HEALTHCARE REGULATORY ROUND-UP - Episode #54

FY2024 Final Rules
Getting Ready for October 1

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WE ARE AN INDEPENDENT MEMBER OF HLB—THE GLOBAL ADVISORY AND ACCOUNTING NETWORK

Introductions

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FY 2024 Final Rules

PYA

1. Hospital Inpatient Prospective Payment System (PPS)
2. Inpatient Rehabilitation Facility PPS
3. Inpatient Psychiatric Facility PPS
4. Skilled Nursing Facility PPS
5. Hospice Wage Index and Payment Rate Update

FY 2024 Hospital Inpatient PPS Final Rule

Released August 1; to be published in Federal Register on August 28

IPPS Payment Update

PYA

- Final rule includes increase in payments of approximately 3.1% over FY 2023 (assumes meaningful user of electronic health records and compliant with quality reporting)
  - Update based on market basket update of 3.3%, less 0.2 percentage points for productivity
    - Standardized rate $6,497.77 (currently $6,375.74)
    - Labor share for hospitals with wage index > 1.0 = 67.6%
- Capital rate increase from current $483.76 to $503.83
- Outlier threshold increased to $42,750 (currently $38,859)

IPPS Payment Update

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
$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)		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
$4,028.62	$2,469.15	$3,931.91	$2,409.88	$3,996.38	$2,449.39	$3,899.67	$2,390.12

MS-DRG Classifications and Relative Weights

PYA

- Will use single year data to set weights with no COVID-19 modifications
  - Uses FY2022 MedPAR claims and FY2021 cost reports
- Modification MS-DRGs subject to post-acute care transfer policy
  - Addition of 5 MS-DRGs; deletion of 13
- Creation of new MS-DRGs (total of 15 new DRGs and deletion of 16)

Severity Level Designation – Z Codes for Homelessness

PYA

- For FY24, the severity level designation will change from non-complication or comorbidity (NonCC) to complication or comorbidity (CC)
  - Applicable codes –
    - Unspecified – Z59.00
    - Sheltered – Z59.01
    - Unsheltered – Z59.02
  - Example – simple pneumonia and pleurisy
    - DRG 195 (NonCC) – 0.6256
    - DRG 194 (CC) – 0.8222

NCTAP and NTAP

PYA

- New COVID-19 Treatments Add-Payment (NCTAP)
  - Add-on payment expires at the end of FY2023; no payment for discharges on or after 10/1/23
- New Technology Add-on Payments (NTAP)
  - Final rule reflects $364m decrease in payments from FY2023
  - Decrease results from expiration of payments for several current technologies
    - Continues payments for 11 technologies still considered new while discontinuing payments for 15 technologies
  - Finalizes policy to require NTAP applicants that are not currently FDA authorized to have a complete and active FDA market authorization application request at time of NTAP application submission
    - Also moves FDA approval deadline from July 1 to May 1, effective with FY2025 applications

Medicare DSH and UCC

- Current Medicare DSH formula
  - DSH Patient Percent = (Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)
- Final rule updates DSH pool to reflect percent of uninsured
  - Proposed rule reflected $115M reduction; final rule reflects $967M reduction
    - Total pool reduced from $6.7B to $5.9B
    - Based on CMS' Office of the Actuary estimate that uninsured rate will be 8.3% (9.2% in FY2023)
      - Issue of Medicaid redeterminations and impact on number of uninsured
- Finalizes policy to limit counting of Medicaid 1115 demonstration days in determining Medicare DSH calculation
  - Will count only those patients covered by waiver that provides either insurance covering inpatient care or ***fully*** subsidized premium assistance to allow the purchase of such insurance
    - Essentially excludes uncompensated care pool days from the calculation

Wage Index Policies

- Maintains low wage index hospital policy through FY2024 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 25th percentile (0.8667)
    - Increases wage index to half the difference between otherwise applicable hospital-specific wage index value and 25th percentile for all hospitals
    - Policy applied in budget-neutral manner by adjusting standardized amounts (winners and losers)
- Treats reclassified rural hospitals same as those that are geographically rural for purposes of rural wage index
  - Would include data from hospitals that reclassified from urban to rural in calculating state-level rural wage index
    - Significant impact across large number of hospitals

LTCH PPS Payment Update

PYA

- Final rule includes increase in payments of approximately 3.3% over FY 2023
- Update based on market basket update of 3.3%, less 0.2 percentage points for productivity
- Labor-related share 68.5% (currently 68.0%)
- Cost outlier threshold $59,873 (currently $38,859)
  - Increase required so that projected outlier payments are equal to 7.975% of projected payments

LTCH PPS Payment Update

TABLE 1E- LTCH PPS STANDARD FEDERAL PAYMENT RATE		
	Full Update (3.3 Percent)	Reduced Update* (1.3 Percent)
Standard Federal Rate*	$48,116.62	$47,185.03

* For LTCHs that fail to submit quality reporting data for FY 2024 in accordance with the LTCH Quality Reporting Program (LTCH QRP), the annual update is reduced by 2.0 percentage points as required by section 1886(m)(5) of the Act.

Inpatient Quality Reporting (IQR) Program

25% reduction of Market Basket Increase

PYA

Additions
(beginning with CY25 reporting period)

- Hospital Harm-Pressure Injury eCQM
- Hospital Harm-Acute Kidney Injury eCQM
- Excessive Radiation Dose/Inadequate Image Quality for Adult Diagnostic CTs

Adjustments

- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (impacting FY27 payment determination)
- Hybrid Hospital-Wide All-Cause Readmission measure (impacting FY27 payment determination)
- COVID-19 Vaccination Among Healthcare Personnel – replace “complete vaccination course” with “up-to-date” (beginning with Q4 CY23 reporting period)

Removals

- Hospital-Level Risk-Standardized Complication Rate Following Elective THA/TKA (beginning with 4/1/25 to 3/1/28 reporting period)
- Medicare Spending Per Beneficiary - Hospital Measure (beginning with CY26 reporting period)
- Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (beginning with CY24 reporting period)

Changes to Data Submission

- HCAHPS Survey Measure (beginning with January 2025 discharges)
- Targeting criteria for hospital validation for extraordinary circumstances exceptions

For FY24, 95 hospitals will be penalized for failure to meet IQR requirements in FY22

Promoting Interoperability (PI) Program

75% Reduction to Market Basket Update

- Define CY25 EHR reporting period
- Beginning with CY24 EHR reporting period, require eligible hospitals/CAHs to attest "yes" to having conducted annual self-assessment of all nine Safety Assurance Factors for EHR Resilience (SAFER) Guides
- Beginning with CY25 reporting period, adopt three new eCQMs for eligible hospitals/CAHs to select as one of three self-selected eCQMs (align with IQR)

For FY24, 164 hospitals will be penalized for failure to meet PI requirements in FY22

Hospital Readmission Reduction Program (HRRP)

Up to 3% Reduction in DRG Payments

- Compare rates of 30-day risk standardized unplanned readmissions among hospitals with similar proportion of dual-eligible beneficiaries
- No proposed changes to conditions/procedures (pneumonia, AMI, HF, elective THA/TKA, COPD, CABG)
- No proposed changes to methodology for calculating readmission rates, imposing penalties
- CMS estimates 2,910 PPS hospitals (84.12%) will be penalized in FY24 based on FY22 performance

Hospital Value-Based Purchasing (VBP) Program

2% Withhold Re-Distributed to Top Performers ($1.7B in FY24 based on FY22 performance)

- Beginning with FY 2026 program year –
  - Adopt Severe Sepsis and Septic Shock: Management Bundle Measure
    - Reported under Hospital IQR Program since FY 2016
  - Add Health Equity Adjustment (HEA) bonus points to Total Performance Score based on both hospital's performance on existing Hospital VBP Program measures and proportion of individuals treated by hospital with dual eligibility status
    - Similar to Medicare Shared Savings Program HEA for quality performance score
- Other modifications impacting later program years

Hospital Acquired Condition (HAC) Reduction Program

1% Penalty for Hospitals Ranked in Worst Performing Quartile

- Rankings to be calculated and penalties to be imposed in FY24 (suspended in FY23)
- No proposed changes to measures
  - Patient Safety and Adverse Events Composite (CMS PSI 90) (claims-based)
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) for abdominal hysterectomy and colon procedures
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)
- Establish validation reconsideration process similar to IQR reconsideration process (beginning in FY25 impacting CY22 discharges)
- Modify targeting criteria for data validation to include hospitals that received an Extraordinary Circumstances Exception (beginning in FY27 impacting CY24 discharges)

Other Issues

PYA

- GME payments for Rural Emergency Hospitals
- Changes in process for physician-owned hospitals to receive exception from expansion prohibition
- Changes to Long-Term Care Hospital Quality Reporting Program (FY 2025 and 2026 program years)
- Changes to PPS-Exempt Cancer Hospital Quality Reporting Program (FY 2025 and 2027 program years)

FY 2024 Inpatient Rehabilitation Facility PPS Final Rule

88 Fed. Reg. 50,956 (Aug. 2, 2023)

IRF PPS Payment Update

PYA

- Final rule includes increase in payments of approximately 4.0% over FY 2023
  - Update based on market basket update of 3.6%, less 0.2 percentage points for productivity, ***plus*** 0.6 percentage points related to change in outlier threshold
    - Standard payment conversion factor $18,541 (currently $17,878)
    - Outlier threshold decreased to $10,423 (currently $12,526)
  - Uses 2021 claims to rebase market basket
    - Also used to adjust labor-related share (from 72.9% to 74.1%)
      - Impact of contract labor
- Finalizes proposal to allow excluded units to begin operating at any time (vs. beginning of cost reporting period)

IRF QRP Updates

PYA

- Beginning with Q4 CY23 reporting period, modify COVID-19 Vaccination Among Healthcare Personnel measure by replacing "complete vaccination course" with "up-to-date" consistent with most recent CDC guidance
- FY 2025 changes
  - Add Discharge Function Score measure - % of IRF patients who meet/exceed expected discharge function score using data collected on IRF Patient Assessment Instrument (IRF-PAI)
  - Remove 3 measures
    - Application of Functional Assessment/Care Plan measure
    - IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (Change in Self-Care Score) measure
    - IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (Change in Mobility Score) measure
- FY 2026 change
  - Add Patient/Resident COVID-19 Vaccine measure - % of patients up-to-date with recommended COVID-19 vaccinations with data collected using new standardized item on IRF-PAI

FY 2024 Inpatient Psychiatric Facility PPS Final Rule

88 Fed. Reg. 51,054 (Aug. 2, 2023)

IPF PPS Payment Update

PYA

- Final rule includes increase in payments of approximately 2.4% over FY 2023
  - Update based on market basket update of 3.5%, less 0.2 percentage points for productivity, ***less*** 0.9 percentage points related to change in outlier threshold
    - Federal per diem base rate $895.63 (currently $865.63)
    - ECT per treatment rate $385.58 (currently $372.67)
    - Outlier threshold increased to $33,470 (currently $24,630)
  - Uses 2021 claims to rebase market basket
    - Also used to adjust labor-related share (from 77.4% to 78.7%)
- Finalizes proposal to allow excluded units to begin operating at any time (vs. beginning of cost reporting period)

IPF QRP Updates

PYA

- Beginning with Q4 CY23 reporting period, modify COVID-19 Vaccination Among Healthcare Personnel measure by replacing “complete vaccination course” with “up-to-date” consistent with most recent CDC guidance
- Add 3 health equity-related measures
  - Facility Commitment to Health Equity measure (reporting of CY 2024 data for the FY 2026 payment determination) – attest to efforts to address health equity across 5 domains: (1) Equity is a Strategic Priority; (2) Data Collection; (3) Data Analysis; (4) Quality Improvement; and (5) Leadership Engagement
  - Screening for Social Drivers of Health (SDOH) measure (voluntary reporting in CY 2024; mandatory reporting of CY 2025 data for FY 2027 payment determination) - % of adult patients screened for 5 health-related social needs (HRSN) (food insecurity, housing instability, transportation needs, utility difficulties, interpersonal safety)
  - Screen Positive Rate for SDOH measure (voluntary reporting in CY 2024; mandatory reporting of CY 2025 data for FY 2027 payment determination) - % of patients screened under the Screening for SDOH measure who screen positive for each of the five HRSNs
- Add Psychiatric Inpatient Experience (PIX) survey measure (voluntary reporting in CY 2025; mandatory reporting of CY 2026 data for FY 2028 payment determination)
  - Calculates scores as five separate rates, one for each of the four domains (relationship with treatment team, nursing presence, treatment effectiveness, and healing environment) and an overall score, based on patient responses to a 23-item survey administered beginning 24 hours prior to discharge
- Remove 2 measures beginning with the FY 2025 payment determination
  - Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5)
  - Tobacco Use Brief Intervention Provided or Offered and Tobacco Use Brief Intervention Provided (TOB-2/2a)

FY 2024 Skilled Nursing Facility PPS Final Rule

88 Fed. Reg. 53,200 (Aug. 7, 2023)

SNF PPS Payment Update

- Final rule includes increase in payments of approximately 4.0% over FY 2023
  - Update based on market basket update of 6.4%, less 0.2 percentage points for productivity, ***less*** 2.3 percentage points related to PDPM parity adjustment (second and final such adjustment)
    - Market basket calculation based on 3% SNF MB increase plus 3.6% MB forecast error adjustment
- Final rule also includes technical changes to the PDPM ICD-10 code mapping
  - Used to assign patients into clinical categories

SNF QRP Updates

PYA

- Modified measure - beginning with Q4 CY23 reporting period, modify COVID-19 Vaccination Among Healthcare Personnel measure by replacing “complete vaccination course” with “up-to-date” per most recent CDC guidance
- Adding 2 new measures
  - Discharge Function Score measure (reporting of FY 2025 data for the FY 2027 payment determination) % of SNF residents who meet or exceed expected discharge function score using mobility and self-care items already collected on the Minimum Data Set (MDS)
  - COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure (reporting of FY 2026 data for FY 2028 payment determination) % of stays in which SNF residents are up to date with recommended COVID-19 vaccinations with data collected using new standardized item on MDS
- Not finalizing proposal to add CoreQ: Short Stay Discharge measure
- Removing 3 measures beginning in FY 2025
  - Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function measure
  - Application of the IRF Functional Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients measure
  - Application of the IRF Functional Outcome Measures: Change in Mobility Score for Medical Rehabilitation Patients
- Beginning in FY 2024, SNFs must report 100% of required quality measures data and standardized resident assessment data collected using MDS on at least 90% of all assessments submitted (up from 80%)

SNF Value-Based Purchasing Program Updates

PYA

- Measure updates
  - Adding Nursing Staff Turnover Measure (reporting of FY 2024 data for the FY 2026 payment determination)
  - Adding Discharge Function Score Measure (reporting of FY 2025 data for FY 2027 payment determination) % of SNF residents who meet/exceed expected discharge function score using mobility and self-care items presently collected on MDS.
  - Adding Long Stay Hospitalization Measure per 1,000 Resident Days (reporting of FY 2025 data for FY 2027 payment determination)
  - Adding Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (reporting of FY 2025 data for FY 2027 payment determination)
  - Replacing SNF 30-Day All-Cause Readmission measure with SNF Within Stay Potentially Preventable Readmissions measure (reporting of FY 2026 data for FY 2028 payment determination)
- Introduction of Health Equity Adjustment in FY 2027 program year
  - Similar to Hospital VBP Program HEA, adjusting scoring methodology to provide bonus points to high-performing facilities that provide care to a higher proportion of duals.
  - Increasing payback percentage policy under the SNF VBP program from current 60% to level such that bonuses provided to high-performing, high duals SNFs do not come at expense of other SNFs (estimated percentage for FY 2027 program year is 66%)

FY 2024 Hospice Wage Index and Payment Rate Update Final Rule

88 Fed. Reg. 51,164 (Aug. 2, 2023)

Hospice Payment Update

PYA

- Final rule provides for 3.1% increase in rates
  - Determined by 3.3% market basket increase less 0.2 percentage point productivity adjustment
- Providers not meeting Hospice Quality Reporting Program (HQRP) requirements will see 4% reduction in annual payments (currently 2%)
  - Results in negative adjustment for 2024 (-0.9%)
- Annual payments (aggregate cap) per patient capped at $33,494.01 (currently $32,486.92)

Certifying Physician

PYA

- Hospice medical director (or physician member of hospice interdisciplinary group) and patient's attending physician must initially certify patient's terminal condition (For subsequent periods, only the hospice physician must do so.)
- Finalizes requirement that both certifying physicians must be enrolled in Medicare or opted out of the program
  - "Requiring enrollment or opt-out will allow us to screen the physician to ensure they are qualified (e.g., licensed) to certify the terminal condition"
  - "[W]e will not implement or enforce this requirement until May 1, 2024, to give unenrolled and non-opted-out physicians more time to enroll in or opt-out of the Medicare program"

Hospice QRP Updates

- Finalize in regulation requirement that hospices submit 90% of all required Hospice Item Set (HIS) records within 30 days of patient's admission/discharge
  - Typically, about 18% of hospices do not meet 90% threshold
- Status report on Hospice Outcomes & Patient Evaluation (HOPE) implementation
  - Standardized tool for assessment of hospice patient’s clinical, psychosocial, spiritual, and emotional status and needs during regular patient care; provides data for outcomes measures to replace current process measures derived from HIS
  - No specific timeline for implementation
- Health equity measures also under development

Hospice Quality Reporting Program
Hospice Item Set
Hospice and Palliative Care Composite Process Measure—HIS-Comprehensive Assessment Measure at Admission includes: 1. Patients Treated with an Opioid who are Given a Bowel Regimen 2. Pain Screening 3. Pain Assessment 4. Dyspnea Treatment 5. Dyspnea Screening 6. Treatment Preferences 7. Beliefs/Values Addressed (if desired by the patient)
Administrative Data, including Claims-based Measures
Hospice Visits in Last Days of Life (HVLDL)
Hospice Care Index (HCI) 1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided 2. Gaps in Skilled Nursing Visits 3. Early Live Discharges 4. Late Live Discharges 5. Burdensome Transitions (Type 1)–Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission 6. Burdensome Transitions (Type 2)–Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital 7. Per-beneficiary Medicare Spending 8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day 9. Skilled Nursing Minutes on Weekends 10. Visits Near Death
CAHPS Hospice Survey
CAHPS Hospice Survey 1. Communication with Family 2. Getting timely help 3. Treating patient with respect 4. Emotional and spiritual support 5. Help for pain and symptoms 6. Training family to care for the patient. 7. Rating of this hospice 8. Willing to recommend this hospice

Our Next Healthcare Regulatory Round-Up:

August 30 – EMTALA Update