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Inpatient Hospital 2024 Pay: +3.8% Final

Rates Up 100 bps Versus Proposal

Relevant Companies

CHS Community Health Systems | Tenet Health | HCA Healthcare | UHS Universal Health Services, Inc.

On August 1, 2023, the Centers for Medicare and Medicaid Services (CMS) released the final FY 2024 hospital inpatient rule (IPPS) and long-term acute care hospital (LTCH) payment rules (here). New policies and pay start October 1, the beginning of FY 2024.

Our Take & Next Up

CMS final hospital '24 pay is an improvement over the proposal (April 2023). Long-term acute care hospital payments also are improved from proposal but not terrific. CMS continues its push for health equity with new hospital categorizations and social determinants of health codes. While CMS has no site-neutral payment policies in its regulations, we believe Congress will pass some limited "site neutral" payments for cuts to acute care hospitals (<$10B over ten), DSH pay will be reduced for some states with 1115 waivers. New rates start Oct 1, 2023, the start of FY24.

Key Points

OVERALL PAY UPDATE (IPPS & LTCH)

Proprietary hospitals final pay +3.8%, a 100-bps improvement. Proposed payment for proprietary was +2.8%. Voluntary hospitals +3.0% update in the final, 20-bps improvement from proposed +2.8%.

The rural hospital update is higher (+3.5%) than urban update (+3.1%). This is up a smidge from the proposed +3.3% for rural hospitals and +2.8% for urban hospitals.

CMS payments to inpatient hospitals will increase by $2.2 B in 2024. The rule also projects that Medicare DSH and uncompensated care payments will decrease by $950 M next year, with a decrease in payments for inpatient cases with new

med tech by $364 M.

The Long-Term Acute Care Hospital (LTCH) standard payment rate increased to -0.2% payment rate from the proposed rate of -2.5% for FY 24. Payments are expected to increase approximately $6 M.

CMS projects for FY 2024 a hospital market basket update of 3.3% in the final rule, a slight increase from the proposed market basket update of 3.0%. This helps rates for next year.

SITE-NEUTRAL PAYMENTS

Similar to the proposed rule, CMS provides no "site neutral payment" policies; we predicted as much and think Congress eventually has its eye on that $100B+ prize. While Congress eyes $100-400 B+ in hospital savings, CMS does not have the authority to regulate this topic. So-called site-neutral payment reforms could save Medicare upward of $100 B over a decade, according to CBO and other projections, and those with private health insurance could see savings.

HEALTH EQUITY AND SDOH

CMS adds 15 new health equity hospital categorizations. The rule helps to advance the CMS Framework for Health Equity 2022-2032 to measure the impact of CMS policies more explicitly on health equity. A priority moving forward is to better collect, report, and analyze health equity data.

CMS makes changes to three social determinants of health (SDOH) codes. The rules finalize a change in the severity designation of the three ICD-10-CM diagnosis codes for homelessness (unspecified, sheltered, and unsheltered) from non-complication or comorbidity codes to complication or comorbidity codes, based on the higher average costs of these diagnosis codes compared to similar cases without them.

PHYSICIAN OWNED HOSPITALS

On physician-owned hospitals, CMS finalizes the changes below (as proposed).

- CMS clarifies they (1) will only consider expansion exception requests from eligible hospitals (2) clarify the data and information that must be included in an expansion exception request (3) identify factors that CMS will consider when making a decision on an expansion exception request and (4) revise the process for requesting expansion exception.
- CMS reinstates, hospitals that meet the criteria for "high Medicaid facilities," (1) program integrity restrictions on the frequency of expansion exception requests, (2) maximum aggregate expansion of a hospital, and (3) location of expansion facility capacity that were removed in the CY 2021 OPPS/ASC final rule.

DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

A slight negative for hospitals, CMS limits the days of patients for which hospitals are paid for under DSH payments. As a reminder, DSH payments are made to qualifying hospitals who serve a large number of Medicaid/uninsured patients.

Limited coverage definitions are as follows. Only the days of those patients who receive from the demonstration (1) health insurance that covers inpatient hospital services or (2) 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, are to be included, provided in either case that the patient is not also entitled to Medicare Part A. In addition, days of patients for which hospitals are paid from demonstration-authorize uncompensated or undercompensated care pools may not be included

CMS proposed this in a separate Feb 2023 rule here. Under the final rule, CMS finalizes that patients whose inpatient hospital costs are paid for with funds from an uncompensated care pool by a section 1115 demonstration are not regarded as

“eligible for Medicaid” and cannot be included in the DSH payment calculation.

NEW REPORTING REQUIREMENTS ACROSS THE BOARD

CMS finalized reporting requirements for a number of programs including, the Medicare Promoting Interoperability Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, Hospital-Acquired Condition (HAC) Reduction Program, Hospital Value-Based Purchasing (VBP) Program, and LTCH Quality Reporting Program.

The start date for these finalized reporting requirements varies. Beginning as early as FY 2025.

HOSPITAL-ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

CMS helps hospitals out by providing more leniency in the HAC Reduction Program, which makes incentive payments to applicable hospitals for reducing hospital-acquired conditions. The finalized changes include: (1) Establishing a validation reconsideration process for hospitals who fail to meet data validation requirements, beginning in FY2025 and (2) Modifying the targeting criteria for data validation to include hospitals that received an extraordinary circumstances exception (ECE) beginning in FY2027.

Ipsita Smolinski
Managing Director | Capitol Street

ipsita@capitol-street.com

900 19th Street, NW 6th Fl
Washington DC 20006

202.250.3741

www.capitol-street.com
