. Cognition and Delirium</li> <li>4. Function and Mobility</li> <li>5. SDOH</li> <li>6. Care Transitions</li> <li>7. Ensuring Quality Care for High-Risk Patients</li> </ol>



# Hospital-Acquired Conditions (HAC) Program

# Overview

**HAC reduces total payments by 1% for the bottom quartile of hospitals.**

- Two domains:
  - Domain 1: Agency for Healthcare Research and Quality measures (AHRQ PSI-90).
  - Domain 2: Centers for Disease Control and Prevention National Healthcare Safety Network (NHSN- Hospital-Acquired Infections) measures.

# Proposed Changes to the HAC Program

**CMS is proposing updates to its validation process, including:**

- Adding a validation reconsideration process, beginning with FY25 program year (impacting 2022 discharges).
- Adding new criterion to the targeting criteria used to select up to 200 additional hospitals for purposes of validation.
- Updating targeting criteria for hospitals granted an extraordinary circumstances exception (ECE), beginning with FY27 program year (impacting 2024 discharges).

# Hospital Readmissions Reduction Program (HRRP)

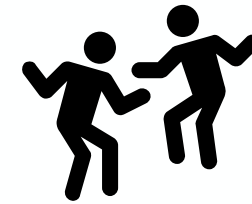


# Overview

**The program's purpose is to incentivize hospitals to reduce their readmissions.**

- Hospitals receive reduced payments if they have excess readmissions; this payment reduction is capped at 3%.

**HRRP includes no rewards.**



***No changes proposed  
for FY 2024.***

# Value-Based Purchasing (VBP) Program

# Overview

**This is a budget neutral program that makes incentive payments to hospitals based on how well they perform compared to other hospitals or how much they improve.**

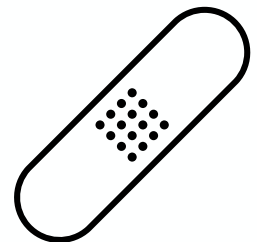
- Focuses on four domains: Clinical Outcomes; Person and Community Engagement; Efficiency and Cost Reduction; and Safety
- 2% of inpatient base operating payments are at risk.

## **FY 2024 Proposed Update:**

- One new measure and two measure modifications
- Adopt a Health Equity Scoring Change

# New: VBP Measure

Measure	Program Year	More Info.
Severe Sepsis and Septic Shock: Management Bundle	FY 2026	<p>Provides a standard operating procedure for the early management of patients with severe infection.</p> <p>Measure was adopted into the IQR program beginning with FY 2017 payment determination, with public reporting beginning with the July 2018 Care Compare Refresh.</p>



# Modify: VBP Measures

Measure	Program Year	More Info.
Medicare Spending Per Beneficiary (MSPB) Hospital	FY 2028	Claims-based measure has undergone three refinements: 1. Allow readmissions to trigger new episodes. 2. Updated risk adjustment methodology to account for inpatient stays in prior 30 days. 3. Revised measure calculation.
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total THA/TKA	FY 2030	Measure has been revised to include 26 additional mechanical complication ICD-10 codes that were identified through measure maintenance.

# VBP: Health Equity Adjustment Bonus

## Measure Performance Scaler

Hospitals will be divided into three “Performance Groups” based on performance in each domain as relative to all other hospitals in the Hospital VBP

- Top third = 4 pts
- Middle third = 2 pts
- Bottom third = 0 pts
- Eligible for up to 16 measure performance scaler points



## Underserved Multiplier

Based on the share of inpatient stays for patients with **Dual Eligible Status (DES)** during the calendar year two years before the respective program year.

- CMS would apply a logistic function to proportion of dual eligible inpatient stays



**Health Equity  
Adjustment  
Bonus**

# VBP: Final Score Calculation

The bonus can award a maximum of 10 points, making the facility eligible for up to a 110 final maximum TPS. CMS propose to begin the bonus with FY 2026 program year.



# VBP: Health Equity Adjustment Bonus

“Unlike the Shared Savings Program's policy, **we are not proposing a minimum percent of patients with DES that a hospital must treat**, such that a hospital serving one percent of patients with DES and a hospital serving 80 percent of patients with DES are both eligible for HEA bonus points **in order to give every hospital an opportunity to participate in this proposed scoring change.**”

- CMS, FY 2024 IPPS Proposed Rule



# Promoting Interoperability (PI) Program

# PI Program Overview

**Originally created to incentivize the use of Certified Electronic Health Record Technology (CEHRT).**

- Requires that eligible hospitals report on objectives and measures to be considered a “meaningful user” of EHRs and avoid a Medicare payment reduction

# PI Program: Proposed Changes

## **Reporting Periods:**

- Set the EHR reporting period for CY 2025 to be a minimum of “any continuous 180-day period” within that year.
- For hospitals that have not been deemed meaningful users previously, set the EHR reporting period to be 2 years prior to the payment adjustment year.

## **Prerequisites (Not Scored):**

- Require that hospitals attest “yes” to SAFER Guides measure, indicating they have conducted a self-assessment at any point during the calendar year, using the nine safety assurance factors for EHR resilience.

# PI Proposed Update: Rubric Design

OBJECTIVES	MEASURES	MAXIMUM POINTS
<b>Prerequisite</b>	Security Risk Analysis <b>SAFER Guides</b>	<i>REQUIRED – NOT SCORED</i>
<b>e-Prescribing</b>	e-Prescribing	10 points
	Query of the Prescription Drug Monitoring Program	10 points
<b>Health Information Exchange</b>	Support Electronic Referral Loops by Sending Health Information Support Electronic Referral Loops by Receiving and Incorporating Health Information <i>or</i>	15 points, each
	Health Information Exchange Bi-Directional Exchange <i>or</i>	30 points
	Enabling Exchange Under TEFCAs	30 points
<b>Provider-to-Patient Exchange</b>	Provide Patients Electronic Access to Their Health Information	25 points
<b>Public Health and Clinical Data Exchange</b>	Syndromic Surveillance Reporting Immunization Registry Reporting Electronic Case Reporting Electronic Reportable Laboratory Result Reporting AUR Surveillance Reporting	25 points
	<b>Choose one for 5 bonus points:</b> <ul style="list-style-type: none"> <li>Public Health Registry Reporting</li> <li>Clinical Data Registry Reporting</li> </ul>	<b>Total Points: 100</b>

# Questions?

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