



FAQ: FY 2024 Inpatient Prospective Payment System (IPPS) Proposed Rule

Updated: April 2023

The Centers for Medicare and Medicaid Services (CMS) released the [Fiscal Year \(FY\) 2024 Hospital Inpatient Prospective Payment System \(IPPS\) and Long-Term Care Hospital Prospective Payment System \(LTCH PPS\)](#) proposed rule, which would update Medicare fee-for-service payment rates and policies for inpatient hospitals and LTCHs for FY 2024. The proposed rule also focuses on improving health equity, capturing social determinants of health in diagnosis codes, and making changes to the Medicare Promoting Interoperability Program, among other proposals. Comments on the FY 2024 IPPS proposed rule are due **June 9, 2023**.

Key Provisions of the Proposed Rule:

- Medical Coding Proposals
 - A proposal for the addition of 15 new Medicare Severity Diagnosis Related Groups (MS-DRGs) for payment and other additional changes to MS-DRG classifications.

- Social Determinants of Health (SDOH) Codes
 - After reviewing its data analysis of the impact on resource use generated using claims data, CMS proposes to change the severity designation of the three ICD-10-CM diagnosis codes describing homelessness from non-complication or comorbidity to complication or comorbidity, based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes.

 - Future editions of the IPPS proposed rule may include, if CMS elects to further develop these activities, requirements for hospitals to report future quality measures related to geriatric care and the SDOH that align with that care, including assessing a patient for psychosocial risk factors and assessing older patients for potential abuse.

- Proposed changes to the Promoting Interoperability Program
 - Modifying the requirements for the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure to require eligible hospitals and CAHs to attest “yes” to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs;

 - Amending the definition of “EHR reporting period for a payment adjustment year” for eligible hospitals and CAHs to define the EHR reporting period in CY 2025 as a minimum of any continuous 180-day period within CY 2025;

 - For eligible hospitals that have not successfully demonstrated meaningful EHR use in a prior year, amending the definition of “EHR reporting period for a payment adjustment year” to remove the requirement to attest to meaningful use by October 1 of the year prior to the payment adjustment year; and

 - For eligible hospitals and CAHs reporting on measures for the Medicare Promoting Interoperability Program, modifying the response options related to unique patients or actions for measures for which there is no numerator and denominator, and for which unique patients or actions are not counted, to read “N/A (measure is Yes/No)”.

If you have questions, please contact the AHIMA Advocacy and Policy Team at advocacy@ahima.org.