Medicare Inpatient Prospective Payment System

Final Payment Rule Brief Provided by the Wisconsin Hospital Association

Program Year: FFY 2025

Overview and Resources

On August 1, 2024, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2025 final rule for the Medicare Inpatient Prospective Payment System (IPPS). The final rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, the following policies are being adopted in this rule:

- Utilizing FFY 2023 Medicare Provider and Review (MedPAR) and FFY 2022 Hospital Cost Reporting Information System (HCRIS) data for standard calculations;
- Updating area wage indexes using county and Core-Based Statistical Area (CBSA) delineations based on Office of Management and Budget (OMB) Bulletin No. 23-01;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies, including hospital eligibility for DSH Uncompensated Care (UCC) payments in FFY 2025 being based on audited FFYs 2019, 2020, and 2021 S-10 data;
- Distribution of additional Graduate Medical Education (GME) residency slots as required by the Consolidated Appropriations Act (CAA) of 2023;
- Implementation of the Transforming Episode Accountability Model (TEAM) which will test whether financial accountability for five procedures will reduce Medicare expenditures while maintaining quality of care for beneficiaries;
- A separate IPPS payment for small, independent hospitals to voluntarily establish and maintain a 6-month buffer stock of one or more essential medicines;
- Updates to the Value-Based Purchasing (VBP) Program; and
- Updates to the payment penalties for non-compliance with the Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) incentive programs.

Program changes will be effective for discharges on or after October 1, 2024, unless otherwise noted. CMS estimates the overall impact of this final rule update to be an increase of approximately $3.2 billion in aggregate payments for acute care hospitals in FFY 2025. This estimate includes increased operating and capital payments and decreases due to the expiration of the low-volume and Medicare Dependent Hospital (MDH) programs as of January 1, 2025.

A copy of the final rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page.

An online version of the final rule will be available on August 28, 2024 at https://www.federalregister.gov/d/2024-17021.

Note: Text in italics is extracted from the August 1, 2024 Display version of the final rule unless otherwise noted.

IPPS Payment Rates

Display pages 893–913, 1116–1143, 2663–2737, and 2739–2763

The table below lists the federal operating and capital rates finalized for FFY 2025 compared to the rates currently in effect for FFY 2024. These rates include all market basket increases and reductions as well as the application of adopted annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g. penalty

for non-compliance under the IQR Program and EHR Meaningful Use (MU) Program, quality penalties/payments, DSH, etc.).

	Final FFY 2024	Final FFY 2025	Percent Change
Federal Operating Rate	**$6,497.77**	**$6,606.51** (proposed at $6,666.10)	**+1.67%** (proposed at +2.59%)
Federal Capital Rate	**$503.83**	**$510.51** (proposed at $516.41)	**+1.33%** (proposed at +2.50%)

The following table provides details for the final annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2025.

	Federal Operating Rate	Hospital Specific Rate	Federal Capital Rate
Market Basket/Capital Input Price Index update	**+3.4%** (proposed at +3.0%)		**+2.6%** (proposed at +2.5%)
ACA-Mandated Productivity Adjustment	**-0.5 percentage points (PPTs)** (proposed at -0.4 PPTs)		—
Forecast Error Adjustment	—		**+0.5 PPTs** (as proposed)
Lowest Quartile Wage Index Adjustment	**-0.02%** (proposed at +0.01%)	—	**-0.06%** (proposed at -0.21%)
Wage Index Cap Policy	**-0.05%** (proposed at -0.25%)	—	
MS-DRG Weight Cap Policy	**-0.01%** (proposed at -0.04%)		**-0.01%** (proposed at -0.04%)
All Other Annual Budget Neutrality Adjustments	**-1.11%** (proposed at +0.27%)	**-0.28%** (proposed at +0.29%)	**-1.65%** (proposed at -0.24%)
Net Rate Update	***+1.67%*** *(proposed at +2.59%)*	***+2.6%*** *(proposed at +2.26%)*	***+1.33%*** *(proposed at +2.50%)*

- **Effects of the IQR and EHR MU Incentive Programs** ***(Display pages 893, 908–913, and 2663–2664)***: The IQR market basket penalty imposes a 25% reduction to the full market basket and the EHR MU penalty imposes a 75% reduction to the full market basket; hence the entirety of the full market basket update is at risk between these two penalty programs. A table displaying the various update scenarios for FFY 2025 is shown below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (3.4% MB less 0.5 PPT productivity adjustment)	**+2.9%**			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.4%)	—	**-0.85 PPT**	—	**-0.85 PPT**
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.4%)	—	—	**-2.55 PPT**	**-2.55 PPT**
Adjusted Net Market Basket Update (prior to other adjustments)	***+2.9%***	***+2.05%***	***+0.35%***	***-0.5%***

- **Outlier Payments** ***(Display pages 2690–2735 and 2750–2752)*****:** On March 28, 2024, CMS issued Change Request 13566, available at https://www.cms.gov/medicare/regulations-guidance/transmittals/2024-transmittals/r12558cp, which expands the criteria for identifying cost reports which Medicare Administrative Contractors (MACs) are to refer to CMS for approval of outlier reconciliation for cost reports beginning on or after October 1, 2024. Specifically, MACs are to identify for CMS any instances where:
    - the actual operating cost-to-charge ratio (CCR) is 20% or more from the operating CCR used during that time period to make outlier payments; and

- the total operating and capital outlier payments for the hospital exceed $500,000 during that cost report period.

These new criteria will be in addition to the previously adopted methodology that incorporates historic cost report outlier reconciliations to develop the outlier threshold. Therefore, for FFY 2025, CMS will incorporate total outlier reconciliation dollars from the FFY 2019 cost reports into the outlier model using a similar methodology to what was finalized in FFY 2020, modified to reflect the additional cost reports identified due to the new criteria. Since the new criteria are not effective until the FFY 2025 cost reports, CMS is adopting to apply the criteria to FFY 2019 cost reports as if they had been in place at the time of cost report settlement and estimate outlier reconciliation dollars based on these cost reports and other supplemental data collected from MACs. CMS lists the adopted steps for this process on *Display* pages 2698–2705 for the operating reconciliations and *Display* pages 2707-2714 for the capital reconciliations.

An analysis done by CMS using this new methodology determined outlier payments at 5.14% (as proposed) of total IPPS payments. CMS is adopting an outlier threshold of $46,152 (proposed at $49,327) for FFY 2025, which includes a charge inflation factor calculated using the March 2023 MedPAR file for FFY 2022 charge data and the March 2024 MedPAR file of FFY 2023 charge data. This threshold is 8.0% higher than the FFY 2024 outlier threshold of $42,750.

Additionally, CMS will continue to use the estimated per-discharge Indian Health Service (IHS)/Tribal and Puerto Rico supplemental payments in the calculation of the outlier fixed-loss cost threshold, consistent with the policy of including estimated uncompensated care payments.

- **Stem Cell Acquisition Budget Neutrality Factor** (***Display page 1610–1611 and 2665–2666***): CMS will continue to not remove the Stem Cell Acquisition budget neutrality factor and to not apply a new factor for FFY 2025 as they do not believe that it would satisfy budget neutrality requirements. CMS intends to consider using cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

Wage Index

Display pages 669–808, 2675–-2677, 2680–2681, 2687–2689, and 2737–2739

- **Updated CBSA Delineations** (***Display pages 672-692, 728-729, and 742-769***)**:** On July 21, 2023, the OMB issued OMB Bulletin No. 23-01 (https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf) that made a number of significant changes related CBSA delineations. To align with these changes, CMS is adopting the newest OMB delineations for the FFY 2025 IPPS wage index.

  In adopting these delineations, 54 counties and 33 hospitals that are currently part of an urban CBSA will be considered located in a rural area (including one urban county in Connecticut being redesignated to a newly adopted rural CBSA), listed in the table on *Display* pages 677–678.

  Providers who will lose their urban status due to these adopted delineation changes will receive an adjustment to their DSH payments equal to two-thirds of the difference between their previous urban DSH payments and current rural DSH payments for the first year after losing urban status. In the second year after losing urban status, these providers will have their DSH payments adjusted to be one-third of the difference between their previous urban DSH payments and current rural DSH payments.

  Additionally, these updated delineations will cause 54 counties and 24 hospitals that are currently located in rural areas to be considered located in urban areas, listed in the table on *Display* pages 679–680. Due to these revisions, some critical access hospitals (CAH) previously located in rural areas may now be located in urban areas. Affected CAHs must reclassify as rural within a two year transition period, beginning from the date the redesignation becomes effective, in order to retain their CAH. Additionally, special statuses limited to hospitals in rural areas may be terminated unless the hospital is granted a rural reclassification prior to October 1, 2024.

  Lastly, adopting these delineations will cause some urban counties to shift between new or existing urban CBSAs. In some cases, this changes the name or numbers of certain CBSAs. This detail can be found in the tables on *Display* pages 681–684.

Along with the above changes, 17 of the urban counties that will become rural will be added to the list of "Lugar" counties whose hospitals are deemed to be in an urban area. CMS also determined 33 rural counties that will become urban will lose "Lugar" status. The tables on *Display* pages 764–768 show the "Lugar" status for all counties and CBSAs for FFY 2025.

CMS is also adopting that for counties that are removed from a CBSA and become rural, a hospital that is reclassified to that CBSA with a current "home area" reclassification will receive the wage index applicable to other hospitals that reclassify into that CBSA, rather than the geographic wage index. CMS notes that this wage index may be lower than the wage index calculated for hospitals geographically located in that CBSA due to hold harmless provisions.

In the case where a CBSA adds or loses a current rural county, a hospital with a current reclassification to the resulting CBSA will be maintained. CMS will maintain Medicare Geographic Classification Review Board (MGCRB) "home area" reclassifications that reclassify a hospital to one of these counties. Additionally, if a county is removed from a CBSA and becomes rural, then a hospital in that county with a "home area" reclassification will no longer be geographically located in the CBSA to which they are reclassified. Thus, these reclassifications will no longer be "home area" reclassifications. The table on *Display* page 520 shows the six hospitals for which CMS will terminate reclassifications.

Hospitals which reclassify to CBSAs where one or more counties move to a new or different urban CBSA will continue to be reclassified to each of their geographic "home area". These could differ from previous years, with affected providers listed in the table on *Display* pages 748–749.

For a hospital that currently have a reclassification that could not continue to their reconfigured CBSA (not including "home area" reclassifications), CMS will assign the hospital to another CBSA under the revised delineations that contains at least one county from their previous reclassified CBSA and that is generally consistent with rules that govern geographic reclassification. Table X on *Display* page 750 lists the eligible CBSAs that hospitals in CBSAs in the situation above could instead reclassify to. Table Y on *Display* pages 752–753 shows all providers subject to this policy. CMS is adopting similar policies to account for reclassifications that will be affected by using Connecticut planning regions rather than counties, which can be found on *Display* pages 753–756.

Hospitals in the case described above that wish to be reassigned to a different eligible CBSA, to which the applicable proximity criteria are met, may request reassignment within 45 days of the display date of the annual notice of proposed rulemaking. This request must be sent to wageindex@cms.hhs.gov and include documentation establishing that they meet the proximity requirements for reassignment to an alternate CBSA that contains one or more counties from the CBSA to which they are currently classified. For hospitals that wish to withdraw or terminate their MGCRB reclassification, CMS is finalizing that that providers will have to submit these requests within 45 days of the display date of a proposed rule or within seven calendar days of receiving a decision from the MGCRB on their classification status, whichever is later.

Since CMS already applies a 5% cap on wage index loses from year to year, CMS does not believe any additional transition policies are needed to account for the changes in wage index.

- **Permanent Cap on Wage Index Decreases** ***(Display pages 802–804 and 2688–2689)*****:** CMS applies a 5% cap on any decrease to the IPPS wage index, compared with the previous year's final wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IPPS provider's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. If a hospital reclassifies as rural under 42 CFR §412.103 with an effective date after this day, the policy will apply to the reclassified wage index instead. Additionally, a new IPPS is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS will not have a wage index in the prior FFY.

This policy is implemented in a budget neutral manner with a final net budget neutrality factor of 0.99953 (proposed at 0.99752) to be applied to the federal operating rate, after backing out the effects of the FFY 2024 adjustment.

- **Out-Migration Adjustments** ***(Display pages 777–780)*****:** For FFY 2025 and onward, CMS will update out-migration adjustments to be based on a custom tabulation of the American Community Survey utilizing data from 2016-2020. This is consistent with methodology used for determining FFY 2012 out-migration adjustments. Adopted out-migration adjustments can be found in Table 2 released with this final rule.

- **Addressing Wage Index Disparities between High and Low Wage Index Hospitals** ***(Display pages 780–802 and 2687–2688)*****:** In the FFY 2019 IPPS proposed rule, CMS had summarized that many comments from the Wage Index Request for Information *"a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals."* As a result, CMS had made a variety of changes in the FFY 2020 final rule to reduce the disparity between high and low wage index hospitals.

  As adopted, this policy was to be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years. CMS believes that the effects of the COVID-19 public health emergency (PHE) has complicated their ability to evaluate how successful this low wage index hospital policy was for increasing employee compensation. As such, CMS will continue the policy that hospitals with a wage index value in the bottom quartile of the nation will have that wage index increased by a value equivalent to half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals. This continuation will be in effect for at least three more years, beginning in FFY 2025, so that the policy will be in effect for at least four full fiscal years after the end of the COVID-19 PHE.

  CMS notes that this policy is subject to litigation (*Bridgeport Hospital, et al., v. Becerra)* in which the court found that the Secretary did not have the authority to adopt this low wage index policy and has ordered additional briefing on an appropriate remedy. On July 23, 2024, the U.S. Court of Appeals for the D.C. Circuit affirmed the lower court's ruling, holding that this policy for FFY 2020 was unlawful and that CMS had no statutory authority to issue it. As a result, the court ordered that the rule be vacated and that hospitals affected by the budget neutrality adjustment are entitled to back-payments, including interest. As of the publication of this rule there is still time for the government to seek further review about this decision.

  CMS will continue to offset these wage index increases in a budget neutral manner by applying a budget neutrality adjustment to the national standardized amount. The value of the 25th percentile wage index for FFY 2025 is 0.9007 (proposed at 0.8879), and the net budget neutrality adjustment will be 0.99975 (proposed at 1.0001) to be applied to the federal operating rate, after backing out the effects of the FFY 2024 adjustment.

- **Occupational Mix Adjustment** ***(Display pages 719–725)*****:** CMS is adopting the use of the calendar year (CY) 2022 Occupational Mix Survey for the calculation of the wage index for FFY 2025. The FFY 2025 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS has finalized a FFY 2025 occupational mix adjusted national average hourly wage of $54.97 (proposed at $54.73).

- **Rural Reclassification Policy Updates** ***(Display pages 726–742)*****:** CMS currently has a policy to terminate MGCRB reclassification status for hospitals with terminated CMS certification numbers (CCN), part of which helps mitigate the impact the hospital has on their area wage index. However, this policy does not consider §412.103 reclassifications as they were less common at the time of this policy's adoption. Due to the wage index policies for calculating rural wage index values adopted in the FFY 2024 final rule, CMS states that hospitals reclassified as rural under §412.103 now have a larger impact on calculating the rural wage index than they had prior to this rulemaking. As such, CMS is adopting that §412.103 reclassifications will be considered cancelled for any hospital with a CCN listed as terminated or "tied-out" as of the date that the hospital ceased to operate with an active CCN. This cancellation policy will be for the purposes of calculating the area wage index and is not intended to impact qualification for rural reclassifications or other effects unrelated to hospital wage index calculations.

Additionally, CMS is updating regulations under §412.230 to clarify that urban hospitals that reclassify as rural under §412.103 are considered to be located in either their geographic area or rural area of the state for the purposes of determining wage index for that hospital, instead of just the rural area of the state in which the provider is located. Under this revision, the regulation text is updated to read: *"An individual hospital may not be redesignated to another area for purposes of the wage index if the pre-reclassified average hourly wage for that area is lower than the pre-reclassified average hourly wage for the area in which the hospital is located. An urban hospital that has been granted redesignation as rural under § 412.103 is considered to be located either in its geographic area or in the rural area of the State for the purposes of this paragraph (a)(5)(i)."*

- **Rural Emergency Hospitals (REH)** (***Display pages 699–700***): CMS believes that REHs should be treated similarly to CAHs when calculating the wage index, since hospitals which converted to REH status do not provide acute care inpatient services. As such, CMS will exclude REHs from the calculation of the wage index.
- **Labor-Related Share** ***(Display pages 805–808)*****:** The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2025, CMS will continue to apply a labor-related share of 67.6% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

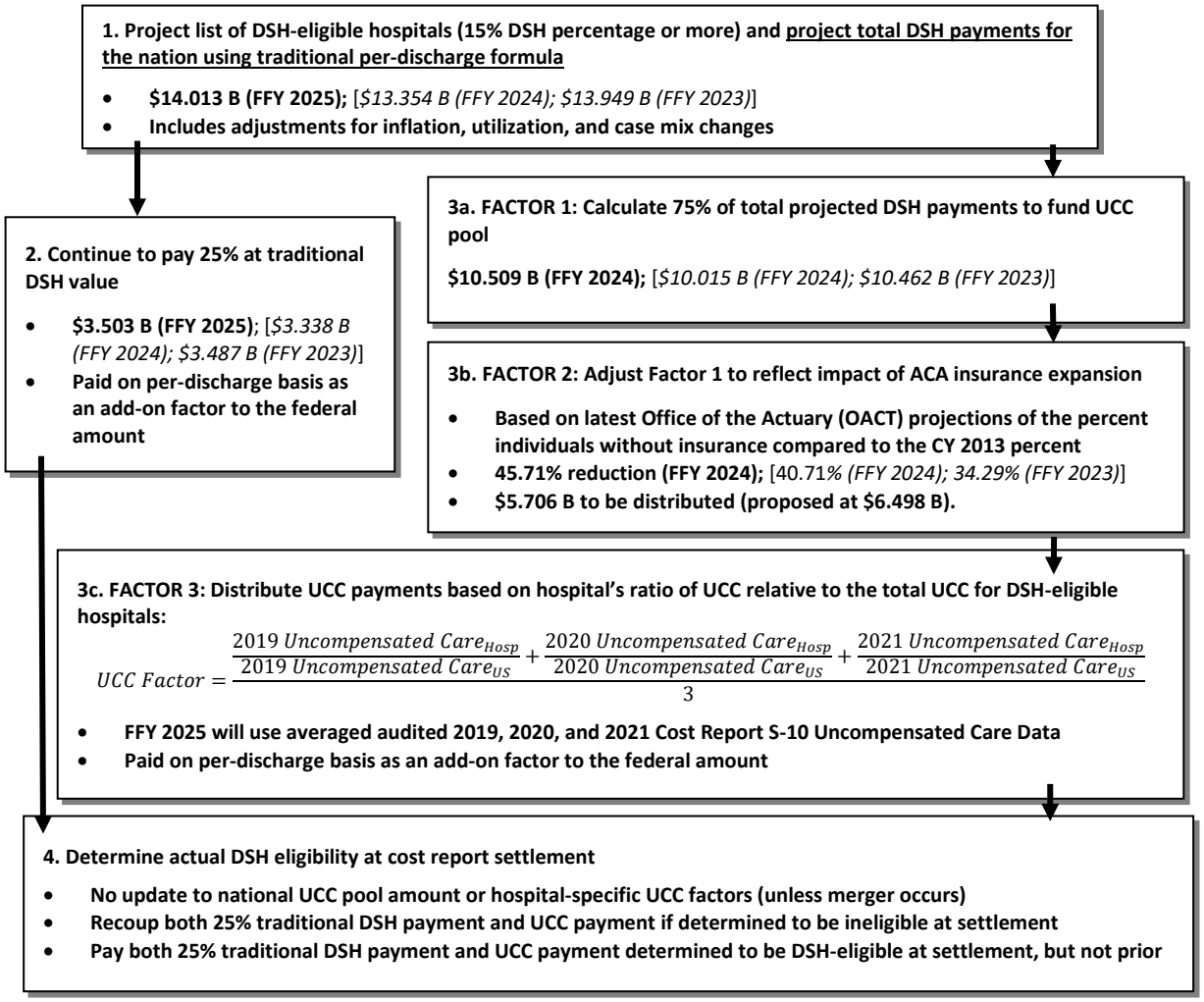
A complete list of the final wage indexes for payments in FFY 2025 is available on the CMS website at https://www.cms.gov/files/zip/fy2025-ipps-nprm-tables-2-3-4a-4b.zip.

DSH Payments

Display pages 809–883

The ACA mandates the implementation of Medicare DSH calculations and payments in order to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds, using the traditional formula, must continue to be paid to DSH-eligible hospitals. The remaining 75% of the funds, referred to as the UCC pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

- **Eligibility for FFY 2025 DSH UCC Payments** ***(Display pages 813–817)*****:** CMS is projecting that 2,399 (proposed at 2,422) hospitals may be eligible for DSH UCC payments in FFY 2025 based on audited FFY 2019, FFY 2020, and FFY 2021 S-10 data. CMS has made a file available that includes estimated DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology. The file is available at https://www.cms.gov/files/zip/fy2025-ipps-nprm-medicare-dsh-supplemental-data-file.zip.
- **DSH Payment Methodology for FFY 2025** ***(Display pages 823–874)*****:** The following schematic describes the DSH payment methodology mandated by the ACA along with how the program will change from FFY 2024 to FFY 2025:



CMS states that final projected CY 2024 and CY 2025 uninsured rates are lower relative than those in the proposed rule due to higher expected enrollment in Marketplace plans due to "*…i) the Inflation Reduction Act's extension of the American Rescue Plan Act's enhanced Marketplace premium subsidies through 2025 and ii) a Special Enrollment Period open to those who are no longer eligible for Medicaid coverage due to state-based redeterminations."* As such, DSH UCC dollars available to hospitals under the ACA's payment formula will decrease by $0.232 billion in FFY 2025 relative to FFY 2024.

- **Adjustment to Factor 3 Determination *(Display pages 846–874)*:** CMS uses the most recent three years of audited cost report data in the determination of Factor 3. Specifically, for FFY 2025 CMS will use FFYs 2019, 2020, and 2021 for this determination. Hospitals that do not have data for all three years will have their Factor 3 determined based on the average of the available data for the appropriate years. In the rare case when CMS uses a cost report that starts in one FFY and spans the entirety of the subsequent FFY, the same cost report will not be used to determine UCC costs for the earlier FFY. As an alternative for the earlier FFYs, the most recent prior cost report that spans some portion of that FFY will be used. To ensure that total UCC payments for all eligible hospitals are consistent with the total estimated UCC amount made available to hospitals, a scaling factor will be applied to the Factor 3 values for each of these hospitals. For each DSH-eligible hospital, this scaling factor is calculated as:

$$\frac{1}{Actual\ sum\ of\ all\ hospital\ Factor\ 3\ values}.$$

This quotient is then multiplied by the UCC payment determined for each DSH-eligible hospital to obtain a scaled UCC payment amount. This process ensures that the sum of the scaled UCC payments for all hospitals is consistent with the estimate of the total amount available to make UCC payments.

For new hospitals, CMS is continuing the policy that if the hospital has a preliminary projection of being eligible for DSH it may receive interim DSH payments but would not receive interim UCC payments. Factor 3 for new hospitals would use a denominator based solely on UCC costs from cost reports for the most recent year for which audits have been conducted. The resulting Factor 3 would then have a scaling factor applied to it to assure that the total UCC pool is paid out. This also applies to newly merged hospitals with data based on the surviving hospital's CCN. If the hospital's cost reporting period is less than 12 months, the data from the newly merged hospital's cost report is annualized.

Based on commenter's concerns regarding a trend in decreasing discharge volume and possible overestimation of discharges in recent years, CMS is modifying its proposal to omit FFY 2021 data from the calculation of interim UCC payments. Thus, FFYs 2022 and 2023 discharge data will be used to calculate this average for FFY 2025. For FFY 2026 and subsequent years, CMS is adopting that a hospital's most recent three-year average discharge number will be used to estimate interim uncompensated care payment per discharge. As in past years, interim payments made using this value will be reconciled at cost report settlement to equal the uncompensated care pool distribution amount that will be published with accompanying final rule.

CMS will continue to trim CCRs in the calculation of Factor 3. If unaudited UCC costs for a FFY are greater than 50% of total operating costs for that FFY, then a ratio of UCC costs to the hospital's total operating costs for the other year is be applied to the total operating costs of the aberrant year. Additionally, for hospitals that have not had their FFY 2019, FFY 2020, and/or FFY 2021 cost reports audited, CMS will continue the policy for an alternative trimming methodology using a threshold of three standard deviations from the mean ratio of insured patients' charity care costs to total uncompensated care costs, and a dollar threshold that is the median total uncompensated care cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible, including IHS, Tribal, and Puerto Rico hospitals. Specifically, in cases where a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care to total UCC costs is greater than 60%, CMS excludes the hospital from the prospective Factor 3 calculation. For hospitals subject to this alternate trim and determined to be DSH-eligible at cost report settlement, CMS will continue to apply its policy where those hospitals' UCC payments will be calculated after their MACs have reviewed the UCC information reported on worksheet S-10, subject to the previously mentioned scaling factor.

- **Impact on Traditional DSH Payment Adjustments due to CBSA Delineation Updates *(Display pages 875–876)*:** Hospitals with less than 500 beds that are currently located in an urban county that becomes rural under the adopted CBSA updates are subject to a maximum DSH payment adjustment of 12% unless they are eligible to be designated as a rural referral center (RRC) or MDH. Providers who lose their urban status due to these policies will receive an adjustment to their DSH payments equal to two-thirds of the difference between their previous urban DSH payments and current rural DSH payments for the first year after losing urban status. In the second year after losing urban status, these providers will have their DSH payments adjusted to be one-third the difference between their previous urban DSH payments and current rural DSH payments.

GME Payments and Additional Residency Slots

Display pages 31–32 and 943–1042

The CAA of 2023 requires CMS to distribute 200 additional residency positions (slots), at least 100 of which must be psychiatry or psychiatry subspecialty residency training programs, to hospitals for FFY 2026. Each qualifying hospital that is approved for these positions will receive an increase to their resident limit, be notified of the positions distributed to them by January 31, 2026, and have the increase effective as of July 1, 2026. It is also required that at least 10% of the total residency positions be distributed to each of:

- Category One - Hospitals located in rural areas or that are being treated as being located in a rural area;

- Category Two - Hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit;
- Category Three - Hospitals in states with new medical schools or additional locations of existing medical schools; and
- Category Four - Hospitals that serve a Health Professional Shortage Area (HPSA).

As such, CMS is defining a qualifying hospital as one that fits into one or more of these categories.

Each qualifying hospital that submits a timely application is required to at least one (or a fraction of one) of the residency positions before any qualifying hospital receives more than one. These include:

- a hospital may not receive more than 10 additional full-time equivalent (FTE) residency positions
- no increase in the otherwise applicable resident limit of a hospital may be made unless the hospital agrees to increase the total number of FTE residency positions under the approved medical residency training program of the hospital by the number of positions made available to that hospital
- if a hospital that receives an increase to its otherwise applicable resident limit is eligible for an increase to its otherwise applicable resident limit, that hospital must ensure that residency positions received are used to expand an existing residency training program and not for participation in a new residency training program

Details on the limitations on the distribution of these residency positions can be found on *Display* pages 963–1024.

In determining the qualifying hospitals for which an increase is provided, CMS must take into account the "demonstrated likelihood" of the hospital filling these positions withing the first five training years beginning after the date the increase would be effective. CMS requires providers to submit copies of their most recently submitted Cost Report Worksheet E, Part A and Worksheet E-4 as part of the application for the increase to its FTE resident cap in addition to demonstrating they meet at least one of the two "demonstrated likelihood" criteria listed on *Display* pages 948–949.

CMS will use the *County to CBSA Crosswalk and Urban CBSAs and Constituent Counties for Acute Care Hospitals* file and Table 2 from the most recent FFY IPPS final rule, or similar successor files, to determine if a provider is located or treated as being located in a rural area.

To determine hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit, CMS uses definitions of the terms "otherwise applicable resident limit", "reference resident level", and "resident level" similar to those adopted in CY 2011 Outpatient Prospective Payment System (OPPS) rulemaking, as revised by the CAA of 2021.

Display page 960 lists states that are finalized as having new medical schools or additional locations of existing medical schools.

For an applying hospital to show that they serve a HPSA, the hospital must train residents in a program in which the residents rotate for at least 50% of their training time to a training site located in a primary care or mental-health-only geographic HPSA. These hospitals must submit an attestation that this requirement is met, signed, and dated by an officer or administrator of the hospital who signs the hospital's cost reports. CMS is also adopting that, specific to mental-health-only HPSAs, the program must be a psychiatry program or subspecialty of psychiatry.

For FFY 2026, the application deadline for these positions will be March 31, 2025, with March 31 of each subsequent year being the deadline for applications starting the following FFY.

In this final rule, CMS is providing public notification of the closure of one teaching hospital for the purposes of the established application process for the resident slots attributed to this hospital.

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME Cap (includes all adjustments)	DGME Cap (includes all adjustments)
520013	Sacred Heart Hospital	Eau Claure, WI	20740	3/22/2024	7.62	7.80

The IME adjustment factor will at 1.35 for FFY 2025.

- **Modifications to the Criteria for New Residency Programs and Requests for Information (RFIs)** ***(pages 1024–1034)*****:** Currently, CMS considers a residency program to be "new" if the residents are new, the program director is new, and the teaching staff are new. In recent years, CMS has received questions regarding the application of these criteria and what constitutes a "new" program, in light of urban hospitals being able to reclassify as rural for IME purposes.

  In the FFY 2025 IPPS proposed rule CMS proposed that, for an "overwhelming majority" of residents in a program to be new, at least 90% of individual residents (not FTEs) enrolled in a program must not have had previous training in the same specialty as the new program. However, CMS understands there may be challenges with small or unique programs, and therefore CMS had solicited comments on what should be considered a "small" program and what percentage threshold, or other approach should be applied to measure newness in terms of residents.

  In the proposed rule, CMS had specifically requested information on the following:
  - *"What is a reasonable threshold for the relative proportions of experienced and new teaching staff? Should there be different thresholds for small, which may include rural, residency programs?*
  - *Should a threshold for determining newness of teaching staff for a new program consider only Core Faculty, or non-core faculty (or key non-faculty staff) as well?*
  - *We seek feedback on our suggestion that 50 percent of the teaching staff may come from a previously existing program in the same specialty, but if so, the 50 percent should comprise staff that each came from different previously existing programs in the specialty.*
  - *In considering whether the presence of a faculty member might jeopardize the newness of a new program, would it be reasonable to consider whether 10 years or 5 years, or some other amount of time, has passed during which that faculty member has not had experience teaching in a program in the same specialty?*
  - *Would it make sense to define a similar period of time (for example, 10 years or 5 years) during which an individual must not have been employed as the program director in a program in the same specialty? Should there be a different criterion for small, which may include rural, residency programs?"*

  Based on comments received, CMS is not finalizing these proposals and is initiating another RFI seeking comment on the appropriate criterion regarding newness of residents. A summary of the comments received can be found on *Display* pages 1029–1033.

Updates to the MS-DRGs

Display pages 43–668, 884–892, 1048–1056, 2671, 2678–2680, and 2752–2758

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. CMS will utilize FFY 2023 MedPAR IPPS claims data and FFY 2022 HCRIS data to calculate FFY 2025 rates.

There will be 771 (as proposed) payable DRGs for FFY 2025 (compared to 764 for FFY 2024), with 78.3% of DRG weights changing by less than +/- 5%, 16.2% changing at least +/-5% but less than +/- 10%, 5.6% changing +/-10% or more, 4.0% that are affected by the relative weight cap on reductions, and 1.6% being new MS-DRGs. The five MS-DRGs with the greatest finalized year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	MS-DRG Title	Final FFY 2024 Weight	Final FFY 2025 Weight	Percent Change
010	PANCREAS TRANSPLANT	4.8136	7.9726	66.63%
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	3.0320	4.3267	42.70%
770	ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7987	1.0759	37.71%
509	ARTHROSCOPY	1.3661	1.7565	28.58%
599	MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	0.6728	0.8549	27.07%

When CMS reviews claims data, they apply several criteria to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within an MS-DRG is needed. A subgroup must meet five criteria in order to warrant creation. Beginning in FFY 2021, CMS expanded the criteria to also include NonCC subgroups with the belief that this would better reflect resource stratification and promote stability of MS-DRG relative weights by avoiding low volume counts for the NonCC level MS-DRGs. CMS found that applying these criteria to all MS-DRGs would cause major changes in the list of MS-DRGs. These updates would have also have an impact on relative weights and payments rates. Due to the PHE and concerns about the impact that implementing major changes to the list of MS-DRG changes at one time, in the FFYs 2022, 2023, and 2024 final rules CMS adopted delays of the application of the NonCC subgroup criteria for these MS-DRGs. For FFY 2024, CMS determined that 135 MS-DRGs (45 base MS-DRGs across 3 severity levels) would potentially be subject to deletion and 86 MS-DRGs would potentially be created when applying the NonCC subgroup criteria. With this in mind, CMS is continuing to delay the application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FFY 2025 so that comments in response to FFY 2024 rulemaking can be considered.

Separately, CMS will only accept MS-DRG classification requests via the Medicare Electronic Application Request Information System™ (MEARIS™) and will not accept requests via email. MEARIS™ can be accessed at https://mearis.cms.gov/, which contains links and documentation related to the new system.

The full list of the final FFY 2025 DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy-2025-ipps-final-rule-table-5.zip. For comparison purposes, the final FFY 2024 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2024-ipps-fr-table-5.zip.

- **Cap for Relative Weight Reductions** ***(Display page 330–331, 2678–2680, and 2752–2758)*****:** CMS previously adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget neutral manner. As such, CMS will continue this policy and apply a budget neutrality adjustment of 0.999874 (proposed at 0.999617) to the operating rate and 0.9999 (proposed at 0.9996) to the capital rate for all hospitals in FFY 2025. This cap policy will only apply to a given MS-DRG if it retains its MS-DRG number from the prior year and will not apply to the relative weight for any new or renumbered MS-DRGs for the year.

- **Chimeric Antigen Receptor (CAR) T-Cell Therapies** ***(Display pages 70–77, 323–329, 1048–1051, and 2671)*****:** In the FFY 2021 final rule, CMS assigned cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a new MS-DRG 018 [Chimeric Antigen Receptor (CAR) T-cell Immunotherapy]. As additional procedure codes for CAR-T cell therapies are created, CMS will use its established process to assign these procedure codes to the most appropriate MS-DRG.

  As providers do not typically pay the cost of a drug for clinical trials, CMS will continue the adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018. The adjustment of 0.34 would be applied to the payment amount for clinical trial cases that would both group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6, contain standardized drug charges of less than $373,000, or when there is expanded access use of immunotherapy. As in the past, CMS will not apply this payment adjustment to cases where a CAR T-cell therapy product is purchased but the case involves a clinical trial of a different product as well as where there is expanded use of immunotherapy.

- **Changes to the Calculation of the IPPS Add-On Payment for Certain End-State Renal Disease (ESRD) Discharges** ***(Display pages 1052–1056)*****:** CMS is finalizing that, effective for cost reporting periods beginning on or after October 1, 2024, the ESRD add-on will be calculated using the annual CY ESRD PPS base rate multiplied by three, for eligible discharges. Under this policy, payments to hospitals will continue to be calculated as the average length of stay of ESRD beneficiaries in the hospital, multiplied by the estimated weekly cost of dialysis (the ESRD base rate multiplied by three), multiplied by the number of ESRD beneficiary discharges.

- **New Technology** ***(Display pages 334–668)***: CMS states that numerous new medical services or technologies are eligible for add-on payments outside the PPS. Table II.E.-01 on *Display* pages 361-362 shows the 24 technologies that will continue to receive add-on payments for FFY 2025 since their three-year anniversary

date will occur on or after April 1, 2025. Table II.E.-02 on *Display* page 366 shows the seven technologies that will no longer receive add-on payments for FFY 2025 since their three-year anniversary date will occur prior to April 1, 2025.

CMS is adopting new technology add-on payments for five technologies under the traditional pathway and twelve under alternative pathways. CMS previously conditionally approved one new technology (taurolidine/heparin) under the alternate pathway for FFY 2024 and will continue payments for this technology for FFY 2025.

To further increase transparency and improve the review process, CMS previously adopted moving the FDA marketing authorization deadline from July 1 to May 1, beginning in FFY 2025. In addition, the applicant must have a complete and active FDA marketing authorization at the time of the new technology add-on payment application submission. After taking further consideration of comments made about these policies, CMS is updating both policies. Beginning with new technology add-on payments for FFY 2026 for those technologies first approved for the add-on in FFY 2025 or a subsequent year, new technology payments could be extended for an additional fiscal year when the three-year anniversary date occurs on or after October 1 of that federal fiscal year. This extension will be part of the assessment on whether to continue the new technology add-on payment. Additionally, based on the variability and the timing of and reasons underlying hold statuses with FDA marketing authorizations, for new technology add-on payment applications for FFY 2026 and forward, a hold status will no longer be considered an inactive status for the purposes of eligibility for the new technology add-on payment.

Due to feedback regarding the adequacy of new technology add-on payments for certain gene therapies used to treat sickle cell disease, CMS will temporarily increase these payments to 75% of the cost of the service, or 75% of the amount by which the costs of the case exceed the standard DRG payment, rather than the typical 65%, beginning in FFY 2025 and concluding at the end of the two to three year newness period for each therapy.

CMS has established a team of new technology liaisons to serve as a centralized resource. This team is available to assist with the following and can be contacted at MedicareInnovation@cms.hhs.gov:

- *"Help to point interested parties to or provide information and resources where possible regarding process, requirements, and timelines.*
- *Coordinate and facilitate opportunities for interested parties to engage with various CMS components.*
- *Serve as a primary point of contact for interested parties and provide updates on developments where possible or appropriate."*

- **Social Determinants of Health (SDOH) Diagnosis Codes *(Display pages 247–265)*:** CMS adopted changes to the severity levels for the following diagnosis codes regarding inadequate housing and homelessness from NonCC to CC for FFY 2025:
  - Z59.10 - Inadequate housing, unspecified
  - Z59.11 - Inadequate housing environmental temperature
  - Z59.12 - Inadequate housing utilities
  - Z59.19 - Other inadequate housing
  - Z59.811 - Housing instability, housed, with risk of homelessness
  - Z59.812 - Housing instability, housed, homelessness in past 12 months
  - Z59.819 - Housing instability, housed unspecified
- **MS-DRG Changes *(Display pages 238–315 and 884–892)*:** Based on the analysis of FFY 2023 MedPAR claims, CMS is making changes to a number of MS-DRGs effective for FFY 2025. Specifically, CMS is adopting the following:
  - Adding ICD-10-PCS codes describing left atrial appendage closure (LAAC) procedures and cardiac ablation procedures to adopted new MS-DRG 317 (Concomitant Left Atrial Appendage Closure and Cardiac Ablation).
  - Delete existing MS-DRGs 453, 454, and 455 (Combined Anterior and Posterior Spinal Fusion with MCC, with CC, and without CC/MCC, respectively) and to reassign procedures from the existing MS-

DRGs, 453, 454, and 455 to adopted new MS-DRG 402 (Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical), adopted new MS-DRGs 426, 427, and 428 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC, with CC, without MCC/CC, respectively), adopted new MS-DRGs 429 and 430 (Combined Anterior and Posterior Cervical Spinal Fusion with MCC and without MCC, respectively), and adopted new MS-DRGs 447 and 448 (Multiple Level Spinal Fusion Except Cervical with MCC, and without MCC, respectively).

- Reassigning cases that report a principal diagnosis of acute leukemia with an "other" O.R. procedure from MS-DRGs 834, 835, and 836 (Acute Leukemia without Major O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) to adopted new MS-DRG 850 (Acute Leukemia with Other O.R. Procedures). CMS notes that they are also adopting the revision of the title of MS-DRGs 834, 835, and 836 from "Acute Leukemia without Major O.R. Procedures with MCC, with CC, and without CC/MCC", respectively to "Acute Leukemia with MCC, with CC, and without CC/MCC".

CMS is modifying their proposal to revise the titles of MS-DRGs 459 and 460. Instead, CMS is deleting MS-DRGs 459 and 460 and renumbering them as MS-DRGs 450 and 451 with the titles "Single Level Spinal Fusion Except Cervical with MCC and without MCC", respectively. These MS-DRGs will also be removed from the post-acute care policy list.

The table on *Display* pages 889–890 details which of these new or revised MS-DRGs are subject to the post-acute care transfer policy for FFY 2025. The table on *Display* page 891 details which of these new or revised MS-DRGs are subject to MS-DRG special payment policy.

Low-Volume Hospital Adjustment

Display pages 34 and 922–935

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The CAA of 2024 extended the current criteria through FFY 2024. The current payment adjustment formula for hospitals located more than 15 miles from another subsection (d) hospital, with between 500 and 3,800 total discharges is:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

Providers with less than 500 total discharges will receive a 25% payment increase. The CAA of 2024 extended this policy through December 31, 2024. On January 1, 2025, and subsequent years, the criteria for the low-volume hospital adjustment will return to more restrictive levels. In order to receive a low-volume adjustment subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

In order for a hospital to acquire low-volume status for FFY 2025, consistent with historical practice, CMS finalized that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for low volume hospital status for the portion of FFY 2025 beginning October 1, 2024–December 31, 2024. The MAC must receive a written request by September 1, 2024 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2024. If accepted, the adjustment would be applied prospectively within 30 days of low-volume hospital determination. Additionally, CMS is adopting that a hospital must submit this documentation showing that they meet the applicable mileage and discharge criteria for the more restrictive low-volume policy beginning January 1, 2025-September 30, 2025 to their MAC no later than December 1, 2024. A hospital may choose to make a single request or separate requests for these to their MAC to determine eligibility.

A hospital that qualified for the low-volume hospital payment adjustment for FFY 2024 may continue to receive the adjustment for FFY 2024 without reapplying if it meets both the final discharge and mileage criteria for October 1, 2024–December 31, 2024, as well as the criteria for January 1, 2024–September 30, 2025.

Rural Referral Center (RRC) Status

Display pages 914–921

Hospitals that meet a minimum case-mix and discharge criteria (as well as one of 3 optional criteria relating to specialty composition of medical staff, source of inpatients, or referral volume) may be classified as RRCs. This special status provides an exemption from the 12% rural cap on traditional DSH payments and exemption from the proximity criteria when applying for geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The final FFY 2025 minimum case-mix and discharge values are available on the pages listed above.

Medicare-Dependent, Small Rural Hospital (MDH) Program

Display pages 936–942

The MDH program has been extended multiple times since its creation for FFY 2012, with the most recent extension being through a portion of FFY 2025, ending December 31, 2024, as granted by the CAA of 2024. As a result of these extensions, any provider that was classified as an MDH as of September 30, 2024 will continue to be classified as an MDH as of October 1, 2024, without the need to reapply. Beginning January 1, 2025, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based on the IPPS federal rate. Hospitals which will lose this status may apply for SCH status in advance of the expiration of the MDH program. Such hospitals have until December 2, 2024 to apply for SCH status effective January 1, 2025. Hospitals unable to meet this deadline would have their SCH classification effective date be the date when the MAC receives the complete application.

Transforming Episode Accountability Model (TEAM)

Display pages 1716–2447

CMS is adopting a new five-year mandatory episode-based payment model with the goal of improving quality of care while reducing Medicare spending for beneficiaries undergoing certain high-expenditure, high-volume surgical procedures. The procedures included in this model will be:

- Lower Extremity Joint Replacement;
- Surgical Hip/Femur Fracture Treatment;
- Spinal Fusion;
- Coronary Artery Bypass Graft; and
- Major Bowel Procedure.

This model is finalized to be mandatory and will last for five years, beginning on January 1, 2026. Hospitals with required participation was determined by CBSA, with CMS selecting 188 CBSAs using a stratified random sampling methodology from a list of 803 eligible CBSAs based on the criteria discussed on *Display* pages 1833–1858. Table X.A.-05 on *Display* pages 1867–1884 list these eligible CBSAs, of which approximately 23.4% were chosen for this model. Table X.A.-07 on *Display* pages 1885–1889 shows the CBSAs selected to participate in TEAM. Hospitals required to participate will continue to bill Medicare FFS but will receive hospital and beneficiary risk-adjusted target prices by episode category and region, subject to a quality performance adjustment, based on historic Medicare episode spend and a 2% discount factor for the Lower Extremity Joint Replacement, Surgical Hip/Femur Fracture Treatment, and Spinal Fusion episode categories and a 1.5% discount factor for the Coronary Artery Bypass Graft and Major Bowel Procedure episode categories.

A full discussion of TEAM, including details on how CBSAs were chosen; adopted episodes, quality measures and reporting; and other details can be found on the pages listed above.

IPPS Payments for Establishing and Maintaining Access to Essential Medicines

Display pages 1057–1097

CMS recognizes the importance of supporting practices that can limit drug shortages of essential medicines and promote resiliency in order to safeguard and improve the care hospitals are able to provide to beneficiaries. In the CY 2024 OPPS proposed rule, CMS sought comment on "…*separate payment under IPPS for the IPPS share of the reasonable costs of establishing and maintaining access to a 3-month buffer stock of one or more essential medicine(s). Essential medicines for the potential IPPS separate payment would be the 86 essential medicines prioritized in the report Essential Medicines Supply Chain and Manufacturing Resilience Assessment. An adjustment under OPPS could be considered for future years."*

Based on comments received, CMS is adopting it's proposed first step in this initiative be that, for cost reporting periods beginning on or after October 1, 2024, a separate payment will be established under the IPPS to small (100 bed or fewer), independent hospitals for the estimated additional resource cost of voluntarily establishing and maintaining access to 6-month buffer stocks of essential medicines. These payments will be provided biweekly or as a lump sum at cost report settlement.

In an effort to mitigate this adopted policy from either exacerbating existing shortages or contributing to hoarding, CMS is adopting any hospital that newly established a buffer stock on an essential medicine listed as "Currently in Shortage" in the FDA Drug Shortages Database would not receive this payment for the duration of the shortage.

Discussion on the adopted list of essential medicines and eligibility criteria can be found on *Display* pages 1063-1066.

A summary of comments received on this topic can be found on *Display* pages 1080–1096.

Provider Reimbursement Review Board (PRRB)

Display pages 2447–2454

The PRRB is a five-member tribunal that adjudicates disputes over Medicare reimbursement for certain providers of services in the Medicare program. Members are selected by the Department of Health and Human Services Secretary and serve 3-year terms. CMS adopted to modify the requirement that Board Members shall be knowledgeable in the area of cost reimbursement, so that it instead requires them to be knowledgeable in the field of payment of providers under Medicare Part A. CMS also adopted to permit a Board Member to serve no more than three consecutive terms, instead of two consecutive terms allowed under current regulations. CMS did not finalize the proposal to permit a Board Member who is designated as Chairperson in their second or third consecutive term to serve a fourth consecutive term to continue leading the Board as Chairperson.

Request for Information - Maternity Care

Display pages 2454–2459

In the FFY 2025 IPPS proposed rule, CMS had requested information on the differences between hospital resources required to provide inpatient pregnancy and childbirth services to Medicare patients as compared to non-Medicare patients. Additionally, CMS is interested to know which non-Medicare payers may be using the IPPS as a basis for determining their payment rates for these services. Specifically, CMS sought feedback on the following questions:

- *"What policy options could help drive improvements in maternal health outcomes?*
- *How can CMS support hospitals in improving maternal health outcomes?*
- *What, if any, payment models have impacted maternal health outcomes, and how?*
- *What, if any, payment models have been effective in improving maternal health outcomes, especially in rural areas?*
- *What factors influence the number of vaginal deliveries and cesarean deliveries?*
- *To what extent do non-Medicare payers, such as state Medicaid programs, use the IPPS MS-DRG relative weights to determine payment for inpatient obstetrical services? What effect, if any, does the use of those relative weights by those payers have on maternal health outcomes?*

- *To what extent are Medicare claims and cost report data reflective of the differences in relative costs between vaginal births and cesarean section births for non-Medicare patients?*
- *Are there other data beyond claims and cost reports that Medicare should consider incorporating in development of relative weights for vaginal births and cesarean section births?*
- *What impact, if any, does the relatively lower numbers of births in Medicare have on the variability of the relative weights?*
- *What effect, if any, does potential variability in the relative weights on an annual basis have on maternal health outcomes?"*

A summary of comments received can be found on *Display* pages 2458–2459.

CoP Requirements for Hospitals and CAHs to Report Respiratory Illness

Display pages 2462–2490

CMS is revising the hospital and CAH infection prevention and control program and antibiotic stewardship program CoPs to extend a modified form of the current COVID-19 and influenza reporting requirements to include data for respiratory syncytial virus (RSV) and reduce the frequency of reporting for hospitals and CAHs. The data elements required for this reporting include:

- *"*Confirmed infections of respiratory illnesses, including COVID-19, influenza, and RSV, among hospitalized patients;
- Hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric]); and
- Limited patient demographic information, including age."

Reporting requirements on respiratory illness ended on April 30, 2024, with this adopted policy going into effect on October 1, 2024. CMS encouraged providers to voluntarily report on these data in the interim. CMS is also adopting that, outside of a declared national PHE for an acute respiratory illness, hospitals and CAHs will have to report this data on a weekly basis through a Centers for Disease Control and Prevention (CDC)-owned or supported system. The following policies will assist in the collection of additional data elements in the event that a PHE is declared in the future:

- *"During a declared federal, state, or local PHE for an infectious disease the Secretary may require hospitals to report data up to a daily frequency without notice and comment rulemaking.*
- *During a declared PHE for infectious disease, the Secretary may require the reporting of additional or modified data elements relevant to infectious disease PHE including but not limited to: confirmed infections of the infectious disease, facility structure and infrastructure operational status; hospital/ED diversion status; staffing and staffing shortages; supply inventory shortages (for example, equipment, blood products, gases); medical countermeasures and therapeutics; and additional, demographic factors*
- *If the Secretary determines that an event is significantly likely to become a PHE for an infectious disease, the Secretary may require hospitals to report data up to a daily frequency without notice and comment rulemaking."*

CMS sought comment as to whether race/ethnicity demographic information should be included as part of the reporting beginning on October 1, 2024, but did not adopt any policies to include these data for reporting beginning on October 1, 2024.

Finally, CMS sought information on health care reporting to the National Syndromic Surveillance Program (NSSP). A discussion of this topic and comments received by CMS can be found on *Display* pages 2487–2490.

Updates to the IQR Program and Electronic Reporting Under the Program

Display pages 1254–1397 and 1142–1594

CMS is finalizing its proposal to adopt the following measures beginning with the CY 2025 reporting period/FFY 2027 payment determination:

- Patient Safety Structural measure (with modification to the attestation statement in Domain 4 Statement B)
- Age Friendly Hospital
- Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (July 1, 2023–June 30, 2025 reporting)

In addition, CMS is adopting the following measures for the CY 2026 reporting period/FFY 2028 payment determination:

- Catheter Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations (CAUTI-Onc)
- Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations (CLABSI-Onc)
- Hospital Harm - Falls with Injury eCQM
- Hospital Harm - Postoperative Respiratory Failure eCQM

CMS is adopting its proposal to remove Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) for the CY 2025 reporting period/FFY 2027 payment determination.

CMS is also removing four clinical episode-based payment measures beginning with the FFY 2026 payment determination:

- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI) (CBE #2431) (AMI Payment)
- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure (HF) (CBE #2436) (HF Payment)
- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia (PN) (CBE #2579) (PN Payment)
- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CBE #3474) (THA/TKA Payment)

Beginning with the CY 2026 reporting period/FFY 2028 payment determination, CMS is finalizing the modification of the Global Malnutrition Composite Score measure to expand the population from hospitalized adults 65 or older to hospitalized adults 18 or older.

Separately, CMS is finalizing an increase in the number of mandatory eCQMs in order to support CMS' commitment to better safety practices over three years (proposed as over two years). CMS modified its proposal to give more time for the industry to implement the new eCQMs. Specifically, CMS will include the five Hospital Harm eCQMs as mandatory. Beginning with CY 2026 reporting period/FFY 2028 payment determination, CMS is modifying its proposal to require hospitals to report on:

- Hospital Harm - Severe Hypoglycemia eCQM; and
- Hospital Harm - Severe Hyperglycemia eCQM.

Beginning with CY 2027 reporting period/FFY 2029 payment determination, CMS will require hospitals to report on:

- Hospital Harm - Opioid-Related Adverse Events eCQM (originally proposed for CY 2026 reporting period/FFY 2028 payment determination)

Beginning with CY 2028 reporting period/FFY 2030 payment determination, CMS will require hospitals to report on:

- Hospital Harm - Pressure Injury eCQM (original proposed for CY 2027 reporting period/FFY 2029 payment determination); and
- Hospital Harm - Acute Kidney Injury eCQM (original proposed for CY 2027 reporting period/FFY 2029 payment determination).

CMS is also modifying the eCQM validation scoring beginning with CY 2025 eCQM data/FFY 2028 payment determination to use accuracy rather than just completeness. Specifically, eCQM validation scores will be determined using the same approach that is used to score chart-abstracted measure validation, removing the 100% submission requirement and including that missing eCQM medical records be treated as mismatches. Hospital eCQM data will be used to compute an agreement rate and an associated confidence interval. The upper bound of the two-tailed 90 percent confidence interval will be used as the final eCQM validation score for the hospital. A minimum score of 75 percent accuracy will be required for the hospital to pass the eCQM validation requirement. With this, CMS will remove the existing combined validation score based on a weighted combination of a hospital's validation performance for chart-abstracted measures and eCQMs (where eCQMs were weighted at 0%). This will be replaced by two separate validation scores, one for chart-abstracted measures and one for eCQMs, equally weighted at 50% each. Hospitals will be required to receive passing validation for both scores to pass validation.

Lastly, with regards to reconsideration and appeals and beginning with CY 2023 discharges/FFY 2026 payment determination, CMS is finalizing that hospitals will no longer be required to resubmit medical records as part of their request for reconsideration of validation.

Updates to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure

Beginning with the CY 2025 reporting period/FFY 2027 payment determination, CMS is finalizing its proposal to modify the HCAHPS Survey measure to include 32 questions that will have a total of eleven sub-measures, with seven of the sub-measures being multi-question sub-measures. Seven of the sub-measures will remain unchanged from the current survey (four multi-question and three single-question).

The update to the survey includes three new sub-measures, to begin publicly reporting in October 2026:

- the multi-item “Care Coordination”,
- the multi-item “Restfulness of Hospital Environment", and
- the “Information About Symptoms” single-item sub-measure.

The updated HCAHPS Survey measure also removes the “Care Transition” sub-measure as the new “Care Coordination” sub-measure expands the “Care Transition” sub-measure and is more consistent with other survey questions. This measure will no longer be reported starting January 2026. The existing “Responsiveness of Hospital Staff” sub-measure will also be modified to replace one of the two survey questions in the current measure with a new question that strengthens the measure. The modified measure will begin public reporting January 2025.

Seven new questions to address aspects of hospital care identified by patients are as follows:

- *“During this hospital stay, how often were doctors, nurses and other hospital staff informed and up-to-date about your care?*
- *During this hospital stay, how often did doctors, nurses and other hospital staff work well together to care for you?*
- *Did doctors, nurses or other hospital staff work with you and your family or caregiver in making plans for your care after you left the hospital?*
- *During this hospital stay, how often were you able to get the rest you needed?*
- *During this hospital stay, did doctors, nurses and other hospital staff help you to rest and recover?*
- *During this hospital stay, when you asked for help right away, how often did you get help as soon as you needed?*
- *During this hospital stay, did doctors, nurses or other hospital staff give your family or caregiver enough information about what symptoms or health problems to watch for after you left the hospital?”*

CMS is removing the following questions. The first is removed because the hospital call button has been replaced by other mechanisms and the other questions are removed because they do not comply with standard CAHPS question wording and are duplicative of existing and new survey questions:

- *“During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?*

- *During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.*
- *When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.*
- *When I left the hospital, I clearly understood the purpose for taking each of my medications."*

A crosswalk of updated HCAHPS survey questions to updated HCAHPS survey sub-measures can be found on Display pages 1350–1352.

The updated HCAHPS Survey measure will be implemented for IQR beginning with patients discharged between January 1, 2025–December 31, 2025. Since the HCAHPS Survey measure is publicly reported on Care Compare on a rolling basis, public reporting will only consist of the eight unchanged sub-measures in the current HCAHPS survey until four quarters of the updated data are available. This will be the case for the January 2026, April 2026, and July 2026 public reporting on Care Compare.

CMS is also modifying the "About You" section of the HCAHPS survey, as follows:

- *"Replacing the existing 'Emergency Room Admission' question with a new, 'Hospital Stay Planned in Advance' question;*
- *reducing the number of response options for the existing 'Language Spoken at Home' question;*
- *alphabetizing the response options for the existing ethnicity question; and*
- *alphabetizing the response options for the existing race question."*

- **Request for Information - Advancing Patient Safety and Outcomes Across the Hospital Quality Programs** ***(Display pages 1142–1420)*****:** CMS is looking for ways to build on current measures to encourage hospitals to improve discharge processes to account for unplanned patient hospital visits. In the proposed rule, CMS requested comment on how quality programs can do as such, including *"introducing measures currently in quality reporting programs into value-based purchasing to link outcomes to payment incentives"*. Comments and CMS's responses can be found on Display pages 1415-1420.

- **Modification to the Hybrid Hospital-Wide All-Cause Readmission and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measures in the Hospital Inpatient Quality Reporting (IQR) Program**
  (CY 2025 Outpatient Prospective Payment System Proposed Rule Display pages 788–794): Based on hospital performance during the most recent voluntary reporting period, CMS has determined that hospitals appear unprepared for mandatory reporting of the Hybrid Hospital-Wide All-Cause Readmission and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measures under the Hospital IQR. CMS states that approximately one-third of IPPS hospitals participated during the voluntary reporting period, and other these, 75% would not have met the reporting thresholds for the core clinical data elements (CCDEs) and linking variables, and so would have received a 25% reduction to their annual payment update for the given fiscal year had reporting been mandatory.

  Due to this information, CMS is finalizing that the submission of CCDEs and linking variables remain voluntary for the FFY 2026 payment determination, with mandatory submission being established for the FFY 2027 payment determination.

Quality-Based Payment Adjustments

Display pages 1098–1115 and 1397–1141

For FFY 2025, IPPS payments will be adjusted for quality performance under the VBP program, RRP, and the HAC Reduction Program. Detail on the FFY 2025 programs and payment adjustment factors are below (future program year changes are addressed in the next section of this brief).

In the August 2020 COVID-19 interim final rule with comment period, CMS updated the extraordinary circumstances exception policy in response to the PHE so that no claims data or chart-abstracted data reflecting services provided January 1, 2020–June 30, 2020 will be used in calculations for the any of the three quality programs.

- **VBP Program *(Display pages 1099–1112)*:** The FFY 2025 program will include hospital quality data for 20 measures in 4 domains: safety; clinical outcomes; person and community engagement; and efficiency and cost reduction. By law, the VBP program must be budget neutral and the FFY 2025 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.67 billion). Hospitals can earn back some, all, or more than their individual 2.0% reduction.

  While the data applicable to the FFY 2025 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the historical baseline and performance periods used in the FFY 2024 program. Hospitals should use caution in reviewing these factors as they do not reflect updated performance periods/standards, nor changes to hospital eligibility.

  The proxy factors published with the final rule are available in Table 16A on the CMS website at https://www.cms.gov/files/zip/fy-2025-ipps-final-rule-table-16a.zip.

  CMS anticipates making actual FFY 2024 VBP adjustment factors available in the fall of 2024. Details and information on the program are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp.

- **RRP *(Display page 1098)*:** The FFY 2025 RRP will use data from July 1, 2020–June 30, 2023 and evaluate hospitals on six conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG).

  The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

  Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual eligible patients as a ratio of total Medicare FFS and Medicare Advantage (MA) patients during the same three-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

  The data applicable to the FFY 2025 RRP program is still being reviewed and corrected by hospitals, and therefore CMS have not yet posted factors for the FFY 2025 program in Table 15. CMS expects to release the final FFY 2025 RRP factors in the fall of 2024.

  Details and information on the RRP currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hrrp.

- **HAC Reduction Program *(Display pages 1113–1115)*:** The FFY 2025 HAC reduction program will evaluate hospital performance on six measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC reduction program is not budget neutral; hospitals with a total HAC score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score.

  CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

  Details and information on the HAC currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hac.

Quality-Based Payment Policies - FFYs 2026 and Beyond

For FFYs 2026 and beyond, CMS is adopting new policies for its quality-based payment programs.

- **VBP Program** ***(Display pages 1098–1112 and 1397–1141)*****:** CMS had already adopted VBP program rules through FFY 2025 and some program policies and rules beyond FFY 2025. CMS is finalizing further program updates through FFY 2030, described below.

  New baseline periods, performance periods, and performance standards are adopted for a subset of measures for the FFYs 2026–2030 programs.

  Given that CMS is adopting the updated HCAHPS Survey measure with the IQR program beginning FFY 2027 (described above in the IQR section), CMS is adopting the same updates to the VBP program beginning FFY 2030. In addition to the updates described above, for the "Cleanliness and Quietness" dimension, CMS is renaming the dimension to "Cleanliness and Information About Symptoms" as the "Quietness" question will move to the new "Restfulness of Hospital Environment" dimensions and the "Cleanliness" question will now be averaged with the "Information about Symptoms" question.

  With the updated HCAHPS Survey measure, CMS is adopting its proposal to modify the scoring of the HCAHPS survey beginning FFY 2030 to account for the modifications to the measure, which includes nine dimensions of the survey, as follows:

  - Score hospitals on the nine dimensions of the survey, which includes the adopted sub-measures.
  - Calculate a normalized HCAHPS Base Score as the sum of the final points for the nine dimensions multiplied by 8/9 and rounded, so that as currently, the HCAHPS Base Score will still range from 0 to 80 points.
  - The Consistency Points will still range from 0 to 20 points, calculated on the nine dimensions.

  Since CMS is adopting the same HCAHPS Survey measure updates to VBP as to the Hospital IQR program beginning FFY 2027, CMS is adopting its proposal to modify the scoring of the HCAHPS survey for FFYs 2027–2029, as follows:

  - Only score hospitals on the six dimensions of the survey that remain unchanged from the current version (Communication with Nurses, Communication with Doctors, Communication about Medicines, Discharge Information, Cleanliness and Quietness, and Overall Rating).
  - Calculate a normalized HCAHPS Base Score calculated as the sum of the final points for the six included dimensions multiplied by 8/6 and rounded, so that as currently, the HCAHPS Base Score will still range from 0 to 80 points.
  - The Consistency Points will still range from 0 to 20 points but be calculated solely on the six unchanged dimensions.

  Separately, beginning with the FFY 2026 program, CMS previously adopted a change to the VBP scoring methodology to reward hospitals for excellent care in underserved populations. This will be through the addition of Health Equity Adjustment (HEA) bonus points to a hospital's Total Performance Score (TPS), calculated using a methodology that incorporates a hospitals performance across all four domains and the hospital's proportion of dual eligible patients.

  Specifically, depending on if a hospital's performance is in the top third, middle third, or bottom third of performance of all hospitals within a domain, the hospital will be awarded four, two, or zero points, respectively. The sum of the points awarded to a hospital for each domain would be the "measure performance scaler", with a maximum score of 16. For hospitals that only score in three domains due to measure case count requirements, the maximum points will be 12.

  CMS is defining the "underserved multiplier" as the number of inpatient stays for dual eligible patients out of the total inpatient Medicare stays during the calendar year two years prior to the start of the respective program year. For the FFY 2026 program, this will be FFY 2024 data. Similar to the RRP program, dual eligible patients will be identified using the State Medicare Modernization Act file of dual eligible beneficiaries. CMS will use a logistic exchange function to calculate the underserved multiplier so that there would be a lower rate of increase at the beginning and the end of the curve. This logistic exchange function was finalized to be:

$$\frac{1}{1 + e^{-(-5+10*\frac{Dual\ Rank}{Max\ Dual\ Rank})}}$$

HEA bonus points will be calculated as the product of the measure performance scaler and the underserved multiplier (formula shown below) and will be capped at 10 points. These points are added to the hospital's TPS.A hospital could earn no more than 110 points maximum as a final TPS, including the HEA bonus points.

Health Equity Adjustment (HEA) bonus points = measure performance scaler × underserved multiplier

- **RRP** ***(Display page 1098)*****:** CMS did not adopt any changes to RRP.
- **HAC Reduction Program** ***(Display pages 1113–1115):*** CMS did not adopt any changes to the HAC reduction program.

Promoting Interoperability Program

Display pages 1658–1715

The Medicare Promoting Interoperability program provides incentive payments and payment reductions for the adoption and meaningful use of certified EHR technology.

CMS is finalizing to separate the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures beginning with CY 2025 EHR reporting:

- *"AU Surveillance measure: The eligible hospital or CAH is in active engagement with CDC's NHSN to submit AU data for the selected EHR reporting period and receives a report from NHSN indicating its successful submission of AU data for the selected EHR reporting period.*
- *AR Surveillance measure: The eligible hospital or CAH is in active engagement with CDC's NHSN to submit AR data for the selected EHR reporting period and receives a report from NHSN indicating its successful submission of AR data for the selected EHR reporting period."*

With this, CMS is finalizing its proposal to adopt the appropriate AUR exclusions to these measures and an additional exclusion for reporting for when a hospital or CAH does not have a data source containing the minimal discrete data elements that are required for reporting.

CMS is also adopting active engagement for both of the measures as well where eligible hospitals and CAHs will be allowed to spend only one EHR reporting period at the Option 1: Pre-production and Validation level of active engagement, and they must progress to the Option 2: Validated Data Production level for the next EHR reporting period for which they report the measure.

CMS believes that the adoption of these measures should not impact scoring and therefore will maintain a scoring value of 25 points for reporting all required measures in the Public Health and Clinical Data Exchange objective, even though the objective will increase from five to six measures.

CMS modified its proposal to increase the minimum scoring threshold from 60 points to 70 points with EHR reporting periods beginning CY 2025 and from 70 points to 80 points beginning with the EHR reporting period in CY 2026 and for subsequent years (proposed at an increase to 80 points with EHR reporting periods CY 2025 and onwards) in order to encourage higher levels of performance. CMS states that the gradual increase will be more feasible for eligible hospitals and CAHs while showing continued growth in the program.

As described, CMS did not adopt any changes to the scoring of the objectives and measures for the CY 2025 EHR reporting period, outlined below:

Final Performance-Based Scoring Methodology Beginning with the CY 2025 EHR Reporting Period			
Objectives	**Measures**	**Maximum Points**	**Redistribution if Exclusion Claimed**
Electronic Prescribing (e-Prescribing)	e-Prescribing	10 points	10 points to Health

			Information Exchange (HIE) Objective
	Query of Prescription Drug Monitoring Program	10 points	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information	15 points	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	15 points	No exclusion
	OR		
	HIE Bi-Directional Exchange measure	30 points	No exclusion
	OR		
	Enabling Exchange under TEFCA	30 points	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	
Public Health and Clinical Data Exchange	Required with yes/no response • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AU Surveillance Reporting **(adopted)** • AR Surveillance Reporting **(adopted)**	25 points	If an exclusion is claimed for all 5 measures, 25 points redistributed to Provide Patients Electronic Access to their Health Information
	Optional to report one of the following • Public Health Registry Reporting • Clinical Data Registry Reporting	5 points (bonus)	

Consistent with the Hospital IQR program, CMS will add two additional eCQMs from the Hospital IQR programs measure set beginning with the CY 2026 reporting period. CMS will also modify one eCQM from the Hospital IQR measure set beginning with CY 2026 reporting. These measures are listed in the IQR section of this brief.

- **Request for Information - Public Health Reporting and Data Exchange *(Display page 1715)*:** CMS believes that decision-making and prioritization about policy change should adhere to four goals:
    - *"The meaningful use of CEHRT enables continuous improvement in the quality, timeliness, and completeness of public health data being reported.*
    - *The meaningful use of CEHRT allows for flexibility to respond to new public health threats and meet new data needs without requiring new and substantial regulatory and technical development.*
    - *The meaningful use of CEHRT supports mutual data sharing between public health and healthcare providers.*
    - *Reporting burden on eligible hospitals and CAHs is significantly reduced."*

  In the proposed rule, CMS asked specific questions to the public regarding these four goals. CMS is not responding to comments in this rule but will consider the feedback in future proposals.

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