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FACT SHEET

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FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule — CMS-1785-F and CMS-1788-F
Fact Sheet

On August 1, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2024 Medicare hospital inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) final rule.

The final rule updates Medicare fee-for-service payment rates and policies for inpatient hospitals and LTCHs for FY 2024. CMS is publishing this final rule to meet the legal requirements to update Medicare payment policies for IPPS hospitals and LTCHs on an annual basis. In this final rule, CMS is also finalizing policies to promote health equity and patient safety. This rule also finalizes the proposals presented in CMS-1788-P, which address the treatment of Section 1115 demonstration days in the calculation of Medicare disproportionate share hospital (DSH) payments. This fact sheet discusses major provisions of the final rule, which can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection/current

Background on the IPPS and LTCH PPS

CMS pays acute care hospitals (with a few exceptions specified in the law) for inpatient stays under the IPPS. LTCHs are paid under the LTCH PPS. Under these two payment systems, CMS sets base payment rates prospectively for inpatient stays generally based on the patient's diagnosis, the services or treatment provided, and the severity of illness. Subject to certain adjustments, a hospital receives a single payment for each case depending on the payment classification assigned at discharge. The classification systems are: IPPS: Medicare Severity Diagnosis-Related Groups (MS-DRGs) and LTCH PPS: Medicare Severity Long-Term Care Diagnosis-Related Groups (MS-LTC-DRGs).

The law requires CMS to update payment rates for IPPS hospitals annually and to account for changes in the prices of goods and services used by these hospitals in treating Medicare patients, as well as for other factors. The index used to do this is known as the IPPS Hospital Market Basket. The IPPS pays hospitals for services provided to Medicare beneficiaries using a national base payment rate, adjusted for a number of factors that affect hospitals' costs, including the patient's condition and the cost of hospital labor in the hospital's geographic area. CMS updates

LTCHs' payment rates annually according to a separate market basket based on LTCH-specific goods and services.

Changes to Payment Rates under IPPS

The increase in operating payment rates for general acute care hospitals that are paid under the IPPS, successfully participate in the Hospital Inpatient Quality Reporting (IQR) program and are meaningful electronic health record (EHR) users is 3.1%. This reflects a projected FY 2024 IPPS hospital market basket update of 3.3%, reduced by a statutorily required 0.2 percentage point productivity adjustment. The update reflects the most recently available forecasts of the price proxies underlying the market basket, including projected increases in compensation.

Hospitals may be subject to other payment adjustments under the IPPS, including:

- Payment reductions for excess readmissions under the Hospital Readmissions Reduction Program (HRRP).
- Payment reduction (1%) for the worst-performing quartile under the Hospital Acquired Condition (HAC) Reduction Program.
- Upward and downward adjustments under the Hospital Value-Based Purchasing (VBP) Program.

The increase in operating and capital IPPS payment rates will generally increase hospital payments in FY 2024 by $2.2 billion. In addition, CMS projects Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments combined will decrease in FY 2024 by approximately $957 million. This change reflects the CMS Office of the Actuary's use of updated estimates and data in its projections. CMS also estimates that additional payments for inpatient cases involving new medical technologies will decrease by $364 million in FY 2024, primarily driven by the expiration of new technology add-on payments for several technologies.

Changes to Payment Rates under LTCH PPS

For FY 2024, CMS expects the LTCH standard payment rate to increase by 3.3% and LTCH PPS payments for discharges paid the LTCH standard payment rate to increase by approximately 0.2%, or $6 million, due primarily to a projected 2.9% decrease in high-cost outlier payments as a percentage of total LTCH PPS standard federal payment rate payments. After consideration of public comments, CMS made modifications to the methodology used to determine the LTCH PPS high-cost outlier threshold for discharges paid the LTCH standard federal payment rate and finalized a threshold that is notably lower than in the proposed rule.

Continuation of the Low-Wage Hospital Policy

CMS will continue temporary policies finalized in the FY 2020 IPPS/LTCH PPS final rule to address wage index disparities affecting low-wage index hospitals, which includes many rural hospitals. At this time, we only have one year of relevant data (from FY 2020) that we could use to evaluate any potential impacts of this policy. As CMS does not have sufficient data from the time period this policy has been in effect, we believe it is appropriate to continue the policy while we obtain and review additional data.

Rural Emergency Hospitals (REHs) and Graduate Medical Education (GME)

This rule also includes changes to GME payments for training in the new Medicare provider type, the rural emergency hospital (REH), which was established by the Consolidated Appropriations Act, 2021, to address the growing concern over closures of rural hospitals. These changes help support graduate medical training in rural areas by allowing these rural hospitals to serve as training sites for Medicare GME payment purposes after they become REHs.

Health Equity Impacts

The rule also advances one of the goals of the CMS Framework for Health Equity 2022-2032 – to more explicitly measure the impact of our policies on health equity. As part of our growing capabilities in this area, we are adding 15 new health equity hospital categorizations for the FY 2024 IPPS payment impacts. Moving forward, one of the priorities of the CMS Framework for Health Equity 2022-2032 is to expand the collection, reporting, and analysis of standardized health equity data. As additional data become available, we plan to incorporate it on an ongoing basis into our impact analyses.

Social Determinants of Health Diagnosis (SDOH) Codes

IPPS payment is made based on the use of hospital resources in the treatment of a patient's severity of illness, complexity of service, and/or consumption of resources. Generally, a higher severity level designation of a diagnosis code results in a higher payment to reflect the increased hospital resource use. After review of our data analysis of the impact on resource use generated using claims data, CMS finalized a change to the severity designation of the three ICD-10-CM diagnosis codes describing homelessness (e.g., unspecified, sheltered, and unsheltered) from non-complication or comorbidity (NonCC) to complication or comorbidity (CC), based on the higher average resource costs of cases with these diagnosis codes compared to similar cases without these codes. This action is also consistent with the Administration's goal of advancing health equity for all, including members of historically underserved and under-resourced communities, as described in the President's January 20, 2021, Executive Order 13985 on "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government." As SDOH diagnosis codes are increasingly added to billed claims, CMS plans to continue to analyze the effects of SDOH on severity of illness, complexity of services, and consumption of resources.

Changes to the New COVID-19 Treatments Add-on Payment (NCTAP)

In response to the COVID-19 Public Health Emergency (PHE), CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) for eligible discharges during the PHE. In the FY 2022 IPPS/LTCH PPS final rule, we finalized a change to our policy to extend NCTAP through the end of the fiscal year in which the PHE ends, for all eligible products, to continue to mitigate potential financial disincentives for hospitals to provide these new treatments, and to minimize any potential payment disruption immediately following the end of the PHE. As the PHE ended on May 11, 2023, discharges involving eligible products will continue to be eligible for the NCTAP through September 30, 2023 (that is, through the end of FY 2023). The NCTAP will expire at the end of FY 2023, and no NCTAP will be made beginning in FY 2024 (that is, for discharges on or after October 1, 2023).

Changes to New Technology Add-on Payment (NTAP) Policies for FY 2024

To increase transparency and improve the efficiency of the NTAP program and application

process, CMS is finalizing its proposal to 1) require NTAP applicants for technologies that are not already FDA market authorized to have a complete and active FDA market authorization application request at the time of NTAP application submission, and 2) to move the FDA approval deadline from July 1 to May 1, beginning with applications for FY 2025. CMS believes these policy changes will improve the completeness of submitted NTAP applications, improve CMS's ability to provide a fuller analysis to identify eligibility concerns and allow the public the opportunity to more knowledgeably analyze applications and supporting data to provide public comment.

Changes to the Rural Wage Index Calculation Methodology

CMS has taken into consideration recent public comments that have urged it to change its wage index policies involving the treatment of hospitals that have reclassified from urban to rural under section 1886(d)(8)(E) of the Social Security Act (implemented in the regulations at §412.103). CMS is finalizing the proposal to interpret section 1886(d)(8)(E) of the Social Security Act as treating rural reclassified hospitals the same as geographically rural hospitals for purposes of calculating the wage index. Specifically, we will include hospitals with §412.103 reclassification along with geographically rural hospitals in rural wage index calculations beginning with FY 2024. Under Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33), the area wage index applicable for any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state. This provision is referred to as the rural floor. We will include the data of all §412.103 reclassified hospitals in the calculation of the wage index for the rural area of the state and the calculation of the rural floor for urban hospitals in the state.

Treatment of Section 1115 Demonstration Days for Purposes of Disproportionate Share Hospital (DSH) Payments

CMS is finalizing the changes to the regulations governing the counting of days associated with individuals 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 is not also entitled to Medicare Part A. In addition, days of patients for which hospitals are paid from demonstration-authorized uncompensated/undercompensated care pools may not be included. These changes were proposed for FY 2024 in a separate proposed rule issued in February 2023 (CMS 1788-P).

Physician-Owned Hospitals

For a hospital to submit claims and receive Medicare payment for services referred by a physician owner or investor (or a physician whose family member is an owner or investor), the hospital must satisfy all of the requirements of either the whole hospital exception or the rural provider exception to the physician self-referral law, commonly referred to as the "Stark Law."

To use the rural provider exception or the whole hospital exception, a hospital may not increase the aggregate number of operating rooms, procedure rooms, and beds above that for which the hospital was licensed on March 23, 2010 (or, in the case of a hospital that did not have a provider

agreement in effect as of March 23, 2010, but did have a provider agreement in effect on December 31, 2010, the effective date of such agreement), unless CMS has granted an exception to the prohibition on expansion. A hospital may request an exception to the prohibition on expansion of facility capacity using the process established in the calendar year (CY) 2012 hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system final rule.

In the FY 2024 IPPS/LTCH PPS final rule, CMS is:

- Revising the regulations to clarify that CMS will only consider expansion exception requests from eligible hospitals, clarifying the data and information that must be included in an expansion exception request, identifying factors that CMS will consider when making a decision on an expansion exception request, and revising certain aspects of the process for requesting an expansion exception.
- Reinstating, with respect to hospitals that meet the criteria for "high Medicaid facilities," program integrity restrictions on the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity that were removed in the CY 2021 OPPS/ASC final rule.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital IQR Program is a pay-for-reporting quality program that reduces payment to hospitals that fail to meet program requirements. Hospitals that fail to submit quality data or to meet all Hospital IQR Program requirements are subject to a one-fourth reduction in their Annual Payment Update under the IPPS.

In the FY 2024 IPPS/LTCH PPS final rule, CMS is finalizing the adoption of three new measures, the removal of three existing measures, and the modification of three current measures. CMS is also finalizing two changes to current policies related to data submission, reporting, and validation.

Specifically, CMS is adding three new electronic clinical quality measures (eCQMs) to the inventory of eCQMs from which hospitals can select to meet the eCQM reporting requirements for a given year for both the Hospital IQR and Medicare Promoting Interoperability Programs:

- Hospital Harm — Pressure Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Hospital Harm — Acute Kidney Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level — Inpatient) eCQM, with inclusion in the eCQM measure set beginning with the CY 2025 reporting period/FY 2027 payment determination.

CMS believes the adoption of the Hospital Harm-AKI and Hospital Harm-PI eCQMs will support CMS' goal of advancing health equity. AKI is more common in Black hospitalized patients than non-Black patients. Research has shown a higher prevalence of pressure injuries in patients with darker skin tones and that patients with darker skin tones are at higher risk of developing higher-stage pressure injuries. This research suggests that current skin assessment protocols could be less effective at assessing lower-stage pressure injuries for people with darker

skin tones. By adding these measures to the Hospital IQR Program, hospitals will be better able to implement appropriate quality improvement to reduce them.

CMS is finalizing modifications to three current measures:

- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality measure beginning with the FY 2027 payment determination. CMS is finalizing a modification to include Medicare Advantage (MA) admissions.
- Hybrid Hospital-Wide All-Cause Readmission measure beginning with the FY 2027 payment determination. CMS is finalizing a modification to include MA admissions.
- COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure beginning with the FY 2025 payment determination. The prior version of this measure reported on the primary vaccination series only, while the updated version of the measure reports the cumulative number of HCP who are up to date with recommended COVID-19 vaccinations to align CMS programs with the Centers for Disease Control and Prevention's (CDC's) definition of "up to date" vaccination, keeping the measure relevant if future vaccination guidance evolves. CDC vaccination guidance can be found at https://www.cdc.gov/nhsn/pdfs/hps/covidvax/UpToDateGuidance-508.pdf. This measure modification is a cross-program change for the Hospital IQR Program, PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, and the Long-Term Care Hospital Quality Reporting Program (LTCH QRP).

CMS is finalizing removal of three measures:

- Hospital-level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty measure beginning with the April 1, 2025, through March 31, 2028, reporting period/FY 2030 payment determination. CMS is finalizing removal of this measure under the Hospital IQR Program in conjunction with the adoption of the recent updates to this measure in the Hospital Value-Based Purchasing Program.
- Medicare Spending Per Beneficiary (MSPB) Hospital measure beginning with the CY 2026 reporting period/FY 2028 payment determination. CMS is finalizing removal of this measure under the Hospital IQR Program in conjunction with the adoption of the recent updates to this measure in the Hospital Value-Based Purchasing Program.
- Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation measure beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS is finalizing the removal of this measure because measure performance is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made (that is, "topped out"). The measure has been topped out for the last six performance periods. While CMS recognizes disparities persist in maternal health, we believe removal of the Elective Delivery measure will create room for us to add additional meaningful maternal health outcome measures in the future. The Biden-Harris Administration remains committed to advancing maternal health in the United States. CMS believes the several measures focused on maternal health (as finalized in the FY 2022 and 2023 IPPS/LTCH PPS final rules), including the Maternal Morbidity structural measure, the Cesarean Birth eCQM, the Severe Obstetrics Complications eCQM, and finalized the creation of the "Birthing-Friendly" hospital quality designation will continue to monitor and drive care improvements.

CMS is finalizing updates to the data submission and reporting requirements for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey measure beginning with the CY 2025 reporting period/FY 2027 payment determination. These updates include three new web-first modes of survey implementation, removal of the survey's prohibition on proxy respondents, extension of the data collection period from 42 to 49 days, limiting the number of supplemental survey items to 12, requiring the official Spanish translation for Spanish language-preferring patients, and removing two administration methods that are not used by participating hospitals. In a 2021 mode experiment, these changes, which are also being made in the Hospital VBP and PCHQR Programs, resulted in higher response rates and better representation of younger, Spanish language-preferring, racial and ethnic minority, and maternity care patients.

In addition, CMS received feedback from stakeholders on the potential future inclusion of two geriatric measures: the Geriatric Hospital and Geriatric Surgical structural measures, and on the establishment of a publicly reported hospital designation to capture the quality and safety of patient-centered geriatric care.

Medicare Promoting Interoperability Program

In 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Medicare Promoting Interoperability Program) to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record (EHR) technology (CEHRT).

CMS is finalizing the following changes to the Medicare Promoting Interoperability Program for eligible hospitals and CAHs:

- Modify 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, beginning with the EHR reporting period in CY 2024.
- Amend the definition of "EHR reporting period for a payment adjustment year" for participating 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.
- Amend the definition of "EHR reporting period for a payment adjustment year" such that eligible hospitals that have not successfully demonstrated meaningful EHR use in a prior year will not be required to attest to meaningful use by October 1st of the year prior to the payment adjustment year, beginning with the EHR reporting period in CY 2025.
- Modify the response options related to unique patients or actions for objectives and measures for the Medicare Promoting Interoperability Program for which there is no numerator and denominator, and for which unique patients or actions are not counted. The response option for these objectives and measures would read "N/A (measure is Yes/No)."
- Adopt three new eCQMs eligible hospitals, and CAHs can select as one of their three self-selected eCQMs, in alignment with the Hospital IQR Program, beginning with the CY 2025 reporting period:
    - Hospital Harm — Pressure Injury eCQM
    - Hospital Harm — Acute Kidney Injury eCQM

- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level — Inpatient) eCQM

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The PCHQR Program is a quality reporting program for the eleven cancer hospitals that are statutorily exempt from the IPPS. CMS collects and publishes data from PCHs on applicable quality measures. In the FY 2024 IPPS/LTCH PPS final rule, CMS is finalizing the following:

- Beginning public display of the Surgical Treatment Complications for Localized Prostate Cancer measure beginning with data from the FY 2025 program year.
- Adoption of four new measures for the PCHQR Program:
  - Facility Commitment to Health Equity beginning with the FY 2026 program year.
  - Screening for Social Drivers of Health beginning with voluntary reporting for the FY 2026 program year and mandatory reporting for the FY 2027 program year.
  - Screen Positive Rate for Social Drivers of Health beginning with voluntary reporting for the FY 2026 program year and mandatory reporting for the FY 2027 program year.
  - Documentation of Goals of Care Discussions Among Cancer Patients beginning with the FY 2026 program year.
- Modification of the COVID-19 Vaccination Coverage among HCP measure, in alignment with the Hospital IQR Program and LTCH QRP.
- Modification of the data submission and reporting requirements for the HCAHPS survey measure beginning with the FY 2027 program year.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program is a value-based purchasing program that reduces payments to hospitals with excess readmissions. It also supports CMS' goal of improving health care for patients by linking payment to the quality of hospital care. CMS did not propose or finalize any changes to the Hospital Readmissions Reduction Program. We note that all previously finalized policies under this program will continue to apply and refer readers to the FY 2023 IPPS/LTCH PPS final rule (87 FR 49081 through 49094) for information on these policies.

Hospital-Acquired Condition (HAC) Reduction Program

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by reducing Medicare fee-for-service (FFS) payment by 1% for applicable hospitals that rank in the worst performing quartile on the measures of hospital-acquired conditions. In the FY 2024 IPPS/LTCH PPS final rule, CMS is finalizing the following proposals to:

- Establish a validation reconsideration process for hospitals that failed to meet data validation requirements, beginning with the FY 2025 program year, affecting CY 2022 discharges.
- Modify the targeting criteria for data validation to include hospitals that received an Extraordinary Circumstances Exception (ECE) during the data periods validated beginning with the FY 2027 program year, affecting CY 2024 discharges.

In addition, CMS provided a summary of the comments received on our request for feedback on potential future measures and program modifications that would advance patient safety and reduce health disparities.

Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program is a budget-neutral program funded by reducing participating hospitals' base operating DRG payments each fiscal year by 2% and redistributing the entire amount back to the hospitals as value-based incentive payments. In the FY 2024 IPPS/LTCH PPS final rule, CMS is finalizing the proposals to:

- Adopt the Severe Sepsis and Septic Shock: Management Bundle measure in the Safety Domain beginning with the FY 2026 program year.
- Adopt a health equity scoring change for rewarding excellent care in underserved populations such that a health equity adjustment would be added to hospitals' Total Performance Scores (TPS) based on both a hospital's performance on existing Hospital VBP Program measures and the proportion of individuals with dual eligibility status that a hospital treats. As a result, CMS is also finalizing the proposal to modify the TPS maximum to 110, such that the numeric score range would be 0 to 110.
- Adopt substantive measure modifications to the MSPB Hospital measure, allowing readmissions to trigger new episodes, beginning with the FY 2028 program year.
- Adopt substantive measure modifications to the Hospital-level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty, adding additional mechanical complication ICD-10 codes to the measure, beginning with the FY 2030 program year.
- Adopt changes to the data submission and reporting requirements of the HCAHPS survey measure beginning with the FY 2027 program year.
- Codify the measure removal factors, the health equity scoring change and modification of the TPS numeric score range, and the minimum number of cases.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

The LTCH QRP is a pay-for-reporting program. LTCHs that do not meet reporting requirements are subject to a two-percentage-point reduction in their Annual Increase Factor. In the FY 2024 IPPS/LTCH PPS final rule, CMS is finalizing the following proposals:

- Beginning with the FY 2026 LTCH QRP, CMS finalized the **adoption of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident level COVID-19 Vaccine) measure**. The measure reports the percentage of stays in which patients in an LTCH are up to date with their COVID-19 vaccinations per the latest guidance of the CDC. Data would be collected using a **new** standardized item on the LCDS. The measure has the potential to increase COVID-19 vaccination coverage of patients in LTCHs.
- Beginning with the FY 2025 LTCH QRP, CMS finalized the adoption of **the Functional Discharge (DC Function) measure**. This assessment-based outcome measure assesses functional status by assessing the percentage of LTCH patients who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the assessment tool. The adoption of this measure would replace the topped-out process measure, Application of Functional Assessment and Care Plan.

- Beginning with the FY 2025 LTCH QRP, we finalized to update **the COVID-19 Vaccination Coverage among HCP measure**, in alignment with the Hospital IQR and PCHQR Programs.
- Beginning with the FY 2025 LTCH QRP, we finalized the removal of the **Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (Application of Functional Assessment/Care Plan) measure**. Our regulations describe eight factors we consider for measure removal from the LTCH QRP. CMS finalized this measure's removal for two reasons. First, the Application of Functional Assessment/Care Plan meets the conditions for measure removal factor 1, "topped out." Second, this measure meets measure removal factor 6, as there is an available measure that is more strongly associated with desired patient functional outcomes.
- Beginning with the FY 2025 LTCH QRP, CMS finalized the removal of the **Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (Functional Assessment/Care Plan) measure.** CMS finalized this measure's removal because it meets the conditions for removal factor 1, "topped out."
- Beginning with the FY 2026 LTCH QRP, CMS finalized to increase the LTCH QRP Data Completion Thresholds for the LCDS Data Items. CMS finalized that LTCHs must report 100% of the required quality measure data and standardized patient assessment data collected using the LCDS on at least 85% of the assessments they submit through the CMS designated submission system. Any LTCH that does not meet the finalized requirement that 85% of all LCDS assessments submitted contain 100% of required data items will be subject to a reduction of two percentage points to the applicable FY APU beginning with FY 2025.
- Beginning with the September 2024 Care Compare refresh or as soon as technically feasible, CMS finalized the public reporting of the **Transfer of Health Information to the Provider** — PAC Measure (TOH-Provider) and the **Transfer of Health Information to the Patient** — PAC Measure (TOH-Patient) measures. The measures report the percentage of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider and/or to the patient/family/caregiver at discharge or transfer.

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