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Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2024 Changes

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Implementation Date: October 2, 2023
Related CR Transmittal Number: R12234CP
Related CR Title: Fiscal Year (FY) 2024 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

Affected Providers

- Hospitals
- LTCHs

Action Needed

Make sure your billing staff knows about:

- FY 2024 IPPS updates
- FY 2024 LTCH PPS updates
- Update to certain hospitals that CMS excludes from the IPPS

Background

The following policy changes for FY 2024 went on display on August 1, 2023, and appeared in the Federal Register August 28, 2023. All items covered in CR 13306 are effective for hospital discharges occurring during FY 2024, unless otherwise noted.

We'll reference the FY 2024 Final Rule Data Files, FY 2024 Final Rule Tables, and FY 2024 MAC Implementation Files in this Article. Medicare Administrative Contractors (MACs) will use these files, when not otherwise specified.

IPPS FY 2024 Update

A. FY 2024 IPPS Rates and Factors

For the Operating Rates and Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, on the FY 2024 Final Rule home page. For other IPPS factors, including applicable percentage increase, budget neutrality factors, High-Cost Outlier (HCO) threshold, and Cost-of-Living adjustment (COLA) factors, see MAC Implementation File

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1 available on the FY 2024 MAC Implementation Files webpage.

B. FY 2024 Puerto Rico Hospital Update Under the IPPS

Section 1886(n)(6)(B) of the Social Security Act (the Act) specifies that the adjustments to the applicable percentage increase under Section 1886(b)(3)(B)(ix) of the Act apply to subsection (d) Puerto Rico hospitals that aren't meaningful electronic health record (EHR) users, starting FY 2022. For FY 2022 and subsequent fiscal years, any subsection (d) Puerto Rico hospital that isn't a meaningful EHR user not subject to an exception under Section 1886(b)(3)(B)(ix) of the Act will have a reduction applied to the applicable percentage increase.

For the applicable operating standardized amount and corresponding update factor for hospitals in Puerto Rico, refer to Table 1C of the FY 2024 IPPS/LTCH PPS Final Rule, available on the FY 2024 Final Rule Tables webpage.

C. Medicare Severity – Diagnosis-Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new ICD-10 MS-DRG Grouper, Version 41.0, software package effective for discharges on or after October 1, 2023. The Grouper assigns each case into an MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information, in other words, age, sex, and discharge status. The ICD-10 MCE Version 41.0, also developed by 3M-HIS, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2023.

Note: That the MCE version continues to match the Grouper version.

We reduced the number of MS-DRGs by 1, for a total of 766 for FY 2024.

See the ICD-10 MS-DRG V41.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V41 manual located on the MS-DRG Classifications and Software webpage for the complete list of FY 2024 ICD-10 MS-DRGs and Medicare Code Edits.

D. Replaced Devices Offered without Cost or with a Credit

We reduce a hospital's IPPS payment for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50% or more of the cost of the replacement device. We add new MS-DRGs to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit when they're formed from procedures previously assigned to MS-DRGs that were already on the list.

See MAC Implementation File 7 for the complete list of MS-DRGs covered under the Replaced Devices Offered without Cost or with a Credit in FY 2024. There were MS-DRG changes under this policy for FY 2024.

E. Post-Acute Transfer and Special Payment Policy

We evaluated the changes to MS-DRGs for FY 2024 against the general post-acute care transfer policy criteria using the FY 2022 MedPAR data. As a result of this review, we're adding new MS-DRGs 276 and 277 to the list of MS-DRGs subject to the post-acute care transfer policy and the special payment policy.

See Table 5 of the FY 2024 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs.

F. New Technology Add-On Payment Policy

For FY 2024, 11 technologies continue to be eligible for new technology add-on payments and 21 technologies are eligible for 19 new technology add-on payments. We granted 1 technology conditional approval pending FDA marketing authorization. We'll issue additional instructions if FDA marketing authorization is granted in time for FY 2024 payments under the conditional approval policy. For more information on FY 2024 new technology add-on payments, specifically regarding the technologies either continuing to receive payments or starting to receive payments, see MAC Implementation File 8. MAC Implementation File 8 also includes information regarding technologies no longer eligible to receive new technology add-on payments.

G. FY 2024 Labor Related Share Percentage

There are no changes to the labor-related share percentages under the IPPS for FY 2024. See MAC Implementation File 1 for the labor related share percentages for FY 2024.

H. Cost of Living Adjustment (COLA) for Hospitals Paid Under the IPPS

There are no changes to the COLA factors for FY 2024. A table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2023, is in the FY 2024 IPPS/LTCH PPS final rule and in MAC Implementation File 1. We use the same COLA factors for the IPPS and the LTCH PPS for FY 2024.

I. Updating the Provider Specific File (PSF) for Wage Index, Reclassifications and Redesignations, and Wage Index Changes and Issues

For hospitals located in rural counties deemed Lugar counties on Table 4B, MACs will make sure that a hospital's Lugar status is applied appropriately.

For FY 2024, the following policies will apply to the wage index:

- Increase the wage index values for hospitals with a wage index value below the 25th percentile wage index value for FY 2024 across all hospitals
- Apply a 5% cap for FY 2024 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2023

- Effective for FY 2024, we'll include wage data from hospitals with dual 42 CFR 412.103 rural reclassifications and Medicare Geographic Classification Review Board (MGCRB) reclassifications in rural wage index calculations

J. Multicampus Hospitals

We allocate the wages and hours to the Core Based Statistical Areas (CBSA) in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. If a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus.

Note: Under certain circumstances, it's permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index is noted in the PSF (see MAC Implementation File 5).

In general, subordinate campuses are subject to the same rules on withdrawals and cancellations of reclassifications as main providers.

K. Treatment of Hospitals Redesignated Under Section 1886(d)(8)(B) of the Act (Lugar Hospitals) Other Than for Wage Index Purposes

42 CFR 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to 1 or more urban areas as urban for the purposes of payment under the IPPS. These counties are commonly referred to as "Lugar counties." Hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments are determined based upon the urban area to which they're redesignated.

For purposes of IPPS provider type or hospital status determinations, other than for determining a hospital's wage index, MACs will make sure they consider the Lugar status of the hospitals and determining the payment and hospital status appropriately. Lugar counties that are deemed urban are listed on Table 4B of each fiscal year's IPPS final rule, or correcting document, as applicable. For a list of hospitals that waived Lugar status for FY 2024, see MAC Implementation File 5. Hospitals located in a Lugar county with active 412.103 reclassifications are considered rural for IPPS payment purposes that are dependent on urban/rural status. Also, hospitals that waive Lugar status to receive the out-migration adjustment are considered rural for IPPS payment purposes that are dependent on urban/rural status. For a list of hospitals that waived Lugar status for FY 2024, see MAC Implementation File 5. (Note, the list of hospitals that waived Lugar status can change each Fiscal Year.)

L. Change of Effective Date for SCH Status and 42 CFR 412.103 Rural Reclassification in the Case of a Merger

42 CFR 412.92(b)(2)(vi) implements provisions for retroactive classification as an SCH when

providers become eligible for SCH status under 42 CFR 412.92(a) by merging with a nearby like hospital. Providers that submit a complete SCH application on or after October 1, 2023, and within 90 days of getting our written approval of the merger are entitled to SCH status retroactive to the effective date of the merger. Note that a complete application for such a provider includes a copy of our written approval of the merger in addition to relevant documentation specified in the Provider Reimbursement Manual 15-1, Section 2810(B). For those providers that fail to submit a complete SCH application within 90 days of our notification of the merger approval, SCH classification would be effective as of the date the MAC receives the complete application, including documentation of the merger approval.

A conforming change to 42 CFR 412.103(d) modifies the effective date of rural reclassification for a hospital that, by merging with another like hospital, meets all criteria for SCH status under 42 CFR 412.92(a), except for being located in a rural area. Such a hospital would qualify for rural reclassification under 42 CFR 412.103(a)(3). The effective date for a hospital applying under such circumstances will be the effective date determined under 42 CFR 412.92(b)(2)(vi).

M. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2024

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2024.

For FY 2024, a hospital must make a written request for low-volume hospital status that's received by its MAC no later than September 1, 2023, in order for the applicable low-volume payment adjustment to be applied to payments for its discharges during FY 2024. A hospital that qualified for the low-volume hospital payment adjustment for FY 2023 may continue to receive a low-volume hospital payment adjustment for FY 2024 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2024.

For FY 2024, such a hospital must send written verification that's received by its MAC no later than September 1, 2023, stating that it meets the mileage criterion applicable for FY 2024. If a hospital's request for low-volume hospital status for FY 2024 is received after September 1, 2023, and if the MAC decides the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable low-volume hospital payment adjustment to determine the payment for the hospital's FY 2024 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

N. Medicare Advantage (MA) Nursing and Allied Health (NAH) Education Payments – Rates for CYs 2020, 2021, and 2022

Under 42 CFR 413.87, hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs and treat MA enrollees receive additional payments. Determining a hospital's NAH MA payment essentially involves applying a ratio of the hospital-specific NAH Medicare Part A payments, total inpatient days, and MA inpatient days, to national totals of those same amounts, from cost reporting periods ending in the fiscal year that's 2 years prior to the current calendar year.

The formula is as follows:

(((Hospital NAH pass-through payment / Hospital Part A Inpatient Days) * Hospital MA Inpatient Days) / ((National NAH pass-through payment / National Part A Inpatient Days) * National MA Inpatient Days)) * Current Year Payment Pool

O. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed on the QualityNet web site. Should a provider later be determined to have met the criteria after the publication of this list, they'll be added to the website. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2024 under the Hospital IQR Program are in MAC Implementation File 3.

P. Hospital-Acquired Condition (HAC) Reduction Program

For FY 2024, hospitals have until late-September 2023 to notify us of any errors in the calculation of their Total HAC Score under the Scoring Calculations Review and Correction period. Because of the delay in the Scoring Calculations Review and Correction period, the list of hospitals that are subject to the HAC Reduction Program for FY 2024 won't be available by October 1, 2023.

Until we issue a final list of hospitals that are subject to the HAC Reduction Program for FY 2024, MACs will hold hospital claims. We anticipate issuing the list on or about October 3, 2023.

Q. Hospital Value-Based Purchasing (VBP) Program

For FY 2024, we'll implement the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2024. We expect to post the final value-based incentive payment adjustment factors for FY 2024 in the near future in Table 16B of the FY 2024 IPPS/LTCH PPS final rule.

R. Hospital Readmissions Reduction Program (HRRP)

We expect to post the HRRP payment adjustment factors for FY 2024 in the near future in Table 15 of the FY 2024 IPPS/LTCH PPS final rule. Hospitals that aren't subject to a reduction under the HRRP in FY 2024, such as Maryland hospitals, have an HRRP payment adjustment factor of 1.0000. For FY 2024, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700.

S. Medicare Disproportionate Share Hospitals (DSH) Program

Counting Days Associated with Section 1115 Demonstrations in the Medicaid Fraction

In the FY 2024 IPPS/LTCH PPS Final Rule, effective with discharges on or after October 1, 2023, we finalized changes to the regulations governing the counting of days associated with people eligible for certain benefits provided by Section 1115 demonstrations in the Medicaid

fraction. Under this finalized policy, 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 isn't also entitled to Part A. Days of patients for which hospitals are paid from demonstration-authorized uncompensated or undercompensated care pools may not be included.

Uncompensated Care Payments

In the FY 2024 IPPS/LTCH PPS Final Rule, we finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. We'll continue to pay interim uncompensated care payments on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2024. The estimate Per Claim Amount and Projected DSH Eligibility for each subsection (d) hospital and subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2024, which is available in the FY 2024 Final Rule Data Files webpage.

Hospitals without Prospective FY 2024 Factor 3 Calculation (New Hospitals, Uncompensated Care Trim, and Newly Merged Hospitals)

For FY 2024, new hospitals for uncompensated care payment purposes, in other words, hospitals with CMS Certification Numbers (CCNs) established after October 1, 2020, that are determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2024 cost report, as reported on Line 30 of Worksheet S-10, annualized, if needed, as the numerator. The denominator used for this calculation is in the FY 2024 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, Factor 3 is multiplied by a scaling factor and multiplied by the total uncompensated care payment amount finalized in the FY 2024 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement.

For new hospitals, newly merged hospitals, and hospitals subject to the Uncompensated Care Data Trim, the MAC will apply a scaling factor for the Factor 3 calculation, if the hospital is determined DSH eligible at cost report settlement. The scaling factor used for the calculation is in the FY 2024 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Also, refer to the MAC Implementation File 1 available on the FY 2024 MAC Implementation Files webpage.

In the FY 2024 final rule, we continued an additional Uncompensated Care Data Trim for hospitals that weren't projected DSH eligible for purposes of interim uncompensated care payments. Similar to new hospitals, the hospitals impacted by this new trim don't have a Factor 3 listed in the FY 2024 Medicare DSH Supplemental File. If the hospital subject to the data trim is ultimately determined DSH eligible at cost report settlement, then the MAC will review Worksheet S-10 and calculate a Factor 3 from the hospital's FY 2024 cost report's Worksheet

S-10 line 30 divided by the national uncompensated care cost denominator.

For FY 2024, newly merged hospitals, for example, hospitals that have a merger during FY 2024 or mergers not known at the time of development of the final rule, will have their interim uncompensated care payments reconciled at cost report settlement by the MAC.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

For FY 2024, we used a 2-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount is divided by the hospital's historical 2-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that's used to make interim uncompensated care payments to each projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the federal fiscal year.

Under this policy, if a hospital submits a request to its MAC for a **lower** per discharge interim uncompensated care payment amount, including a reduction to 0, **once** before the start of the federal fiscal year or **once** during the federal fiscal year, then the MAC will review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment, for example, 10% or more of the hospital's total uncompensated care payment or at least $100,000, at cost report settlement if the per discharge amount weren't lowered.

The MAC will evaluate the request for strictly reducing the per discharge uncompensated payment amount and the supporting documentation before the start of the federal fiscal year or with midyear request when the 2-year average of discharges is lower than hospital's projected FY 2024 discharges. If following review of the request and the supporting documentation, the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to **lower** the per discharge amount either to the amount requested by the hospital or another amount the MAC decides appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request doesn't change how the total uncompensated care payment amount will be reconciled at cost report settlement. The interim uncompensated care payments made to the hospital during the fiscal year are still reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the federal fiscal year.

T. Supplemental Payment for Indian Health Service (IHS) and Tribal Hospitals and Hospitals located in Puerto Rico

For the supplemental payment for IHS and Tribal hospitals and hospitals located in Puerto Rico, we based eligibility to receive interim supplemental payments on a projection of DSH eligibility

for the applicable fiscal year. The DSH Supplemental Data File includes the combined interim uncompensated care payment and interim supplemental payment.

MACs make a final determination with respect to a hospital's eligibility to receive the supplemental payment for a fiscal year, in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that fiscal year. If a hospital is determined not to be DSH eligible for a fiscal year, then the hospital wouldn't be eligible to receive a supplemental payment for that fiscal year.

MACs reconcile the interim supplemental payments at cost report settlement to make sure the DSH eligible hospital receives the full amount of the supplemental payment that was determined prior to the start of the fiscal year. Projected DSH eligible hospitals have a total supplemental payment available in the Medicare DSH Supplemental Data File.

Consistent with the process used for uncompensated care payments cost reporting periods that span multiple federal fiscal years, a pro rata supplemental payment calculation must be made if the hospital's cost reporting period differs from the federal fiscal year. Thus, the final supplemental payment amounts that would be included on a cost report spanning 2 federal fiscal years would be the pro rata share of the supplemental payment associated with each federal fiscal year. This pro rata share would be determined based on the proportion of the applicable federal fiscal year that's included in that cost reporting period.

U. Outlier Payments

IPPS Statewide Average Cost-to-Charge Ratios (CCRs)

Tables 8A and 8B contain the FY 2024 statewide average operating and capital CCRs for urban and rural hospitals. Per the regulations in 42 CFR 412.84(i)(3)(iv)(C), for FY 2024, statewide average CCRs are used in the following instances:

- New hospitals that haven't submitted their first Medicare cost report. For this purpose, a new hospital is defined as an entity that hasn't accepted assignment of an existing hospital's provider agreement under 42 CFR 489.18.
- Hospitals whose operating or capital CCR ratio is in excess of 3 standard deviations above the corresponding national geometric mean. We recalculate this mean annually and publish it in the annual notice of prospective payment rates. For FY 2024 operating CCR and capital CCR trim values, see MAC Implementation File 1.
- Hospitals for whom accurate data with which to calculate either an operating or capital CCR ratio, or both, aren't available.

NOTE: Hospitals or MACs can request an alternative CCR to the statewide average CCR per the instructions in Section 20.1.2.1 of the Medicare Claims Processing Manual, Chapter 3.

V. Payment Adjustment for Clinical Trial and Expanded Access Use Immunotherapy Cases in MS-DRG 018

We make an adjustment to the payment amount for clinical trial and expanded access use

immunotherapy cases that group to MS-DRG 018.

Under this policy, we apply a payment adjustment to claims that group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there's expanded access use of immunotherapy. However, when the chimeric antigen receptor (CAR) T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, the payment adjustment won't be applied in calculating the payment for the case.

In a case where there was expanded access use of CAR T-cell therapy or other immunotherapy products, the provider may submit condition code "90" on the claim so that the Pricer will apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, and ICD-10-CM diagnosis code Z00.6 is on the claim, you may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim, and MACs will add payer-only condition code "ZC" so that the Pricer won't apply the payment adjustment in calculating the payment for the case.

LTCH PPS FY 2024 Update

A. FY 2024 LTCH PPS Rates and Factors

The FY 2024 LTCH PPS Standard Federal Rates are located in Table 1E on the FY 2024 Final Rule Tables webpage. Other FY 2024 LTCH PPS Factors are in MAC Implementation File 2.

We've updated the LTCH PPS Pricer with the Version 41 MS-LTC-DRG table, weights, and factors, effective for discharges occurring during FY 2024.

B. Discharge Payment Percentage

Starting with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their Discharge Payment Percentage (DPP), which is the ratio, expressed as a percentage, of the LTCHs' Fee-for-Service (FFS) discharges which received LTCH PPS standard federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs will continue to notify the LTCH of its DPP upon settlement of the cost report.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods starting on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that isn't at least 50% be informed of such a fact. Section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by Section 1886(m)(6)(C)(iii) of the Act.

C. LTCH Quality Reporting (LTCHQR) Program

Under the LTCHQR Program, for FY 2024, the annual update to a standard federal rate will

continue to be reduced by 2.0 percentage points if an LTCH doesn't submit quality-reporting data under the LTCHQR Program for that year.

D. Provider Specific File (PSF)

LTCH Statewide Average CCRs

Table 8C contains the FY 2024 statewide average LTCH total CCRs for urban and rural LTCHs. For FY 2024, we use statewide average CCRs in the following instances:

- New hospitals that haven't submitted their first Medicare cost report. For this purpose, we define a new hospital as an entity that hasn't accepted assignment of an existing hospital's provider agreement.
- LTCHs with a total CCR in excess of the applicable maximum CCR threshold, in other words, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR. For the FY 2024 LTCH total CCR ceiling, refer to MAC Implementation File 2.
- Any hospital for which data to calculate a CCR isn't available.

NOTE: Hospitals or MACs can request an alternative CCR to the statewide average CCR per the instructions in Section 150.24 of the Medicare Claims Processing Manual, Chapter 3.

LTCH Labor Market Areas and Wage Indexes

For FY 2024, a 5% cap will be applied to any decrease in an LTCH's wage index from its FY 2023 wage index. A list of LTCHs whose FY 2024 LTCH PPS wage index decreased by more than 5% along with their capped FY 2024 LTCH PPS wage index value is on the FY 2024 MAC Implementation Files webpage.

For FY 2024, a 5% cap will also be applied to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2023 applicable IPPS comparable wage index. A list of LTCHs whose FY 2024 applicable IPPS comparable wage index decreased by more than 5% along with their capped FY 2024 applicable IPPS comparable wage index value is on the FY 2024 MAC Implementation Files webpage.

E. Cost of Living Adjustment (COLA) under the LTCH PPS

There are no updates to the COLAs for FY 2024. The COLAs effective for discharges occurring during FY 2024 are in the FY 2024 IPPS/LTCH PPS final rule and are also in MAC Implementation File 2. Note that we use the same COLA factors under the IPPS and the LTCH PPS for FY 2024.

Hospitals Excluded from the IPPS

In the FY 2024 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2024 of 3.3%.

More Information

We issued CR 13306 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
September 14, 2023	Initial article released.