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Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2023 Changes

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Related CR Title: Fiscal Year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes

Provider Types Affected

This MLN Matters Article is for inpatient hospitals, including Long-Term Care Hospitals (LTCH), billing Medicare Administrative Contractors (MACs) for inpatient hospital services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about:

- FY 2023 IPPS updates
- FY 2023 LTCH PPS updates
- Update to certain hospitals that CMS excludes from the IPPS

Background

We update the rates and factors for the IPPS and the LTCH PPS every year. CR 12814 outlines the FY 2023 updates. The following FY 2023 policy changes went on display on August 1, 2022, and appeared in the Federal Register on August 10, 2022. All items covered in this Article are effective for hospital discharges occurring on or after October 1, 2022 - September 30, 2023, unless otherwise noted.

We'll release new IPPS and LTCH PPS Pricer software packages that include these updates.

The FY 2023 Final Rule page has the FY 2023 Data Files, FY 2023 Final Rule Tables, and FY 2023 MAC Implementation Files referenced throughout this Article. The files are also available on the IPPS page. Click on the link on the left side of the screen titled, "FY 2023 IPPS Final Rule Home Page," or the link titled, "Acute Inpatient – Files for Download" (and select "Files for FY 2023 Final Rule").

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IPPS FY 2023 Update

A. FY 2023 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2023 IPPS/LTCH PPS Final Rule. 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 1 of the FY 2023 MAC Implementation Files website.

B. FY 2023 Puerto Rico Hospital Update Under the IPPS

Section 1886(n)(6)(B) of the Social Security Act (the Act) was amended to specify 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, effective starting in FY 2022. So, starting in FY 2022, any subsection (d) Puerto Rico hospital that isn't a meaningful EHR user as defined in section 1886(n)(3) of the Act and 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 2023 IPPS/LTCH PPS Final Rule, available on the FY 2023 Final Rule Tables website.

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

The Grouper contractors (3M Health Information Systems (3M-HIS)) developed the new ICD-10 MS-DRG Grouper, Version 40.0, software package effective for discharges on or after October 1, 2022. The Grouper assigns each case into an MS-DRG based on the reported diagnosis and procedure codes and demographic information (age, sex, and discharge status). The ICD-10 MCE Version 40.0, which is 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, 2022.

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

We maintained the number of 767 MS-DRGs for FY 2023. See the ICD-10 MS-DRG V40.0 Definitions Manual Table of Contents and Definitions of Medicare Code Edits V40.0 manual for the complete list of FY 2023 ICD-10 MS-DRGs and Medicare Code Edits.

D. Replaced Devices Offered Without Cost or With a Credit

For specified MS-DRGs, a hospital's IPPS payment is reduced when the implementation of a device is replaced free 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 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 2023. There were no MS-DRG changes under this policy in FY 2023.

E. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2023 have been evaluated against the general post-acute care transfer policy criteria using the FY 2021 Medical Provider Analysis and Review (MedPAR) data. Based on this review, we're not adding or removing any MS-DRGs from the list of MS-DRGs subject to either the post-acute care transfer policy or the special payment policy. See Table 5 of the FY 2023 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2023 Final Rule Tables webpage.

F. New Technology Add-On Payment Policy

For FY 2023, 15 technologies continue to be eligible for new technology add-on payments, and 9 technologies are newly eligible for 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 2023 payments under the conditional approval policy.

For more information on FY 2023 new technology add-on payments, specifically about the technologies either continuing to get payments or starting to get payments, see MAC Implementation File 8. Starting FY 2023, MAC Implementation File 8 also includes information about technologies no longer eligible to get new technology add-on payments.

G. FY 2023 Labor Related Share Percentage

There are no changes to the labor-related share percentages under the IPPS for FY 2023.

H. COLA for Hospitals Paid Under the IPPS

There are no changes to the COLA factors for FY 2023. We use the same COLA factors under the IPPS and LTCH PPS for FY 2023.

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

MACs update the PSF by following the steps, in order, in the file on the FY 2023 MAC Implementation File 5 in the Wage Index and Reclassifications PDF file to determine the appropriate wage index and other payments.

For FY 2023, the following policies will apply to the wage index:

- Increase the wage index value for hospitals with a wage index value below the 25th percentile wage index for FY 2023 across all hospitals
- Apply a 5% cap for FY 2023 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2022

Note: Under the 5% cap policy, new hospitals that opened during FY 2023 aren't eligible for the 5% cap.

J. Multicampus Hospitals

We allocate the wages and hours to the Core Based Statistical Area (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. So, 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. Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

The special payment provisions provided to MDHs aren't authorized by statute beyond FY 2022. Starting in FY 2023, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the federal rate. (We note that our sole community hospital (SCH) policy at 42 CFR 412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.)

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2023

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, 2022. Under current law, starting on October 1, 2022, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect before the amendments made by the Affordable Care Act and subsequent legislation (the low-volume hospital payment adjustment policy of FYs 2005-2010). The regulations implementing the hospital payment adjustment policy are at 42 CFR 412.101.

For FY 2023, you must make a written request for low-volume hospital status. Your MAC must get the request no later than September 1, 2022, for the applicable 25% low-volume payment adjustment to be applied to payments for discharges starting on or after October 1, 2022 - September 30, 2023. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2022 may continue to get a low-volume hospital payment adjustment for FY 2023 without reapplying if it meets both the discharge criteria (less than 200 total discharges, including both Medicare and non-Medicare patients), and the mileage criterion applicable for FY 2023.

Such a hospital must send written verification that its MAC gets no later than September 1, 2022, stating that it meets the mileage criteria applicable for FY 2023, which is increasing to 25 miles. If the MAC gets a hospital's request for low-volume hospital status for FY 2023 after September 1, 2022, and if the MAC decides the hospital meets the criteria to qualify as a low-volume hospital, the MAC will apply the applicable 25% low-volume hospital payment adjustment to decide the payment for the hospital's FY 2023 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

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

Under 42 CFR 413.87, hospitals that operate approved nursing or allied health education programs and get Medicare reasonable cost payment for these programs and treat MA enrollees get additional payments. Determining a hospital's NAH MA payment essentially involves applying a ratio of the hospital-specific NAH 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

In the FY 2023 IPPS/LTCH final rule (87 FR page 49075), we published the final national rates and percentages, and their data sources for CYs 2020 and 2021. MACs will use these rates to make MA N&AH payments and DGME payments to applicable providers for portions of cost reporting periods occurring in CYs 2020 and 2021. For policy guidance on these payments, MACs may refer to CR 11642.

N. Hospital Quality Initiative

A list of the hospitals that will get the quality initiative bonus is available. A list of hospitals that will get the statutory reduction to the annual payment update for FY 2023 under the Hospital Inpatient Quality Reporting (IQR) Program is in MAC Implementation File 3.

O. Hospital-Acquired Condition (HAC) Reduction Program

We won't adjust payments for any hospital in the HAC Reduction Program for FY 2023.

P. Hospital Value-Based Purchasing (VBP) Program

We won't adjust payments for any hospital in the Hospital VBP Program for FY 2023.

Q. Hospital Readmission Reduction Program (HRRP)

We'll post the HRRP payment adjustment factors for FY 2023 in Table 15 of the FY 2023 IPPS/LTCH PPS final rule. Hospitals that aren't subject to a reduction under the HRRP in FY 2023 (such as Maryland hospitals), have an HRRP payment adjustment factor of 1.0000. For FY 2023, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700.

R. Medicare Disproportionate Share Hospitals (DSH) Program

In the FY 2023 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 (UCP) amount to be paid to Medicare DSH hospitals, along with a total UCP amount. We'll continue to pay interim UCPs on the claim as an estimated per claim amount to the hospitals that have been projected to get Medicare DSH payments in FY 2023. The estimate Per-Claim Amount and Projected DSH Eligibility for each subsection (d) hospital and subsection (d) Puerto Rico hospital are in the Medicare DSH Supplemental Data File for FY 2023, which is available on the FY 2023 Final Rule Data Files website.

MACs will update the PSF by entering the updated estimated per claim uncompensated care payment amounts or if the hospital is an IHS/Tribal hospital or hospital located in Puerto Rico, entering the total of the estimated per discharge UCP amount and estimated per discharge supplemental payment amount, from the FY 2023 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File. For IHS/Tribal hospitals and hospitals located in Puerto Rico, MACs will enter the total amount from the MAC Implementation File, which has the total amount for both uncompensated care payment per discharge and the supplemental payment per discharge amount. (Additional information on the supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico can be found in Section S. below.) The interim estimated UCPs paid on a per-claim basis will be reconciled at cost report settlement with the total UCP amount displayed in the Medicare DSH Supplemental Data File. Likewise, the interim estimated supplemental payments paid on a per-claim basis will be reconciled at cost report settlement using the total supplemental payment displayed in the Medicare DSH Supplemental Data File.

a. Hospitals Without Prospective FY 2023 Factor 3 Calculation (New Hospitals, Uncompensated Care Trim and Newly Merged Hospitals)

For UCP purposes in FY 2023, new hospitals (those with CCNs established after October 1, 2019) that are determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the UCP costs from the hospital's FY 2023 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 2023 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 by the total UCP amount finalized in the FY 2023 IPPS Final Rule to decide the total UCP amount to be paid to the hospitals, if the hospital is decided to be DSH eligible at cost report settlement.

Starting in FY 2023, for new hospitals, newly merged hospitals, and hospitals subject to the Uncompensated Care Data Trim, MACs will apply a scaling factor for the Factor 3 calculation. The scaling factor used for the calculation can be found in the FY 2023 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description.

Note: It's possible that there will be additional new hospitals during FY 2023, and those wouldn't be available in the Medicare DSH Supplemental Data File list.

In the FY 2023 Final Rule, we continued an additional Uncompensated Care Data Trim for hospitals that weren't projected to be DSH eligible for UCPs. Like new hospitals, those hospitals affected by this new trim don't have a Factor 3 listed in the FY 2023 Medicare DSH Supplemental File. If such hospitals are ultimately decided to be DSH eligible at cost report settlement, then MACs will review Worksheet S-10 and calculate a Factor 3 from the hospital's FY 2023 cost report's Worksheet S-10 line 30, divided by the national UCP cost denominator.

For FY 2023, newly merged hospitals, for example, those that have a merger during FY 2023 or mergers not known at the time of Final Rule development, will have their interim UCPs reconciled at cost report settlement by their MAC.

b. Voluntary Request of Per-Discharge Amount of Interim UCPs

We use a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of UCPs per discharge. Specifically, the hospital's total UCP amount is divided by the hospital's historical 3-year average of discharges, according to the most recent available data. That calculation is a per-discharge payment amount used to make interim UCPs to each projected DSH-eligible hospital. The interim UCPs made to the hospital during the FY are reconciled at FY's end to ensure that the final payment amount is consistent with the hospital's prospectively decided UCP for the federal FY.

Under this policy, if a hospital submits a request to its MAC for a **lower** per discharge interim UCP amount (including a reduction to 0), **once** before the starting of the federal FY or once during the federal FY, 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 UCP, or at least $100,000) at cost report settlement if the per-discharge amount wasn't lowered. Examples include, but aren't limited to:

1. A request showing a large projected increase in discharges during the FY to support reduction of its per-discharge UCP amount

2. A request that its per-discharge UCP amount be reduced to 0 midyear if the hospital's interim UCPs during the year have already surpassed the total UCP calculated for the hospital

MACs will evaluate requests for strictly reducing the per-discharge UCP amount and the supporting documentation before the start of the federal FY and with midyear requests when the 3-year average of discharges is lower than the hospital's projected FY 2023 discharges. If after this review, a MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare UCPs at cost report settlement, the only change made would be to **lower** the per-discharge amount either to the amount requested by the hospital or another amount decided by the MAC to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request doesn't change how the total UCP amount will be reconciled at cost report settlement. The interim UCPs made to the hospital during the FY are still reconciled following the end of the FY to ensure that the final payment amount is consistent with the hospital's prospectively decided UCP for the federal FY.

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

Starting in FY 2023, we established a new supplemental payment for IHS and Tribal hospitals and hospitals located in Puerto Rico. Consistent with the process for determining eligibility to get interim uncompensated care payments adopted in the FY 2014 IPPS/LTCH final rule, for the supplemental payment, we based eligibility to get interim supplemental payments on a projection of DSH eligibility for the applicable fiscal year. Consistent with the approach that's used to calculate interim UCPs on a per discharge basis, for the supplemental payment, we've used an average of historical discharges to calculate a per discharge amount for interim supplemental payments. The DSH Supplemental Data File includes the combined interim UCP and interim supplemental payment.

Your MAC makes the final determination with respect to your eligibility to get the supplemental payment for a fiscal year, in conjunction with its final determination of the hospital's eligibility for DSH payments and UCPs for that fiscal year. If a hospital is decided not to be DSH eligible for a fiscal year then the hospital wouldn't be eligible to get a supplemental payment for that fiscal year.

The MAC will reconcile the interim supplemental payments at cost report settlement to make sure that the DSH eligible hospital gets the full amount of the supplemental payment that was decided before 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 UCP 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 decided based on the proportion of the applicable federal fiscal year that's included in that cost reporting period.

T. Outlier Payments

a. IPPS Statewide Average Cost to Charge Ratios (CCRs)

Tables 8A and 8B contain the FY 2023 statewide average operating and capital CCRs for urban and rural hospitals. These tables are available on the FY 2023 Final Rule Tables website. For FY 2023, statewide average CCRs are used in the following instances:

1. New hospitals that haven't yet 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.)
2. Hospitals with operating or capital CCR exceeding 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 issued per 42 CFR 412.8(b). For FY 2023 operating CCR and capital CCR trim values, refer to MAC Implementation File 1.
3. Hospitals for whom accurate data to calculate an operating or capital CCR (or both) aren't available.

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per instructions found in Chapter 3, section 20.1.2.1 of the Medicare Claims Processing Manual.

Also, for all hospitals, use of an operating and/or capital CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

U. 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. See MAC Implementation File 1 for the FY 2023 MS-DRG weighting factor used for such discharges.

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, we won't apply the payment adjustment 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, you may submit condition code "90" on the claim so that the Pricer will apply the payment adjustment in calculating the payment for the case. (Note, MACs no longer append Condition Code 'ZB' to inpatient claims reporting Billing Note NTE02 "Expand Acc Use" on the

electronic claim 837I or a remark “Expand Acc Use” on a paper claim, effective for claims for discharges that occur on or after October 1, 2022.)

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 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 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 2023 Update

A. FY 2023 LTCH PPS Rates and Factors

The FY 2023 LTCH PPS Standard Federal Rates are in Table 1E on the FY 2023 Final Rule Tables website. Other FY 2023 LTCH PPS Factors are in MAC Implementation File 2.

The LTCH PPS Pricer has been updated with the Version 40 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2022 - September 30, 2023.

B. Discharge Payment Percentage

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

For cost reporting periods starting on or after October 1, 2019, section 1886(m)(6)(C)(ii)(I) of the Act requires any LTCH with a DPP for the cost reporting period below 50% to be informed of this fact. Section 1886(m)(6)(C)(ii)(II) of the Act requires all 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 2023, the annual update to a standard federal rate will continue to be reduced by 2% if an LTCH doesn’t submit quality-reporting data per the LTCHQR Program for that year.

D. Provider Specific File (PSF)

MACs update their Inpatient PSF for each LTCH as needed, and update all applicable fields for LTCHs effective October 1, 2022, or effective with cost reporting periods that start on or after

October 1, 2022, or upon receipt of an as-filed (tentatively) settled cost report.

a. LTCH Statewide Average CCRs

Table 8C contains the FY 2023 statewide average LTCH total CCRs for urban and rural LTCHs. Table 8C is available on the FY 2023 Final Rule Tables website. Statewide average CCRs are used in the following instances:

1. New hospitals that haven't yet 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.
2. LTCHs with a total CCR above the applicable maximum CCR threshold (the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR). For the FY 2023 LTCH total CCR ceiling, see MAC Implementation File 2.
3. Any hospital for which data to calculate a CCR isn't available.

Note: Hospitals and MACs can request an alternative CCR to the statewide average CCR per instructions found in Chapter 3, section 150.24 of the Medicare Claims Processing Manual.

For all LTCHs, use of a total CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

b. LTCH Labor Market Areas and Wage Indexes

For FY 2023, we'll apply a 5% cap to any decrease in an LTCH's wage index from its FY 2022 wage index. A list of LTCHs that had their FY 2023 LTCH PPS wage index decreased by more than 5% along with their capped FY 2023 LTCH PPS wage index value is on the FY 2023 MAC Implementation Files webpage. We note that hospitals newly classified as an LTCH during FY 2023 aren't eligible for the 5% cap.

For FY 2023, we'll also apply a 5% cap to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2022 applicable IPPS comparable wage index. A list of LTCHs that had their FY 2023 applicable IPPS comparable wage index decreased by more than 5% along with their capped FY 2023 applicable IPPS comparable wage index value is on the FY 2023 MAC Implementation Files webpage. We note that hospitals newly classified as an LTCH during FY 2023 aren't eligible for the 5% cap.

E. COLA under the LTCH PPS

There are no updates to the COLAs for FY 2023.

Note: The same COLA factors are used under the IPPS and LTCH PPS for FY 2023.

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospitals' target amount is the applicable annual

rate-of-increase percentage specified in 42 CFR 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2023 IPPS/LTCH PPS Final Rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2023 of 4.1%.

More Information

We issued CR 12814 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
December 1, 2022	Initial article released.