MS–DRGs subject to the postacute care transfer policy for FY 2024 to determine if any of these MS–DRGs would also be subject to the special payment methodology policy for FY 2024. Based on our analysis of proposed changes to MS–DRGs included in the proposed rule, we determined that proposed new MS–DRG 276 meets the criteria for the MS–DRG special payment methodology. As described in the regulations at § 412.4(f)(6)(iv), MS–DRGs that share the same base MS–DRG will all qualify under the MS–DRG special payment policy if any one of the MS–DRGs that share that same base MS–DRG qualifies. Therefore, we proposed that proposed new MS–DRG 277 also would be subject to the MS–DRG special payment methodology, effective for FY 2024. For this FY 2024 final rule, we updated this analysis using data from the March 2023 update of the FY 2022 MedPAR file.

LIST OF NEW OR REVISED MS–DRGs SUBJECT TO REVIEW OF SPECIAL PAYMENT POLICY STATUS FOR FY 2024

New or Revised MS–DRG	MS–DRG Title	Geometric Mean Length of Stay	Average Charges of 1-Day Discharges	50 Percent of Average Charges for all Cases within MS–DRG	FY 2023 Special Payment Policy Status	Special Payment Policy Status
166	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH MCC	8.385896	$39,911	$84,881	No	No
167	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITH CC	3.460597	$47,236	$41,988	No	No
168	OTHER RESPIRATORY SYSTEM O.R. PROCEDURES WITHOUT CC/MCC	1.837013	$45,547	$32,813	No	No
276	CARDIAC DEFIBRILLATOR IMPLANT WITH MCC	6.296602	$182,624	$132,972	New	Yes
277	CARDIAC DEFIBRILATOR IMPLANT WITHOUT MCC	3.326289	$186,031	$106,855	New	Yes*

* As described in the policy at 42 CFR 412.4(f)(6)(iv), MS–DRGs that share the same base MS–DRG will all qualify under the special payment transfer policy if any one of the MS–DRGs that share that same base MS–DRG qualifies.

Comment: One commenter, citing extremely high early stay costs, expressed concern about adding MS–DRGs 276 and 277 to the post-acute transfer policy unless the full cost of the cardiac defibrillator and the cost to implant is covered. The commenter stated that payment to the transferring hospital for these MS–DRGs would be twice the per-diem amount the first day and with each subsequent day paid at the per-diem amount up until the full MS–DRG payment.

Response: The commenter described the payment methodology under the post-acute care transfer policy. However, CMS proposed that these MS–DRGs also be added to the list of MS–DRGs subject to the special payment policy. Under this policy, the transferring hospital would receive 50 percent of the full MS–DRG payment, plus a single per diem payment, for the first day of the stay, as well as a per diem payment for subsequent days (up to the full MS–DRG payment). The intent of the special payment policy is specifically to address MS–DRGs with high initial costs, such as the one-time cost of surgically implanted devices. We believe the proposed addition of MS–DRGs 276 and 277 to the special payment policy adequately addresses the specific concerns expressed by the commenter.

After consideration of public comments we received, we are finalizing our proposal to add new MS–DRGs 276 and 277 to the list of MS–DRGs that are subject to the postacute care transfer policy and the MS–DRG special payment methodology for FY 2024.

The postacute care transfer and special payment policy status of these MS–DRGs is reflected in Table 5 associated with this final rule, which is listed in section VI. of the Addendum to this final rule and available on the CMS website.

B. Changes in the Inpatient Hospital Update for FY 2024 (§ 412.64(d))

1. FY 2024 Inpatient Hospital Update

In accordance with section 1886(b)(3)(B)(i) of the Act, each year we update the national standardized amount for inpatient hospital operating costs by a factor called the ''applicable percentage increase.'' For FY 2024, we stated in the proposed rule that we are setting the applicable percentage increase by applying the adjustments listed in this section in the same sequence as we did for FY 2023. (We note that section 1886(b)(3)(B)(xii) of the Act required an additional reduction each year only for FYs 2010 through 2019.) Specifically, consistent with section 1886(b)(3)(B) of the Act, as amended by sections 3401(a) and 10319(a) of the Affordable Care Act, we stated that we are setting the applicable percentage increase by applying the following adjustments in the following sequence. The applicable percentage increase under the IPPS for FY 2024 is equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to all of the following:

- A reduction of one-quarter of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals that fail to submit quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act.
- A reduction of three-quarters of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals not considered to be meaningful EHR users in accordance with section 1886(b)(3)(B)(ix) of the Act.
- An adjustment based on changes in economy-wide multifactor productivity (MFP) (the productivity adjustment).

Section 1886(b)(3)(B)(xi) of the Act, as added by section 3401(a) of the

Affordable Care Act, states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

We note, in compliance with section 404 of the MMA, in the FY 2022 IPPS/LTCH PPS final rule (86 FR 45194 through 45204), we replaced the 2014-based IPPS operating and capital market baskets with the rebased and revised 2018-based IPPS operating and capital market baskets beginning in FY 2022.

We proposed to base the FY 2024 market basket update used to determine the applicable percentage increase for the IPPS on IHS Global Inc.'s (IGI's) fourth quarter 2022 forecast of the 2018-based IPPS market basket rate-of-increase with historical data through third quarter 2022, which was estimated to be 3.0 percent. We also proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket update), we would use such data, if appropriate, to determine the FY 2024 market basket update in the final rule.

Comment: Several commenters stated that hospitals continue to face significant inflationary pressures. Commenters specifically expressed concern that the proposed hospital IPPS payment update for FY 2024 does not adequately consider the cost growth that hospitals have faced over the last few years, noting cost increases related to workforce (including contract labor), drugs, medical supplies, personal protective equipment (PPE), and capital investment. The commenters stated that the significant inflation over the past several years has not been fully captured by the IPPS payment updates during the COVID years.

Several commenters requested that CMS use its exceptions and adjustments authority to increase the FY 2024 IPPS hospital market basket update higher than proposed. One commenter urged CMS to review the hospital cost data and the margin on Medicare reimbursement and readjust payment rates based on the new baseline cost of care that has resulted from supply shocks and labor shortages. A few commenters suggested CMS apply a market basket increase of at least 3.8 percent, reflecting MedPAC's March 2023 Report to Congress recommending a one-percent increase to the FY 2024 market basket and requested that CMS consider a FY 2024 market basket that more accurately represents inflation on hospital expenses. One commenter supported a higher market basket payment update under the IPPS to reflect the actual effects of inflation on hospital operating costs and endorsed an annual inflation-based payment update based on the full Medicare Economic Index (MEI) while one commenter requested CMS use its authority to increase the FY 2024 IPPS hospital payment update to at least 5 percent.

Many commenters stated that they have experienced their lowest margins in decades and anticipated additional worse operating losses in at least the next two fiscal years. One commenter stated that in its March 2023 report to Congress, MedPAC reported overall Medicare hospital margins were negative 6.2 percent in 2021 (after accounting for temporary COVID–19 relief funds). Moreover, the commenter stated that MedPAC also projected hospitals' Medicare margins in 2023 to be lower than in 2021, driven in part by the growth in hospitals' input costs, which exceeded the forecasts CMS used to set Medicare payment rate updates, and in part by the expected expiration of Federal relief funds and temporary Medicare payment increases related to the public health emergency. The commenter stated that MedPAC also projects that even ''relatively efficient'' hospitals' Medicare margins will fall below break-even in 2023.

One commenter stated that while the 2022 market basket increase of 4 percent provided some relief from the additional costs of COVID–19 for 2023, the proposed FY 2024 market basket update would not carry these elevated costs associated with COVID–19 forward into 2024 even though the commenter stated that additional costs of COVID–19 still exist. The commenter noted that hospitals are now faced with rebuilding long-term funds, paying longer-term inflated costs of supplies and equipment and high wages due to the lack of staffing that still exists as a result of COVID burn out. Several commenters stated that this year's proposed update is inadequate and requested that CMS address the market basket update in the final rule.

One commenter noted that CMS proposed ''that if more recent data subsequently become available, we would use such data, if appropriate, to determine the FY 2024 market basket update in the final rule.'' The commenter urged CMS to use more recent data that include the recent inflationary increases in cost; and in the absence of such data urged CMS to consider an alternative approach to better align the market basket increases with increases in cost to treat patients. A few commenters appreciated the proposed payment increase but also stated agreement with other commenters that the proposed increase is inadequate given inflation and labor and supply pressures that hospitals, particularly rural hospitals, have been facing and continue to face.

Many commenters had significant concerns that the proposed IPPS payment update does not adequately reflect labor costs. Commenters stated the significant increases in labor expenses over the last couple of years have been largely driven by increased utilization of contract staff (due to workforce shortages) and growth in employee salaries. One commenter cited their own analysis of payroll data to calculate the increased cost of labor, which it stated was significantly higher than the annual increases for compensation prices that CMS finalized over the last several years. Given what they stated was the significant difference between the increased cost of labor versus what CMS estimates using the ECIs, the commenters stated they had significant concerns that CMS' data source for estimating the cost of labor does not capture current market dynamics and underestimates the actual cost of healthcare labor. Many commenters cited analysis that nursing staff shortages are predicted to continue for the next several years. Specifically, commenters raised concerns about the CMS use of the Bureau of Labor Statistics' Employment Cost Index (ECI) in the IPPS market basket. Commenters stated they believe the BLS' ECI does not accurately reflect the shift from salaried employees to contract labor since the ECI does not collect data for contract staff, and thus does not capture extraordinary labor cost growth associated with hospitals' increased reliance on clinicians contracted through staffing agencies in response to supply shortages. One commenter highlighted their belief that a closely related measure—the Employer Costs for Employee Compensation (ECEC)—may be a better and more timely data source for growth in hospital compensation costs compared to the ECI. The commenter claimed that all else equal, if the hospital ECI growth had matched the hospital ECEC growth, this would have meant an additional three percentage point increase in the IPPS hospital market basket over the 2019 to 2022 time period. Several commenters recommended that CMS use its exceptions and adjustments authority to adopt new or supplemental data sources such as commercial databases on hospital payrolls, to ensure labor costs are adequately reflected in the FY 2024 payment update in the final rule.

One commenter also requested CMS identify more accurate data inputs and use its existing authority to calculate the

final rule ''base'' (before additional adjustments) market basket update with data that better reflect the rapidly increasing input prices facing hospitals. The commenter suggested that CMS should consider using the average growth rate in allowable Medicare costs per risk adjusted discharge for IPPS hospitals between FY 2019 and FY 2021 to calculate the FY 2024 final rule market basket update rather than using the growth in the ECI as the price proxy for compensation in the IPPS market basket. The commenter requested using Medicare cost report data from Worksheets D–1, Part II, Lines 48 and 49 and S–3, Part 1, Column 13 to determine the Medicare costs per discharge. The commenter stated that this growth rate will capture the increased cost of contract labor, unlike the ECI. Based on their analysis of Medicare cost report data, they found that this methodology would yield an unadjusted market basket update of 4.39 percent for FY 2024 rather than the 2.8 percent net market basket update proposed by CMS. The commenter also stated that Medicare margins have declined over the last 20 years and believes this is due to persistently inadequate Medicare market basket updates. They further stated that hospitals' financial situations are so precarious that MedPAC recommended to Congress that it increase IPPS and OPPS payments over current law to preserve access.

Response: We acknowledge commenters' concerns regarding recent trends in inflation. Section 1886(b)(3)(B)(iii) of the Act states the Secretary shall update IPPS payments based on a market basket percentage increase based on an index of appropriately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in such inpatient hospital services. The 2018-based IPPS market basket is a fixed-weight, Laspeyres-type price index that measures the change in price, over time, of the same mix of goods and services purchased by hospitals in the base period. As we discussed in response to similar comments in the FY 2023 IPPS/LTCH PPS final rule (87 FR 49053), the IPPS market basket increase would reflect the prospective price pressures described by the commenters as increasing during a high inflation period (such as faster wage price growth or higher energy prices), but would inherently not reflect other factors that might increase the level of costs, such as the quantity of labor used or any shifts between contract and staff nurses (which would be reflected in the Medicare cost report data). We disagree that costs as reported on the Medicare cost report are a suitable data source for determining the trend in compensation prices for the market basket update. The Medicare cost report data also reflects factors that are beyond those that impact wage or price growth. For instance, overall Medicare costs per discharge as reported by hospitals on the Medicare cost report would also reflect observed IPPS case-mix (and associated higher payments to hospitals), which from 2019 to 2022 has increased faster than in prior years and would be associated with the use of more skilled care and medical/drug supplies needed to provide these services.

Regarding commenters' request that CMS consider other methods and data sources to calculate the final rule market basket update, we believe that the 2018-based IPPS market basket continues to appropriately reflect IPPS cost structures and we believe the price proxies used (such as those from BLS that reflect wage and benefit price growth) are an appropriate representation of price changes for the inputs used by hospitals in providing services. As discussed in appendix B of this final rule, in its March report, MedPAC recommended that the Congress update the inpatient hospital rates by the amount specified in current law plus one percent. Given that we believe the 2018-based IPPS market basket reflects an index of appropriately weighted indicators of changes in wages and prices that are representative of the mix of goods and services included in such inpatient hospital services and the percentage change of the 2018-based IPPS market basket is based on IGI's more recent forecast reflecting the prospective price pressures for FY 2024, we do not believe it would be appropriate to use our exceptions and adjustment authority to create a separate payment that would have the effect of modifying the current law update.

The ECI (published by the BLS) measures the change in the hourly labor cost to employers, independent of the influence of employment shifts among occupations and industry categories. We acknowledge that the ECI measures only reflect price changes and does not capture changes in quantity or mix of labor such as increased utilization of contract staff as noted by the commenter. We believe that the ECI for hospital workers is accurately reflecting the price change associated with the labor used to provide hospital care and appropriately does not reflect other factors that might affect labor costs (such as a shift in occupations that may occur due to increases in case-mix). The ECEC data cited by the commenter is limited in its usefulness in the market basket because it reflects averages across all employees (similar to another BLS wage series, Average Hourly Earnings, available from the Current Employment Statistics program). According to BLS documentation, the ECEC reflects average compensation in the economy at a point in time, including both changes in compensation and changes in employment. The wage measure in the market basket should not reflect changes in employment to be consistent with the statute that the market basket percentage increase be based on an index of appropriately weighted indicators of changes in wages and prices. The ECEC, an indicator that also includes changes in employment, is not as appropriate to use as the ECI in the IPPS market basket. For these reasons, we believe the ECI continues to be an appropriate measure to use in the IPPS market basket.

We note that the Medicare cost report data shows contract labor hours account for about 4 percent of total compensation hours (reflecting employed and contract labor staff) for IPPS hospitals in 2021. Therefore, while we acknowledge that the ECI measures only reflect price changes for employed staff, we believe that the ECI for hospital workers is accurately reflecting the price change associated with the labor used to provide hospital care (as employed workers' hours account for 96 percent of hospital compensation hours). Therefore, we believe it continues to be an appropriate measure to use in the IPPS market basket. We also note that when developing its forecast for the ECI for hospital workers, IGI considers overall labor market conditions (including rise in contract labor employment due to tight labor market conditions) as well as trends in contract labor wages, which both have an impact on wage pressures for workers employed directly by the hospital.

We would highlight that the market basket percentage increase is a forecast of the price pressures that are expected to be faced in 2024. As projected by IGI (a nationally recognized economic and financial forecasting firm with which CMS contracts to forecast the price proxies of the market baskets) and upward price pressures are expected to slow in FY 2024 relative to FY 2022 and FY 2023. As is our general practice, we proposed that if more recent data became available, we would use such data, if appropriate, to derive the final FY 2024 IPPS market basket update for the final rule. We appreciate the commenter's concern regarding inflationary pressure and the request to use more recent data to determine the

FY 2024 IPPS market basket update. For this final rule, we are incorporating a projection of the 2018-based IPPS market basket that is based on the most recent forecast from IHS Global Inc. For this final rule, based on the more recent IGI second quarter 2023 forecast with historical data through the first quarter of 2023, the projected 2018-based IPPS market basket increase factor for FY 2024 is 3.3 percent, which is 0.3 percentage point higher than the projected FY 2024 market basket increase factor in the proposed rule based on IGI's fourth quarter 2022 forecast, and reflects a projected increase in compensation prices of 4.3 percent. We would note that the 10-year historical average (2013–2022) growth rate of the 2018-based IPPS market basket is 2.5 percent reflecting a 10-year historical average (2013–2022) growth rate compensation prices equal to 2.4 percent.

Comment: One commenter recommended that CMS reevaluate the data sources it uses for rebasing its market basket and calculating the annual market basket update, including labor costs. They strongly encouraged CMS to adopt new or supplemental data sources in future rulemaking that more accurately reflect the costs to hospitals, such as through use of more real time data from the hospital community. They stated that they believe that the current market basket does not account for the higher costs of contract labor, which has become more common in hospitals in an era of clinical labor shortages. One commenter requested that CMS rebase the market baskets more frequently and at least every three years to ensure the market basket reflects the appropriate mix of services provided to Medicare beneficiaries.

Response: CMS appreciates the commenter's request to rebase more frequently. Section 404 of Public Law 108–173 states the Secretary shall establish a frequency for revising the cost weights of the IPPS market basket more frequently than once every 5 years. As published in the FY 2006 IPPS final rule (70 FR 47403), we established a rebasing frequency of every four years, in part because the cost weights obtained from the Medicare cost reports do not indicate much of a change in the weights from year to year. The most recent rebasing of the IPPS market basket was for the FY 2022 payment update and reflected a base year of 2018 costs. Given recent concerns raised by commenters regarding changes in costs as a result of recent inflation and the COVID–19 pandemic, we also have been regularly monitoring the Medicare cost report data to assess whether a rebasing is technically appropriate, and we will continue to do so in the future. Based on a preliminary analysis of the Medicare cost report data for IPPS hospitals for 2021 that became available for this final rule, the IPPS compensation cost weight for 2021 is estimated to be about 1 percentage point lower than the 2018-based IPPS market basket compensation cost weight of 53.0 percent, and reflects a combined decrease in the salary and benefit cost weights that is larger than the increase in the contract labor cost weight. The major cost categories that preliminarily show an increase in the cost weight over this period are pharmaceuticals (proxied by the PPI—Commodity—Special Index—Pharmaceuticals for human use, prescription) and home office contract labor compensation costs (which would be proxied by the ECI for Professional and Related workers). We plan to review the 2021 Medicare cost report data in more detail as well as 2022 Medicare cost report data as soon as complete information is available and evaluate these data for future rebasing of the IPPS market basket.

Regarding the comment about using new or supplemental data sources in future rulemaking, we believe the Medicare cost report data is the most complete, timely and relevant data source for the development of the cost weights. We also welcome feedback on alternative publicly available data sources that could be used to evaluate the cost conditions facing hospitals and the subsequent derivation of the market basket cost weights.

Comment: Several commenters, including many associations, urged CMS to use its special exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to implement a retrospective adjustment for FY 2024 to account for the difference between the market basket update that was implemented for FY 2022 and what the currently projected market basket is for FY 2022. Commenters stated this is, in large part, because the market basket is a time-lagged estimate that cannot fully account for unexpected changes that occur, such as historic inflation and increased labor and supply costs. They stated this is exactly what occurred at the end of the calendar year 2021 into calendar year 2022, which resulted in a large forecast error in the FY 2022 market basket update. Commenters stated the IPPS reimbursement has failed to keep pace with inflation as costs for drugs, supplies, insurance premiums, and labor have increased. They recommended that CMS utilize the FY 2024 update to include a retrospective adjustment and methodology change to make the FY 2022 actual 5.7 percent market basket percentage increase to be more reflective of the costs hospitals face, including the true impact of inflation. One commenter also urged CMS to reflect the forecast error in FY 2022 as well as an additional 1.0 percent on top of the proposed FY 2024 market basket increase. One commenter requested that CMS use its special exceptions and adjustment authority to make a one-time retrospective adjustment of 10–15 percent to the market basket to account for what it stated hospitals should have received in 2022 when accounting for inflation, while another commenter stated that at a minimum, CMS should address what it stated was the gross underpayment that occurred in FY 2022 via a one-time adjustment of at least 3 percent.

One commenter urged CMS to use its exceptions and adjustments authority to apply a one-time adjustment to course correct for its significantly lower estimates of costs for FY 2021 through FY 2023. The commenter stated that because the annual payment update builds on the prior year's payment rate, failing to correct what it described as CMS' gross underestimation of the payment updates during the pandemic will further perpetuate inaccuracies in the payment rate moving forward, resulting in a permanent cut to hospital payments. Similarly, another commenter stated that in three of the last five years for which they had data to compare, they observed that the forecasted hospital market basket data used to set IPPS payment rates has fallen short of actual market basket data. They estimated, based on actual expenditure data from the 2023 Medicare Trustees Report, that in 2021 hospitals may have lost nearly $1 billion and in 2022 hospitals may have lost more than $4 billion as a result of the forecast error assumptions.

Several commenters suggested CMS should consider implementing a market basket forecast error adjustment within the methodology for calculating the annual IPPS payment update. One commenter stated that this change would reduce the risk hospitals face when rapid inflation causes CMS's forecasted hospital market basket percentage increase to be out of alignment with the actual hospital market basket percentage increase. One commenter stated that CMS should do so if forecast error is more than 0.5 percentage point while another commenter recommended a threshold of 1.5 percentage points. One commenter stated that unlike other industries, hospitals cannot simply raise prices to

bring in additional revenue, but rather can only bring in additional revenue by renegotiating higher payments with employers and health insurers, something that is increasingly difficult in the current fiscal environment. They stated that if hospitals are unable to grow revenue from other sources, they must make cuts to important service lines just like any other business to remain financially viable.

One commenter also noted that for both the SNF PPS and the capital IPPS, CMS is making the forecast error adjustments based on a threshold level of difference between the update and the market basket that was adopted through rulemaking in prior years.

Response: While the projected IPPS hospital market basket updates for FY 2021 and FY 2022 were under forecast (actual increases less forecasted increases were positive), this was largely due to unanticipated inflationary and labor market pressures as the economy emerged from the COVID–19 PHE. However, an analysis of the forecast error of the IPPS market basket over a longer period of time shows the forecast error has been both positive and negative. For example, the 10-year cumulative forecast error showed a negative forecast error (that is, forecasted increases were greater than actual increases) of 1.1 percentage points (2013 through 2022). In addition, for each year from 2012 through 2020, the forecasted FY hospital market basket update implemented in the final rule was higher than the actual hospital market basket update once historical data were available, with 7 out of the 9 years having a negative forecast error greater than 0.5 percentage point (in absolute terms). Only considering the forecast error for years when the final hospital market basket update was lower than the actual market basket update does not consider the numerous years that providers benefited from the forecast error. Relatedly, the capital PPS and SNF PPS forecast error adjustments were adopted very early in both payment systems and, unlike what commenters are requesting here for the IPPS, forecast errors over many years have been consistently addressed within each of the Capital PPS and SNF PPS

For these reasons, we do not believe it is appropriate to include adjustments to the market basket update for future years based on the difference between the actual and forecasted market basket increase in prior years. We thank the commenters for their comments. After consideration of the comments received and consistent with our proposal, we are finalizing to use more recent data to determine the FY 2024 market basket update for the final rule. Specifically, based on more recent data available, we determined final applicable percentage increases to the standardized amount for FY 2024, as specified in the table that appears later in this section.

In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51689 through 51692), we finalized our methodology for calculating and applying the productivity adjustment. As we explained in that rule, section 1886(b)(3)(B)(xi)(II) of the Act, as added by section 3401(a) of the Affordable Care Act, defines this productivity adjustment as equal to the 10-year moving average of changes in annual economy-wide, private nonfarm business MFP (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, year, cost reporting period, or other annual period). The U.S. Department of Labor's Bureau of Labor Statistics (BLS) publishes the official measures of private nonfarm business productivity for the U.S. economy. We note that previously the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by BLS as private nonfarm business multifactor productivity. Beginning with the November 18, 2021, release of productivity data, BLS replaced the term multifactor productivity (MFP) with total factor productivity (TFP). BLS noted that this is a change in terminology only and will not affect the data or methodology. As a result of the BLS name change, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) is now published by BLS as private nonfarm business total factor productivity. However, as mentioned, the data and methods are unchanged. Please see *www.bls.gov* for the BLS historical published TFP data. A complete description of IGI's TFP projection methodology is available on the CMS website at *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketResearch*. In addition, we note that beginning with the FY 2022 IPPS/LTCH PPS final rule, we refer to this adjustment as the productivity adjustment rather than the MFP adjustment to more closely track the statutory language in section 1886(b)(3)(B)(xi)(II) of the Act. We note that the adjustment continues to rely on the same underlying data and methodology.

For FY 2024, we proposed a productivity adjustment of 0.2 percent. Similar to the proposed market basket update, for the proposed rule, the estimate of the proposed FY 2024 productivity adjustment was based on IGI's fourth quarter 2022 forecast. As noted previously, we proposed that if more recent data subsequently became available, we would use such data, if appropriate, to determine the FY 2024 productivity adjustment for the final rule.

Comment: Several commenters expressed concern about the application of the productivity adjustment, stating that the PHE has had unimaginable impacts on hospital productivity. They state that even before the PHE, OACT indicated that hospital productivity will be less than the general economy-wide productivity, which is the measure that is required by law to be used to derive the productivity adjustment. Given that CMS is required by statute to implement a productivity adjustment to the market basket update, commenters asked the agency to work with Congress to permanently eliminate what they stated is an unjustified reduction to hospital payments. Further, they asked CMS to use its ''exceptions and adjustments'' authority to remove the productivity adjustment for any fiscal year that was covered under PHE determination (*i.e.,* 2020 (0.4 percent), 2021 (0.0 percent), 2022 (0.7 percent), and 2023 (0.3 percent) from the calculation of the market basket update for FY 2024 and any year thereafter. A few commenters expressed concerns about the proposed productivity adjustment given the extreme and uncertain circumstances under which hospitals and health systems are currently operating and urged CMS to eliminate the productivity cut for FY 2024.

Response: While we appreciate the commenters' concerns, section 1886(b)(3)(B)(xi) of the Act requires the application of the productivity adjustment. As required by statute, the FY 2024 productivity adjustment is derived based on the 10-year moving average growth in economy-wide productivity for the period ending FY 2024.

We thank the commenters for their comments. After consideration of the comments received and consistent with our proposal, we are finalizing as proposed to use more recent data to determine the FY 2024 productivity adjustment for the final rule.

Based on more recent data available for this FY 2024 IPPS/LTCH PPS final rule (that is, IGI's second quarter 2023 forecast of the 2018-based IPPS market basket rate-of-increase with historical data through the first quarter of 2023), we estimate that the FY 2024 market basket update used to determine the applicable percentage increase for the IPPS is 3.3 percent. Based on more

recent data available for this FY 2024 IPPS/LTCH PPS final rule (that is, IGI's second quarter 2023 forecast of the productivity adjustment), the current estimate of the productivity adjustment for FY 2024 is 0.2 percentage point.

As previously discussed, based on the more recent data available, for this final rule, we have determined four final applicable percentage increases to the standardized amount for FY 2024. For FY 2024, depending on whether a hospital submits quality data under the rules established in accordance with section 1886(b)(3)(B)(viii) of the Act (hereafter referred to as a hospital that submits quality data) and is a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act (hereafter referred to as a hospital that is a meaningful EHR user), there are four possible applicable percentage increases that can be applied to the standardized amount, as specified in this table.

FY 2024 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

FY 2024	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	3.3	3.3	3.3	3.3
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.825	-0.825
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.475	0.0	-2.475
Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.2	-0.2	-0.2	-0.2
Applicable Percentage Increase Applied to Standardized Amount	**3.1**	**0.625**	**2.275**	**-0.2**

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42344), we revised our regulations at 42 CFR 412.64(d) to reflect the current law for the update for FY 2020 and subsequent fiscal years. Specifically, in accordance with section 1886(b)(3)(B) of the Act, we added paragraph (d)(1)(viii) to § 412.64 to set forth the applicable percentage increase to the operating standardized amount for FY 2020 and subsequent fiscal years as the percentage increase in the market basket index, subject to the reductions specified under § 412.64(d)(2) for a hospital that does not submit quality data and § 412.64(d)(3) for a hospital that is not a meaningful EHR user, less a productivity adjustment. (As previously noted, section 1886(b)(3)(B)(xii) of the Act required an additional reduction each year only for FYs 2010 through 2019.)

Section 1886(b)(3)(B)(iv) of the Act provides that the applicable percentage increase to the hospital-specific rates for SCHs and MDHs equals the applicable percentage increase set forth in section 1886(b)(3)(B)(i) of the Act (that is, the same update factor as for all other hospitals subject to the IPPS). Therefore, the update to the hospital-specific rates for SCHs and MDHs also is subject to section 1886(b)(3)(B)(i) of the Act, as amended by sections 3401(a) and 10319(a) of the Affordable Care Act. As discussed in section V.F. of the preamble of this final rule, section 4102 of the Consolidated Appropriations Act, 2023 (Public Law 117–328), enacted on December 29, 2022, extended the MDH program through FY 2024 (that is, for discharges occurring on or before September 30, 2024). We refer readers to section V.F. of the preamble of this final rule for further discussion of the MDH program.

For FY 2024, we proposed the following updates to the hospital-specific rates applicable to SCHs and MDHs: A proposed update of 2.8 percent for a hospital that submits quality data and is a meaningful EHR user; a proposed update of 0.55 percent for a hospital that submits quality data and is not a meaningful EHR user; a proposed update of 2.05 percent for a hospital that fails to submit quality data and is a meaningful EHR user; and a proposed update of ¥0.2 percent for a hospital that fails to submit quality data and is not an meaningful EHR user. We proposed that if more recent data subsequently became available (for example, a more recent estimate of the market basket update and the productivity adjustment), we would use such data, if appropriate, to determine the update in the final rule.

We did not receive any public comments on our proposed updates to hospital-specific rates applicable to SCHs and MDHs. The general comments we received on the proposed FY 2024 update (including the proposed market basket update and productivity adjustment) are discussed earlier in this section. For FY 2024, we are finalizing the proposal to determine the update to the hospital specific rates for SCHs and MDHs in this final rule using the more recent available data, as previously discussed.

For this final rule, based on more recent available data we are finalizing the following updates to the hospital specific rates applicable to SCHs and MDHs (the same update factor as for all other hospitals subject to the IPPS, consistent with the applicable percentage increases for the IPPS): An update of 3.1 percent for a hospital that submits quality data and is a meaningful EHR user; an update of 0.625 percent for a hospital that submits quality data and is not a meaningful EHR user; an update of 2.275 percent for a hospital that fails to submit quality data and is a meaningful EHR user; and an update of ¥0.2 percent for a hospital that fails to submit quality data and is not a meaningful EHR user.

2. FY 2024 Puerto Rico Hospital Update

Section 602 of Public Law 114–113 amended section 1886(n)(6)(B) of the Act to specify that subsection (d) Puerto Rico hospitals are eligible for incentive payments for the meaningful use of certified EHR technology, effective beginning FY 2016. In addition, section 1886(n)(6)(B) of the Act was amended to specify that the adjustments to the applicable percentage increase under section 1886(b)(3)(B)(ix) of the Act