Addressing New Requirements Under the FY24 Medicare Inpatient Prospective Payment System (IPPS) Rule

February 2024

BDO

Healthcare providers are facing a difficult financial environment, characterized by cost increases, labor shortages, supply chain disruption, and reimbursement decreases.

At the same time, new regulatory requirements are placing significant resource burdens on a labor force that is already stretched thin. These new regulatory requirements lead to greater audit scrutiny and risk of compliance issues, which can further jeopardize reimbursement and lead to expensive penalties.

The Centers for Medicare & Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) **2024 rule**, which was released on August 1, 2023, decreased reimbursement for uncompensated care (UCC) and Disproportionate Share Hospital (DSH) payments by $950 million. The new rule increases risks regarding Medicaid eligible days, which jeopardizes DSH payments and 340B eligibility. Expansion of reporting requirements for Medicare bad debts, DSH, UCC, and total bad debts further increase the risk of lost reimbursement and compliance issues.

In addition to the IPPS 2024 rule, the Health Equity CMS framework is expanding in FY24, meaning hospitals will need to implement new processes to capture health equity data appropriately. These requirements add an additional layer of complexity for organizations already trying to adhere to the new IPPS rule.

To be successful in the year ahead, healthcare organizations will need to find ways to decrease costs, improve quality of care, increase reimbursement, and improve margins, all while remaining compliant with the new IPPS rule.

UCC Payments, DSH Payments, and 340B Eligibility

The $950 million reduction in reimbursement for UCC and DSH payments means organizations must be more diligent in reporting reimbursement components.

CMS also used this rule to finalize the proposed change to Section 1115 regarding days that can be included in the Medicaid fraction of the DSH payment calculation, resulting in a decrease in Medicare DSH payments. The days reduction could significantly impact 340B qualification as well as increase the risk of hospitals not qualifying for DSH and UCC payments.

Improperly reported Medicaid Eligible Days could result in:

- A decrease in or elimination of DSH reimbursement
- Loss of 340B eligibility, should the DSH percentage fall below the 340B threshold

The potential impact to UCC could include:

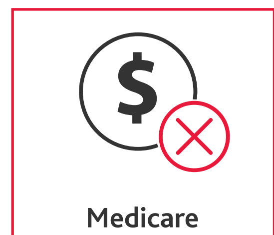
- Failure to obtain hospital's full UCC reimbursement due to processes not capturing all charity care and bad debts
- Loss of expected reimbursement due to non-compliance with Medicare regulations

BDO can help healthcare organizations comply with these requirements by:

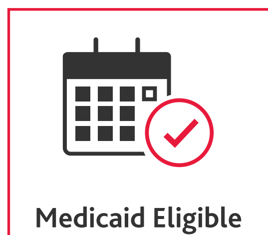
- Providing an assessment of current processes for DSH reimbursement
- Assisting in accurate identification of all Medicaid Eligible Days, including Section 1115 waiver days, as well confirmation of total days to be included
- Providing reports to identify opportunities and risks
- Providing an auditable days report in compliance with Transmittal 18 requirements
- Assessing current processes for identifying and reporting charity care and bad debts
- Reviewing complete population of charity care and bad debt accounts to identify and report accurate data on the Medicare cost report
- Providing compliant reports in accordance with Transmittal 18

Additional Reporting Requirements for Medicare Bad Debts, Medicaid Eligible Days for DSH, Charity Care Reporting, and Total Bad Debts

Prior to the FY24 rule issuance, on December 29, 2022, Transmittal 18 was released. This transmittal was effective for all cost reports beginning after October 1, 2022. The first cost reporting period affected by these changes is Fiscal Year End (FYE): September 30, 2023. Specifically, the transmittal implemented additional exhibits or changes to existing exhibits for reporting of the following data:

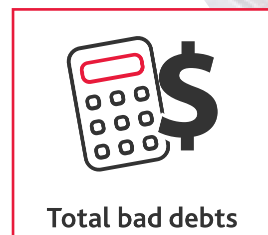


Medicare bad debts



Medicaid Eligible Days for DSH

Charity care charges by patient



Total bad debts by patient

The new requirements introduce or revise the reporting of elements for these areas, which will increase the complexity of reporting for reimbursement on the Medicare cost report. Along with the additional work involved, these new requirements will also bring increased compliance scrutiny and Medicare Administrative Contractor (MAC) audit risk, which could lead to reduced payments or complete elimination of payments for Medicare bad debts, DSH, and UCC, which may result in loss of 340B eligibility.

BDO can help healthcare organizations comply with these requirements by:

- Assessing current reporting processes to identify gaps in current reporting and implement improvements to meet new requirements and provide compliant reports
- Enhancing processes through technology to decrease the risk of missed accounts and increase reimbursement
- Helping organizations prepare for increased audit scrutiny to mitigate potential loss of reimbursement

Health Equity

The final rule continues to expand on the CMS Framework for Health Equity 2022-2032, adding 15 new health equity elements. This plan puts forth measures for hospitals to document the impact of their health equity policies on their patient population and outlines five priorities:

Expand the collection, reporting, and analysis of standardized health equity data

Assess the cause of disparities within CMS programs and address inequities in policies and operations to close gaps

Build the capacity of healthcare organizations and the workforce to reduce health and healthcare disparities

Advance language access, health literacy, and the provision of culturally tailored services

Increase all forms of accessibility to healthcare services and coverage

These health equity measures will be incorporated into reimbursement methodologies. In addition, providers can receive bonus payments called the Health Equity Adjustment Bonus. Through this methodology they can also earn up to 10 bonus points in their Hospital Value Based score.

The new health equity elements fall under three different categories:

CATEGORY	OPTIONAL	MANDATORY
Facility Commitment to Measure Health Equity	FY25	FY26
Screening for Social Drivers of Health	FY26	FY27
Screen Positive Rate for Social Drivers of Health	FY26	FY27

BDO can help healthcare organizations comply with these requirements by:

- Assessing data collection processes to determine readiness for health equity measures monitoring
- Analyzing current year health equity measures against the CMS' measures to develop a baseline for determining areas for enhancement
- Calculating the Health Equity Adjustment Bonus to identify areas for further enhancement and help optimize associated additional reimbursement
- Assisting management in identifying ideas to improve community outreach so as to improve individual health equity components

Final Thoughts

The final FY24 IPPS rule will have a significant impact on reimbursement rates for healthcare organizations, as well as the resources needed to maintain compliance with the IPPS. To meet these new requirements, healthcare organizations may need to work with a third party, who can provide additional specialized resources and knowledge that may not be available in house.

To read the FY 2024 IPPS/LTCH PPS final rule in full, click **here**.

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