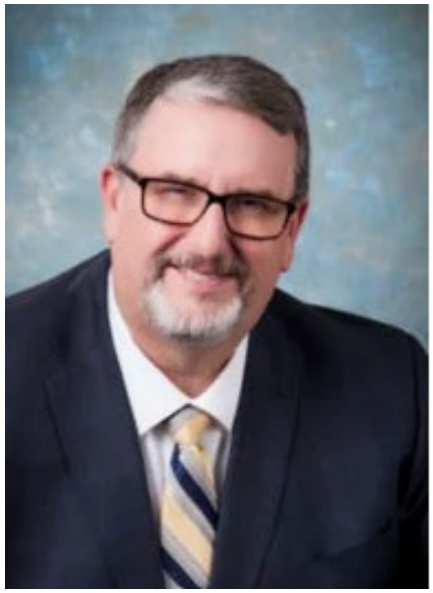
We Make Healthcare Reimbursement Easy

FY 2024 IPPS Final Rule and Other Reimbursement Updates

Richard Reid and Jesse Parker, The Rybar Group

September 21, 2023

With You Today



Richard Reid, MPA, FHFMA, CHFP, CPA
President, CEO

Jesse Parker, CPA
Director, Provider Reimbursement

FY 2024 IPPS Final Rule

Center of Medicare and Medicaid Services (CMS) published the FY 2024 IPPS Final Rule on August 28, 2023.

Areas that we will focus on from the FY 2024 IPPS Final Rule will be:

- Finalized IPPS Rates Table 1
- Changes to Wage Index
- Payment Adjustment for Medicare DSH Hospitals
- Other Decisions and Changes to the IPPS for Operating System
- Changes to the IPPS for Calculated Cost

FY 2024 IPPS Payment Rate Updates

- Base Rate: Net increase of 3.1% (FY 2023 IPPS Final Rule = 3.8%) (p. 59359 *or* p. 720)
  - 3.3% Market Basket
  - -0.2% Productivity Adjustment Reduction
  - Low Volume Add-on and MDH Program Extended through FFY 2024
- LTCH Payments increase by 0.2% in comparison to FY 2023 (p. 59383 *or* p. 744)
  - 3.3% Market Basket
  - -2.2% Reduction to High-Cost Outlier Threshold

FY 2024 IPPS Finalized Rates (Tables 1A – 1E)

P. 59381 *or* p. 742

	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 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
FFY 2024:	$4,392.49	$2,105.28	$4,287.05	$2,054.74	$4,357.34	$2,088.43	$4,251.90	$2,037.89
FFY 2023:	$4,310.00	$2,065.74	$4,182.32	$2,004.54	$4,267.44	$2,045.34	$4,139.76	$1,984.15

	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)		Hospital Did NOT 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
FFY 2024:	$4,028.62	$2,469.15	$3,931.91	$2,409.88	$3,996.38	$2,449.39	$3,899.67	$2,390.12
FFY 2023:	$3,952.96	$2,422.78	$2,835.85	$2,351.01	$3,913.92	$2,398.86	$3,796.82	$2,327.09

FY 2024 IPPS Finalized Rates (Tables 1A – 1E)

P. 59382 *or* p. 743

TABLE 1C. ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)						
		Rates if Wage Index Greater Than 1		Hospital is a Meaningful EHR User and Wage Index Less Than or Equal to 1 (Update = 3.1)		Hospital is NOT a Meaningful EHR User and Wage Index Less Than or Equal to 1 (Update = 0.625)	
		Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
FFY 2024:	National[1]	Not Applicable	Not Applicable	$4,028.62	$2,469.15	$3,931.91	$2,409.88
FFY 2023:	National[1]	Not Applicable	Not Applicable	$3,952.96	$2,422.78	$3,874.89	$2,374.93

TABLE 1D. - CAPITAL STANDARD FEDERAL PAYMENT RATE		
		Rate
FFY 2024:	National	$503.83
FFY 2023:	National	$483.76

TABLE 1E- LTCH PPS STANDARD FEDERAL PAYMENT RATE			
		Full Update	Reduced Update
FFY 2024:	Standard Federal Rate*	$48,116.62	$47,185.03
FFY 2023:	Standard Federal Rate*	$46,432.77	$45,538.11

Changes to Wage Index

Changes to Hospital Wage Index for Acute Care Hospitals
(p. 589580-58988 *or* p. 319 – 349)

Continuation of the Low-Wage Index Hospital Policy

- To help mitigate wage-index disparities between high-wage and low-wage hospitals, CMS adopted a policy in the FY 2020 IPPS/LTCH PPS final rule to increase wage index values for certain hospitals with low-wage index values. In this rule for FY 2024, CMS is finalizing its proposal to continue the low-wage index hospital policy and the related budget neutrality adjustment.

Changes to Hospital Wage Index for Acute Care Hospitals
(p. 589580-58988 *or* p. 319 – 349)

Rural Wage Index Calculation

- Based on public comments and court rulings, CMS finalized its proposal to consider hospitals reclassified as rural under Section 412.103 to be the same as geographically rural hospitals for wage index calculations beginning FY 2024. CMS estimated that this policy will result in 596 hospitals receiving the rural floor in FY 2024. The rule states that the area wage index for any hospital in an urban area may not be less than the area wage index for rural hospitals. This change will affect all hospitals (**see table in next slide which documents five highest rural wage index and surrounding states**)

Changes to Hospital Wage Index for Acute Care Hospitals
(p. 589580-58988 *or* p. 319 – 349)

Rural Wage Index Calculation

CBSAGEO	STATE	CBSAGEO occmix wage index	RANK (1-47)
22	MASSACHUSETTS	1.2420	1
05	CALIFORNIA	1.2402	2
02	ALASKA	1.1768	3
12	HAWAII	1.1319	4
29	NEVADA	1.0433	5
52	WISCONSIN	0.8645	15
15	INDIANA	0.8385	22
23	MICHIGAN	0.8355	23
36	OHIO	0.7906	35

Note - Delaware, New Jersey, Rhode Island, and Washington D.C do not have any hospitals classified as Rural

THE RYBAR GROUP

Payment Adjustments for Medicare DSH Hospitals

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

(p. 58988 – 59026 *or* p. 349 – 387)

- **Definitions**
  - **Medicare DSH Payment** – an empirically justified DSH payment equal to 25% of the amount determined under the statutory formula in section 1886(d)(5)(F) of the Act
  - **Medicare DSH Uncompensated Care Payment** – an uncompensated care payment determined as the product of Factors 1 – 3:
    - **Factor 1 -** 75% of the total amount of DSH payments that would otherwise be made under section 1886(d)(5)(F) of the Act.
    - **Factor 2 –** 1 minus the percent change in the percent of individuals who are uninsured (minus 0.2 percentage point for FYs 2018 and 2019).
    - **Factor 3** – the hospital's uncompensated care amount relative to the uncompensated care amount for all DSH hospitals, expressed as a percentage.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024
(p. 58988 – 59026 *or* p. 349 – 387)

- **Definitions (continued)**
  - **Section 1115 Waivers** – authority, granted under Section 1115, in which the he HHS Secretary can waive almost any Medicaid state plan requirement under §1902 (with the exception of citizenship and requirements of another agency as in the case of ERISA) to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

(p. 58988 – 59026 *or* p. 349 – 387)

- **DSH UCP Factor 1**
  - CMS initially proposed that Factor 1 for FY 2024 would be $10,216,040,319.50, which was equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2024 ($13.621 billion minus $3.405 billion).
  - The final Factor 1 for FY 2024 is $10,015,191,021.88, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2024 ($13,353,588,029.18 minus $3,338,397,007.29).

- **DSH UCP Factor 2**
  - Proposed – 65.71%; Finalized = 59.29%

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

(p. 58988 – 59026 *or* p. 349 – 387)

- **Impact of FY 2024 Uncompensated Care Amount**
  - Changes to proposed DSH UCP Factor 1 and Factor 2 reduce Uncompensated Care Pool from $6,712,960,093.94 to $5,938,006,756.87 (decrease of $774,953,337).
  - **For Michigan hospitals**, that are projected to receive Uncompensated Care Payments (66, per Medicare DSH Supplemental Data), this change has a combined impact of approximately $11.3 million in the current year and a combined impact of approximately $16.8 million when compared to the FY 2023 Uncompensated Care Payment.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024

(p. 58988 – 59026 or p. 349 – 387)

- **Worksheet S-10**
  - For FY 2024, CMS is finalizing to 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.

- **Section 115 Waiver Days**
  - Effective for discharges occurring on or after October 1, 2023, the DSH Medicaid fraction numerator includes only the days of those patients who receive from the section 1115 demonstration:
    - Health insurance that covers inpatient hospital services, or
    - Premium assistance that covers 100% of the premium cost to the patient, which the patient uses to buy health insurance that covers inpatient hospital services
  - Excludes any days of patients for which hospitals are paid from section 1115 demonstration authorized uncompensated/undercompensated care pools.

Other Decisions and Changes to the IPPS for Operating System

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

- **Sole Community Hospitals (SCHs)**
  - Effective date of SCH classification, where that classification is dependent on a merger, has been revised to be effective on the day of a merger, *if the MAC receives the complete application within 90 days of the CMS' written notification to the hospital of the approval of the merger*– ***no changes to the requirements to be classified as a SCH.***
  - ***No impact on hospitals that have previously received classification.***

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

- **Rural Referral Center (RRC) Thresholds**
  - No impact on hospitals that have previously received classification.
  - Case-mix Index (CMI)
    - For cost reporting periods on or after October 1, 2023, hospital must have a CMI value for FY 2022 that is at least:
      1. 1.80655 (national—all urban); or
      2. The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located (**see table on next slide**)

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

Region	Proposed Case-Mix Index Value
1. New England (CT, ME, MA, NH, RI, VT)	1.5272
2. Middle Atlantic (PA, NJ, NY)	1.5791
3. East North Central (IL, IN, MI, OH, WI)	1.6726
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7392
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.65775
6. East South Central, (AL, KY, MS, TN)	1.662
7. West South Central (AR, LA, OK, TX)	1.8348
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.8582
9. Pacific (AK, CA, HI, OR, WA)	1.8094

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

3. A hospital seeking to qualify as an RRC should obtain its hospital-specific CMI value (not transfer-adjusted) from its MAC. Data are available on the Provider Statistical and Reimbursement (PS&R) System. In keeping with our policy on discharges, the CMI values are computed based on all Medicare patient discharges subject to the IPPS MS–DRG based payment.

- For cost reporting periods beginning on or after October 1, 2023, must have, as the number of discharges for its cost reporting period that began during FY 2021, at least—
  - 5,000 (3,000 for an osteopathic hospital); or
  - If less, the median number of discharges for urban hospitals in the census region in which the hospital is located (see table).

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

Region	Proposed Number of Discharges
1. New England (CT, ME, MA, NH, RI, VT)	8,497
2. Middle Atlantic (PA, NJ, NY)	9,251
3. East North Central (IL, IN, MI, OH, WI)	7,798
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	6,678
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	10,125
6. East South Central, (AL, KY, MS, TN)	8,672
7. West South Central (AR, LA, OK, TX)	5,831
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	8,031
9. Pacific (AK, CA, HI, OR, WA)	8,455

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

- **Indirect Medical Education (IME) Prior Year Intern to Bed Ratio**
  - The Medicare cost report instructions for Worksheet E Part A Line 20.00 have been revised to state the following:

If the provider is participating in a Medicare GME affiliation agreement or rural track Medicare GME affiliation agreement under 42 CFR 413.79(f, and the provider increased its current year FTE cap (*difference of* ***the sum of*** *current year line 8* ***and line 7.02****, and* ***sum of*** *prior year line 8* ***and line 7.02*** *is positive) and increased its* current year allowable FT count (*difference of current year line 12 (excluding current year dental and podiatry from line 11) and prior year line 12 (excluding prior year dental and podiatry from line 11) is positive*) due to this affiliation agreement, identify the lower of: (a) the difference between the current year numerator *line 15* and the prior year numerator *line 12 of the prior year cost report*, and (b) the number by which the FTE cap increased per the affiliation agreement (*difference* ***of sum of*** *current year line 8* ***and line 7.02****, and sum of prior year line 8* ***and line 7.02***), and add the lower of these two numbers to the prior year's *numerator line 12 of the prior year cost report.* ***If the lower of these two numbers is a negative number, do not adjust the prior year numerator line 12****.*

Other Decisions and Changes to the IPPS for Operating System

(p. 59027 - 59116 *or* p. 388 – 477)

- **Indirect Medical Education (IME) Prior Year Intern to Bed Ratio (example)**

2552-10:

Computed RBR Cap (E, Part A, Line 20):

Number of Interns/Residents from PY: (PY W/S E Pt. A, L 12)												10.00
Add:	PY Displaced Residents included in	(PY W/S E Pt. A, L 17)										0.00
Add:	PY Initial Year Residents included in	(PY W/S E Pt. A, L 16)										0.00
Add:	Net Increase of Affiliated Programs											1.00
		CY FTE count	(CY W/S E Pt. A, L 18)	13.00	*minus*	PY FTE count	(PY W/S E Pt. A, L 12)	10.00	*equals*	3.00		
	Lessor of:	CY RTP afilliated cap	(CY W/S E Pt. A, L 7.02)	3.00		PY RTP afilliated cap	(PY W/S E Pt. A, L 7.02)	2.00	*equals*	1.00		
		CY affiliated cap	(CY W/S E Pt. A, L 8)	4.00	*minus*	PY affiliated cap	(PY W/S E Pt. A, L 8)	4.00	*equals*	0.00		
Add:	Net Increase of residents in the initial years of a new program				(CY W/S E Pt. A, L 16)	0.00	*minus*	(PY W/S E Pt. A, L 16)	0.00	*equals*		0.00
Add:	Displaced residents that were not reported in the prior year				(CY W/S E Pt. A, L 17)							0.00
Less:	Displaced residents reported in the PY, no longer reported in the CY				(PY W/S E Pt. A, L 17)							0.00
Total Adjusted P/Y Residents												11.00
P/Y Number of Beds	(PY W/S E Pt. A, L 4)											100.00
P/Y RBR Cap	**(CY W/S E Pt. A, L 20)**											0.110000

Changes to the IPPS for Capital Related Costs

Changes to the IPPS for Capital Related Costs

(p. 59116 - 59117 *or* p. 477-478)

- **Treatment of Rural Reclassifications for Capital DSH Payments**
  - In the FY 2007 IPPS/LTCH PPS final rule (71 FR 48104), CMS codified at § 412.320(a)(1)(iii) that hospitals reclassified as rural under § 412.103 also are considered rural under the capital IPPS for purposes of determining eligibility for capital DSH payments. Under the capital IPPS, as set forth in § 412.320(a), only urban hospitals with 100 or more beds are eligible for capital DSH payments. Therefore, under the current regulations, hospitals reclassified as rural under § 412.103 are not eligible to receive capital DSH payments.

Changes to the IPPS for Capital Related Costs

(p. 59116 - 59117 *or* p. 477-478)

- **Treatment of Rural Reclassifications for Capital DSH Payments (continued)**
  - On September 30, 2021, in Toledo Hospital v. Becerra, the U.S. District Court for the District of Columbia issued a decision that the FY 2007 final rule codifying CMS's policy of not providing capital DSH payments to urban hospitals that are reclassified as rural under § 412.103 was arbitrary and capricious because, the court concluded, the record did not demonstrate that CMS took relative costs into account when considering the rule and the policy at issue.

Changes to the IPPS for Capital Related Costs

(p. 59116 - 59117 *or* p. 477-478)

- **Treatment of Rural Reclassifications for Capital DSH Payments (continued)**
  - ***Effective for discharges occurring on or after October 1, 2023***, hospitals reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining eligibility for capital DSH payments.
  - **Based on the most recently filed Medicare cost reports, this change will impact 29 Michigan hospitals and increase Medicare reimbursed by $6.2 million (in total for all applicable hospitals).**

FY 2024 IPF PPS Final Rule

FY 2024 IPF Final Rule – Key Provisions

Center of Medicare and Medicaid Services (CMS) published the FY 2024 IPF PPS Final Rule on August 2 , 2023.

Key provisions include:

A 3.5% net increase to the IPF federal per diem base rate for providers that comply with the CMS IPF quality reporting (QR) program requirements, resulting in a final rate of $895.63, an increase from the current rate of $865.63.

A 3.5% increase to the electroconvulsive therapy per diem payment rate from the current $372.67 to $385.58 for providers that comply with the CMS IPF QR program requirements.

A rebased IPF PPS market basket to use FY 2021 data instead of FY 2016.

FY 2024 IPF Final Rule – Key Provisions

Key provisions include (continued):

An increase in the labor-related share from the current 77.4% to 78.7%.

A 36% increase in the outlier threshold amount from the current $24,630 to $33,470 to maintain estimated outlier payments at 2% of total estimated aggregate IPF PPS payments. This will result in fewer cases qualifying for an outlier payment.

Modifying the excluded unit regulation to allow a hospital to open a new IPF unit and begin being paid under the IPF PPS at any time during the cost reporting period if the hospital meets certain requirements. Currently facilities cannot attain excluded unit status in the middle of a cost reporting period.

Other Reimbursement Updates

Other Reimbursement Updates

- For cost reports beginning on or after October 1, 2023, templates published by CMS in Transmittal 18 (December 2022), will be required by the MAC, effecting the following cost report components:

  - DSH Medicaid Eligible Days
  - Medicare Bad Debts
  - S-10 Charity Care Charges
  - S-10 Total Bad Debts

Reimbursement Opportunities

- **Acute Care/PPS Hospitals**
  - Ensure that all programs eligible for pass-through reimbursement are being properly and optimally reported
  - Ensure that calculations impacting Graduate Medical Education (IME and DGME)- including any adjustments proposed by Medicare auditors
  - Ensure that cost-to-charge ratios are reviewed in detail for purposes of Medicaid DSH reporting

Reimbursement Opportunities

- **Critical Access Hospitals/Cost-based Reimbursement**
  - Ensure expenses and revenues are allocated consistently between Worksheet A and Worksheet C
  - Ensure that Rural Health Clinic visits are properly reported
  - Ensure that physician contracts, time studies, and employment agreements have been reviewed to properly document and support the allocation between Worksheet A-8-2 Provider and Professional component renumeration.

Questions?

Contact Us

Richard Reid
President, CEO
The Rybar Group, Inc.

(810) 853-6167
RReid@TheRybarGroup.com

Jesse Parker
Director, Provider Reimbursement
The Rybar Group, Inc.

(810) 853-6176
JParker@TheRybarGroup.com

THE RYBAR GROUP

AN INDEPENDENT MEMBER OF BDO ALLIANCE USA

To learn more, visit:

www.TheRybarGroup.com

https://www.linkedin.com/company/the-rybar-group/