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FY 2025 IPPS and LTCH PPS Rule Finalizes 2.9 Percent Overall Increase for Hospitals; Areas Required to Participate in Mandatory TEAM Announced

Today, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2025 inpatient prospective payment system (IPPS) and long-term care hospital prospective payment system (LTCH PPS) final rule (press release, fact sheet), which applies to acute care hospital and LTCH payments beginning Oct. 1, 2024. The rule finalizes a 2.9 percent increase (+$2.9 billion including the payment update and other policies) in operating payments for acute care hospitals in FY 2025, and LTCHS would receive a 2.0 percent increase ($45 million) despite a 3.0 percent increase to the payment rate.

- **What it is.** The wide-ranging final rule would affect payments for discharges occurring on or after Oct. 1, 2024 at 3,090 acute care hospitals and approximately 330 LTCHs.

- **Why it is important for you.** CMS finalizes a 2.9 percent increase in payments to acute care hospitals, as well as technology add-on payments for gene therapy for sickle cell disease and a separate payment for small independent hospitals for maintaining access to a stock of essential medications. CMS also finalizes a number of cross-cutting quality changes across quality programs related to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Additionally, CMS finalizes policies to distribute new graduate medical education (GME) slots, and anticipates a $0.2 billion decrease in Disproportionate Share Hospital (DSH) payments after the adoption of new Core-Based Statistical Areas (CBSAs).

  The rule also finalizes policies for a new Center for Medicare and Medicaid Innovation (CMMI) model. The mandatory Transforming Episode Accountability Model (TEAM; fact sheet; FAQs) will require select acute care hospitals to test whether episode-based payments reduces expenditures by incentivizing coordination between care providers. The surgical procedures include lower joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedure.

- **Next steps.** The final rule takes effect on October 1, 2024.

Highlights of the final rule follow:

- ***Proposed Payment Updates*** –

- **Acute Care Hospitals (p. 893):** Under the final rule, acute care hospitals that successfully participate in the hospital inpatient quality reporting (IQR) program and are meaningful users of electronic health records (EHRs) would receive an estimated 2.9 percent increase (0.3 percent higher than proposed) in operating payments for FY 2025, consisting of a +3.4 percent market basket update and -0.5 percent multifactor productivity adjustment. The change between the proposed and final rules was due to the use of updated data. Overall, the agency estimates hospital payments will increase by $2.9 billion in FY 2025, including a $3.2 billion increase in operating and capital IPPS payment rates, a $0.2 billion decrease in uncompensated care payments, and $0.3 billion in additional payments for inpatient cases involving new medical technologies.

  CMS notes that the Consolidated Appropriations Act, 2024 extended additional payments for Medicare-Dependent Hospitals (MDHs) and the temporary change in payments for low-volume hospitals for the first three months of FY 2025 (through December 31, 2024). Congress has previously extended these payments, but CMS estimates that payments to these hospitals would decrease by $0.4 billion in FY 2025 if they were to expire.

- **Long-Term Care Hospitals (LTCHs):** CMS is finalizing an annual update to the standard payment rate of 3.0 percent in FY 2025, a 0.2 percent increase from the proposed rate of 2.8 percent. CMS estimates LTCH PPS payments for FY 2025 for discharges paid the standard LTCH payment will increase by approximately 2.0 percent ($45 million) largely due to a projected 0.08 percent decrease in high-cost outlier payments. The agency states that it is increasing the LTCH outlier threshold higher than it has in recent years to meet statutory requirements.

- ***Proposed Changes to the Hospital Wage Index for Acute Care Hospitals (p. 669)*** – CMS finalizes to adopt the updated Core-Based Statistical Areas (CBSAs) based on the revised urban/rural delineations from the Office of Management and Budget (OMB) beginning with the FY 2025 IPPS wage index. CMS believes that the revised delineations will increase the integrity of the IPPS wage index. CMS also continues to believe that the five percent cap on any decrease in a hospital's wage index will sufficiently mitigate any potential significant disruptive financial impacts on hospitals. Tables on p. 667-684 crosswalk counties that will change CBSA assignments.

  CMS also finalizes as proposed to continue the low wage index hospital policy for at least three more years beginning FY 2025 because the agency was unable to evaluate the effect of the policy on hospitals' wage increases during the COVID-19 pandemic.

- Other – Additional details pertaining to the wage index include:
  - Worksheet S–3 Wage Data for the Proposed FY 2025 Wage Index (p. 692);
  - Verification of Worksheet S–3 Wage Data (p. 694);
  - Method for Computing the Proposed FY 2025 Unadjusted Wage Index (p. 711);
  - Occupational Mix Adjustment to the FY 2025 Wage Index (p. 719);
  - Implementation of the Occupational Mix Adjustment and the Proposed FY 2025 Occupational Mix Adjusted Wage Index (p. 725);
  - Hospital Redesignations and Reclassifications (p. 726);
  - Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment (p. 769);
  - Proposed FY 2025 Wage Index Tables (p. 556);
  - Hospital Redesignations and Reclassifications (p. 726);
  - Proposed Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (p. 777);
  - Process for Requests for Wage Index Data Corrections (p. 701);
  - Labor-Related Share for the FY 2025 Wage Index (p. 805); and
  - Policies for Canceling § 412.103 Reclassifications of Terminated Providers (p. 731).

- ***Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2025 (p. 809)*** – CMS projects Medicare uncompensated care payments to disproportionate share hospitals (DSH) will decrease in FY 2025 by approximately $0.2 billion.

  - **Uncompensated Care Payments (p. 571)** – CMS finalizes that Factor 1 for FY 2025 will be $10,509,750,000, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2025 ($14,013,000,000 minus $3,503,250,000). For Factor 2, CMS finalizes that Factor 2 for FY 2025 will be 54.29 percent, after updating the calculation for Factor 2 to incorporate more recent data from the National Health Expenditure Accounts (NHEA) in response to comments received. The final FY 2025 uncompensated care amount is equivalent to Factor 1 multiplied by Factor 2, which is $10.509 billion * 0.5429 = $5.705 billion. Regarding Factor 3, CMS is following the same methodology as applied in FY 2024, using the most recent 3 years of audited cost reports, from FY 2019, FY 2020, and FY 2021. CMS used the March 2024 update of HCRIS to calculate the final Factor 3 for the FY 2025 IPPS/LTCH PPS final rule. The steps CMS will take to calculate Factor 3 for all hospitals can be found on p. 856.

- **Per-Discharge Amount of Interim Uncompensated Care Payments for FY 2025 (p. 866)** – CMS finalizes its proposal to calculate the per-discharge amount for interim uncompensated care payments for FY 2025 and subsequent fiscal years with modifications. Specifically, for FY 2025, the per-discharge amount will be determined using the average of the most recent two years of discharge data, excluding FY 2021 due to concerns about overestimation related to a decreasing trend in discharge volumes. This adjustment aims to provide a more accurate estimate for FY 2025 discharges. Additionally, for FY 2026 and subsequent fiscal years, the interim uncompensated care payments will be calculated using the average of the most recent three years of available historical discharge data, as initially proposed.

- **Impact on Medicare DSH Payment Adjustment of Proposed Implementation of New OMB Labor Market Delineations (p. 875)** – CMS finalizes to implement new OMB labor market area delineations based on 2020 Decennial Census data for the FY 2025 wage index. CMS notes this will affect the calculation of Medicare DSH payment adjustments, particularly impacting hospitals with less than 500 beds that would transition from urban to rural designations under the new delineations. Additionally, CMS finalizes to withdraw a regulation (42 CFR 412.106) related to the calculation of DSH payments, which previously only included "covered" Medicare patient days in the Supplemental Security Income (SSI) ratio. The withdrawal follows a Supreme Court ruling (Empire Health) affirming that the Medicare fraction includes all days associated with patients entitled to Medicare Part A, regardless of whether Medicare paid for those days. CMS notes that the withdrawal is not considered retroactive rulemaking and will not reopen previous determinations. CMS is obligated to apply the statute as interpreted by the Supreme Court, despite potential impacts on hospitals' reimbursement expectations.

- ***Medicare Severity Diagnosis-Related Group (MS-DRG) Proposed Changes (p. 44)*** – The new diagnosis and procedure codes that are effective for FY 2025 can be found here in Tables 6A and 6B and codes that are invalid can be found in Table 6C. Notably, CMS finalizes to change the severity level designation for diagnosis codes 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) and Z59.819 (Housing instability, housed unspecified) from non-complication or comorbidity (NonCC) to CC for FY 2025.

  Regarding the recalibration of MS-DRG relative weights, CMS calculated the FY 2025 relative weights based on 19 cost-to-chare ratios (CCRs) and finalized to calculate the FY 2025 MS-DRG

cost-based relative weights based on claims data in the FY 2023 MedPAR file and data from the FY 2022 Medicare cost reports. Additional details on the methodology are on p. 317.

Specific to the relative weight calculation for MS-DRG 018, which is for cases that include procedures describing CAR T-cell therapies, CMS finalizes to continue to use its FY 2024 IPPS/LTCH PPS final rule methodology for identifying clinical trial claims and expanded access use claims. The agency also finalizes to use the methodology as modified in the FY 2024 IPPS/LTCH PPS final rule to calculate the adjustment to account for the CAR T-cell therapy cases identified as clinical trial cases in calculating the national average standardized cost per case that is used to calculate the relative weights for all MS–DRGs.

- **Add-on Payments for New Services and technologies (p. 334)** – CMS is finalizing to increase the NTAP percentage from 65 percent to 75 percent for gene therapies that are indicated to treat sickle cell disease for FY 2025. It is the agency's intent that the bump will increase access to such treatments.

  Additionally, CMS is finalizing to use the start of the fiscal year, October 1, to determine whether the technologies fall into the two- to three-year window of newness, effective beginning FY 2026. CMS will no longer consider a hold status to be an inactive status for the purposes of eligibility for the new technology add-on payment.

  For FY 2025, CMS finalizes the continuation of add-on payments for technologies that can be found on Table II.E.-01 of the proposed rule and finalizes to discontinue add-on payment for the technologies found on table II.E.02 of the proposed rule.

- ***Other Decisions and Changes to the IPPS for Operating Costs*** –

  - **Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (p. 914)** – CMS finalizes that rural hospitals with fewer than 275 beds must meet specific Case Mix Index (CMI) criteria to qualify for initial Rural Referral Center (RRC) status for cost reporting periods beginning on or after October 1, 2024. These criteria include having a CMI value for FY 2023 of at least 1.7789 (national—all urban) or at least the median CMI value for urban hospitals (excluding those with approved teaching programs) calculated by CMS for the hospital's census region. CMS has updated the CMI values based on the best available FY 2023 data through March 2024 (see table on p. 917).

CMS is finalizing the criteria for rural hospitals with fewer than 275 beds to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2024. According to section 412.96(c)(2)(i), hospitals must meet specific discharge criteria, which for FY 2025 will be based on discharges from cost reporting periods beginning during FY 2022. The national standard is set at 5,000 discharges, or 3,000 for osteopathic hospitals, with regional standards calculated using the median number of discharges for urban hospitals in each census region. This approach is consistent with CMS's proposal to use the latest available cost reporting data from FY 2022 for setting rates. The final rule incorporates these updated regional discharge medians, and as all regional medians exceed the national standard, the minimum criterion remains 5,000 discharges for most hospitals and 3,000 for osteopathic hospitals. CMS also finalizes that to qualify under the lower discharge criterion, a hospital must be specifically recognized as an osteopathic hospital, and an accreditation letter from a successor organization to the American Osteopathic Healthcare Association is not alone sufficient to demonstrate this status. The updated regulations now require hospitals to demonstrate their osteopathic status, which may include evidence such as the hospital's scope of services and mix of medical specialties.

- **Extension of Temporary Changes to Low-Volume Hospital Payment Definition and Payment Adjustment Methodology and Conforming Changes to Regulations (p. 923)** – CMS finalizes the extension of temporary changes to the low-volume hospital payment definition and payment adjustment methodology through December 31, 2024. This continuation uses the previously specified continuous, linear sliding scale formula for the portion of FY 2025 before January 1, 2025. Conforming changes to the regulation text reflect these extensions, maintaining the low-volume hospital payment adjustment policy from FYs 2019 through 2024. Starting January 1, 2025, the policy will revert to the adjustment methodology used from FYs 2005 through 2010 unless further extended by legislation.

  CMS finalizes the reversion of the low-volume hospital definition and payment adjustment methodology to pre-Affordable Care Act (ACA) standards starting January 1, 2025. As mandated by section 1886(d)(12) of the Act, hospitals will need to be more than 25 road miles from another subsection (d) hospital and have fewer than 200 discharges to qualify, with a 25-percent payment adjustment for qualifying hospitals with less than 200 discharges. The policy, which temporarily included hospitals with up to 800 discharges under recent legislation, will revert to the original criteria. Although commenters supported continuing the enhanced low-volume hospital payment policy beyond December 31, 2024, CMS clarified that, without further legislation, the policy will return to its original state. CMS has acknowledged the feedback but emphasized that

current law does not permit the continuation of the temporary changes. Therefore, effective January 1, 2025, the qualifying criteria and payment adjustment will revert to those in place prior to the ACA amendments.

CMS also finalizes the process for hospitals to request low-volume hospital payment adjustments for FY 2025, which requires hospitals to submit written requests to their MACs, demonstrating compliance with specified mileage and discharge criteria. For the period from October 1, 2024, to December 31, 2024, requests must be received by September 1, 2024, and for the period from January 1, 2025, to September 30, 2025, by December 1, 2024. Hospitals may submit a single request for both periods or separate requests. Hospitals that qualified in FY 2024 can continue to receive adjustments without reapplying, provided they meet the new criteria. If requests are submitted late, MACs may still apply the adjustments prospectively within 30 days of determination. The criteria include being more than 25 road miles from another subsection (d) hospital and having fewer than 200 total discharges for the latter period. CMS did not receive comments on this process and is finalizing it without modification.

- **Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (p. 936)** – CMS finalizes changes to the Medicare-Dependent, Small Rural Hospital (MDH) program to reflect its extension through December 31, 2024, as enacted by the Consolidated Appropriations Act (CAA), 2024. Under this extension, hospitals classified as MDHs as of September 30, 2024, will retain their status without needing to reapply. However, beginning January 1, 2025, the MDH program will expire, and all previously qualifying hospitals will transition to payment based on the IPPS Federal rate.

- **Distribution of GME residency slots under section 4122 of the Consolidated Appropriations Act (CAA), 2023 Proposed Medical Education Changes (p. 944)** – The proposed rule outlined CMS's proposal for distributing 200 new graduate medical education (GME) positions (or slots) in FY 2026 as required by Section 4122 of the Consolidated Appropriations Act of 2023. These additional slots are only to be allocated to primary care and mental-health positions. At least 100 of the slots are required to be allocated to psychiatry or psychiatry subspecialty residency training programs. For purposes of determining which programs are considered psychiatry subspecialties, CMS will refer to the specialties currently listed on the ACGME website: Addiction Medicine, Addiction Psychiatry, Brain Injury Medicine, Child and Adolescent Psychiatry, Consultation-Liaison Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, Hospice and Palliative Medicine, and Sleep Medicine.

The criteria for receiving these slots is very similar to the criteria CMS established for receiving slots under section 126 of the Consolidated Appropriations Act (CAA), 2021, which made available an additional 1,000 full-time equivalent (FTE) resident cap slots beginning in FY 2023 (details). The proposal was adopted without any modifications, with one exception: Minnesota, Montana and Oregon were added to the list of states with new medical schools that qualify to apply for GME slots under category 3. The final rule's criteria for application includes:

- CMS will require that a hospital show a "demonstrated likelihood" of filling the additional GME slots for which it applies by demonstrating that it does not have sufficient room under its current FTE resident cap(s) to accommodate a planned new program or expansion of an existing program.
- A hospital may not receive more than 10 additional FTE residency positions.
- A hospital must qualify into one of the following four categories to receive additional GME slots:
    - Hospitals located in rural areas or that are treated as being located in a rural area;
    - Hospitals in which the reference resident level of the hospital is greater than the otherwise applicable resident limit;
    - Hospitals in states with new medical schools or additional locations and branches of existing medical schools (Montana, Minnesota and Oregon were added to the list of eligible states); and
    - Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs).
- Specific to Category Four, an applicant hospital qualifies under Category Four if it participates in training residents in a program in which the residents rotate for at least 50 percent of their training time to a training site(s) physically located in a primary care or mental-health only geographic HPSA.
- Unlike the formula for distribution of the 1,000 GME slots made available through the CAA, 2021, a "super-prioritization" of HPSA designated hospitals was not established. Instead, CMS a hospital may not submit more than one application under section 4122 of the CAA, 2023. If any residency slots remain after distributing up to 1.00 FTE to each qualifying hospital, then CMS will prioritize the distribution of the remaining slots based on the HPSA score associated with the program for which each hospital is applying.
- 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.

- In accordance with current regulations, in order to ensure that residents are educated and trained in culturally and linguistically appropriate policies and practices, all applicant hospitals are required to attest that they meet the National CLAS Standards.

- All qualifying hospitals seeking increases in their FTE resident caps must submit timely applications for this distribution by March 31, 2025.

- **Proposed Payments for Indirect and Direct Graduate Medical Education** –
  - **Distributing At Least 10 Percent of Positions to Each of the Four Categories (p. 1000)** – The Secretary is required to distribute at least 10 percent of the aggregate number of total residency positions available to each of the four categories, however this has proven to be difficult. The proposed rule modified how slots would be allocated in rounds 4 and 5 (FY 26 and FY 27). CMS proposed to prioritize the distribution of slots to hospitals that qualify under Category Four, regardless of HPSA score. That is, the remaining slots will be distributed to hospitals qualifying under Category One, Category Two, or Category Three, or hospitals that meet the definitions of more than one of these categories, based on the HPSA score associated with the program for which each hospital is applying. The proposed changes were finalized without modification.

  - **Proposed Modifications to the Criteria for New Residency Programs and Requests for Information (p. 1024)** – CMS continues to focus on what constitutes a "new" program for purposes of receiving additional Medicare-funded GME slots. As urban hospitals have begun to reclassify as rural for IME purposes and receive additional IME cap slots for any new program started, questions have arisen as to what qualifies as a "new" program. After reviewing the comments, CMS elected to not finalize the proposal that at least 90 percent of the individual resident trainees (not FTEs) must not have previous training in the same specialty as the new program. Instead, CMS will initiate another RFI particularly focused on the criterion regarding newness of residents.

  - **Proposed Reimbursements for Educational Activities (p. 1042)** – To formulate the reimbursement costs for educational activities such as nursing and allied health (NAH) education programs, CMS proposes the consistent use of HCRIS data for past calendar years: NAH pass-through payment, Part A Inpatient Days, MA Inpatient Days. The proposal was adopted without changes.

- **Payment Adjustment for Certain Clinical Trial and Expanded Access Use Immunotherapy Cases (p. 1048)** – For FY 2025, CMS finalizes to continue to apply an adjustment to the payment amount for expanded access use of immunotherapy and applicable clinical trial cases, which inclusive of procedure codes for CAR T-cell and non-CAR T-cell therapies.

- **Separate IPPS payment for establishing and maintaining access to essential medicines (p. 1057)** – Given the Administration's focus on combatting drug shortages, and following the CY 2024 request for information on this proposal, CMS finalizes to establish a separate payment for small, independent hospitals for the IPPS shares of the additional resource costs to voluntarily establish and maintain a 6-month buffer stock of one or more of 86 essential medicines, either directly or through contractual arrangements with a pharmaceutical manufacturer, distributor, or intermediary. Small, independent hospitals are defined as hospitals with 100 beds or fewer that are not part of a chain organization. The list of essential medicines is a prioritized list of 86 medicines that are either critical for minimum patient care in acute settings or important for acute care with no comparable alternatives available.

  CMS finalizes that the costs of buffer stocks that would be eligible for separate payment are the additional resource costs of establishing and maintaining access to a 6-month buffer stock for any eligible medicines on ARMI's List of 86 essential medicines, including any subsequent revisions to that list of medicines. CMS notes that this payment is made in a non-budget neutral manner and the adjustments would begin for cost reporting periods beginning on or after October 1, 2024. The agency estimates that approximately 500 hospitals would qualify for the payment.

- **Hospital Readmission Reduction Program (p. 1098)** – There are no new proposals or updates for the HRRP in the FY 2025 rule. Financial impact estimates for FY 2025, covering July 1, 2020, to June 30, 2023, can be found in section I.G.7. of Appendix A.

- **Hospital Value-Based Purchasing (VBP) Program (p. 1099)** – CMS finalizes that FY 2025 program will use a 2% applicable percent, with an estimated $1.67 billion available for value-based payments. For FY 2025, value-based incentive payments will be determined using a linear exchange function. No new quality measures were proposed for FY 2025. Changes to the HCAHPS Survey will affect scoring starting FY 2027, focusing on six dimensions until FY 2030, when a new version of the survey will be adopted. FY 2027 will see modifications to HCAHPS scoring. Performance standards for Clinical Outcomes and Efficiency measures for FY 2028, FY 2029, and FY 2030 are outlined in respective tables.

- **Hospital-Acquired Condition (HAC) Reduction Program (p. 1113)** – CMS finalizes that the program will continue to use previously finalized measures, including CMS PSI 90 and CDC NHSN healthcare-associated infection (HAI) measures. Although no new policies were proposed for FY 2025, feedback from stakeholders included suggestions for new measures like hospital-onset COVID-19 and endoscope-associated infections. Recommendations also included defining hospital-onset COVID-19 as infections diagnosed after five days of admission and improving reporting and prevention strategies. These suggestions will be considered for future updates to the program.

- ***Quality Data Reporting for Specific Providers and Suppliers (p. 1254)***

  - **Crosscutting Quality Program Proposals and Request for Comment (p. 1255)** – CMS is finalizing four changes across multiple quality programs:
    - The agency is adopting the Patient Safety Structural Measure for the Hospital IQR Program (CY 2025 reporting period/FY 2027 payment determination) and the PCHQR Program (CY 2025 Reporting Period/FY 2025 Program Year) (p. 1255)
    - CMS is modifying the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure for the Hospital IQR Program (CY 2025 Reporting Period/FY 2027 Payment Determination), PCHQR Program (CY 2025 Reporting Period/FY 2027 Program Year), and the Hospital VBP Program (FY 2023 Program Year) (p. 1346) The agency is finalizing its proposal to add three new sub-measures to the HCAHPS: 'care coordination', 'restfulness of hospital environment', and 'information about symptoms'. The agency will also remove the 'care transition' sub-measure and modify the 'responsiveness of hospital staff' sub-measure. All new and removed survey questions can be found starting on p. 1349.
    - CMS is finalizing an update to the HCAHPS Survey Measure and Associated Scoring Modifications in the Hospital VBP Program beginning with the FY 2030 program year (p. 1397) to support hospitals during the measure transition period.

    - **Proposed Modifications to Scoring of the HCAHPS Survey for the Hospital VBP Program for the FY 2027 through FY 2029 Program Years (p. 1397)** – CMS is modifying the scoring of the HCAHPS Survey for the Hospital VBP Program for the FY 2027 through FY 2029 program years. These modifications are due to the adoption of an updated version of the survey, which hospitals can begin using for discharges starting January 1, 2025, for reporting purposes in the Hospital Inpatient Quality Reporting (IQR) and PPS-Exempt Cancer Hospital Quality

Reporting (PCHQR) Programs. However, due to statutory requirements, the updated survey cannot be incorporated into the VBP Program until the FY 2030 program year. To ease the transition for hospitals, CMS is finalizing that hospitals can administer the updated survey from 2025 onwards but will only be scored on six dimensions of the survey that remain unchanged until FY 2030. Specifically, CMS will exclude the "Responsiveness of Hospital Staff" and "Care Transition" dimensions from scoring in the VBP Program for the FY 2027 through FY 2029 program years. The scoring modification methodology involves calculating Achievement and Improvement Points for the six remaining dimensions, creating a pre-normalized HCAHPS Base Score, and incorporating Consistency Points, resulting in a total score ranging from 0 to 100 points. The agency aims to provide a smooth transition for hospitals while ensuring consistent scoring until the updated survey can be fully integrated into the VBP Program.

- **Adoption of the Updated HCAHPS Survey Measure and Associated Scoring Modifications in the Hospital VBP Program Beginning with the FY 2030 Program Year (p. 1403)** – CMS is finalizing its proposal to modify scoring of the Person and Community Engagement Domain for the FY 2027 through FY 2029 program years to only score six unchanged dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. The agency is also finalizing the adoption of the updated HCAHPS Survey in the Hospital VBP Program beginning with the FY 2030 program year after the updated survey would have been publicly reported under the Hospital Inpatient Quality Reporting (IQR) Program for 1 year. Finally, CMS is adopting the updated HCAHPS Survey measure beginning with the FY 2030 program year, which would result in nine HCAHPS Survey dimensions for the Person and Community Engagement Domain.

- **Solicitation of comment on adopting measures across the hospital quality reporting and value-based purchasing programs which capture more forms of unplanned post-acute care and encourage hospitals to improve discharge processes (p. 1415)** – In the proposed rule, CMS invited comment on opportunities for the QRP and VBP to improve the discharge process. Many respondents to this request were in favor of a broader range of post-discharge patient outcomes, and specifically identified including ED visits and observation services, while others disagreed that this was within program statute. Commenters also raised concerns to CMS about the potential negative impact on patient care if unplanned hospital returns are measured. CMS will consider

all comments for future notice-and-comment rulemaking, stating that the agency will continue to prioritize the reduction of health disparities as well as harmonizing measurements across settings.

- **Hospital Inpatient Quality Reporting (IQR) Program (p. 1421)** –CMS is finalizing its proposed adoption of seven new measures, the refinement of two measures, and the removal of five measures.

  - **New Measures for the Hospital IQR Program Measure Set (p. 1423):**
    - Patient Safety Structural measure beginning with the CY 2025 reporting period/FY 2027 payment determination;
    - Age Friendly Hospital measure beginning with the CY 2025 reporting period/FY 2027 payment;
    - Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination;
    - Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination;
    - Hospital Harm - Falls with Injury eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination;
    - Hospital Harm - Postoperative Respiratory Failure eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination; and
    - Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) measure beginning with the July 1, 2023 – June 30, 2025 reporting period/FY 2027 payment determination.

  - **Measure Removals for the Hospital IQR Program Measure Set (p. 1536):**
    - Proposal to Remove the Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) Measure Beginning with the CY 2025 Reporting Period/FY 2027 Payment Determination;
    - Hospital-level, Risk Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) measures beginning with the July 1, 2021 – June 30, 2024 reporting period/ FY 2026 payment determination;
    - Hospital-level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Heart Failure (HF) measure beginning with the July 1, 2021 – June 30, 2024 reporting period/FY 2026 payment determination;

- Hospital-level, Risk Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN) measure beginning with the July 1, 2021 – June 30, 2024 reporting period/FY 2026 payment determination; and
- 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) measure beginning with the April 1, 2021 – March 31, 2024 reporting period/FY 2026 payment determination.

▪ **Refinements to Current Measures in the Hospital IQR Program Measure Set (p. 1551):**

- Global Malnutrition Composite Score (GMCS) eCQM: CMS is expanding the applicable population from adults 65 and older to adults 18 and older beginning with the CY 2026 reporting period/FY 2028 payment determination and for subsequent years.
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey: CMS is modifying the scoring of the Person and Community Engagement Domain for FY 2027 through FY 2029 program years to only score six unchanged dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. The updated HCAHPS Survey will be adopted beginning with the FY 2030 program year after being publicly reported under the Hospital IQR Program for one year. The six dimensions would be:
  - Communication with Nurses,
  - Communication with Doctors,
  - Communication about Medicines,
  - Discharge Information,
  - Cleanliness and Quietness, and
  - Overall Rating.

  CMS would exclude the "Responsiveness of Hospital Staff" and "Care Transition" dimensions measure beginning with the CY 2025 reporting period/FY 2027 payment determination.

- **PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) (p. 1595)** – CMS is adopting two changes to PCHQR requirements. See Table IX.D.-01 starting on p. 1596 for a list of previously and newly adopted measures for the PCHQR Program measure set beginning with the CY 2025 reporting period/FY2027 program year.

- **CMS is Adopting the Patient Safety Structural measure** beginning with the CY 2025 reporting period/FY 2027 program year (p. 1595)
- **CMS is Modifying the HCAHPS Survey measure** to move up the start date for publicly displaying hospital performance on the Hospital Commitment to Health Equity measure, beginning with the CY 2025 reporting period/FY 2025 program year.

- **Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (p. 1600)** – CMS is finalizing several changes to quality reporting requirements.

  - **Quality Measure Proposals**
    - **CMS is adding four new items related to the social determinants of health (SDOH) category** to be collected as standardized patient assessment data elements under the LTCH QRP: Living Situation (one item); Food (two items); and Utilities (one item), beginning with the FY 2028 LTCH QRP. The selected SODH items are from the Accountable Health Communities Health-Related Social Needs Screening Tool. CMS believes that requiring LTCHs to report these items will further standardize the screening of SDOH across quality programs.
    - **CMS is modifying the transportation item**, beginning with the FY 2028 LTCH QRP. CMS is acting to remove ambiguity and simplify response options. The proposed modifications do not substantially change the measure.
    - **CMS is extending the admission assessment window from three to four days** for the LTCH Continuity Assessment and Record of Evaluation (CARE) Data Set, beginning with the FY 2028 LTCH QRP.

  - **LTCH QRP Quality Measure Concepts Under Consideration for Future Years: Request for Information (RFI) (p. 1639)** – In the proposed rule, CMS sought input on the importance, relevance, appropriateness, and applicability of each of the following concepts for future years in the LTCH QRP: vaccination composite, pain management, and depression. CMS received both positive and negative comments for each of the three concepts and will use the information in future measure development.

  - **Future LTCH Star Rating System: Request for Information (RFI) (p. 1644) –** In the proposed rule, CMS sought feedback on the development of a five-star methodology for LTCHs that can meaningfully distinguish between quality of care offered by providers. CMS was particularly interested in how a rating system

would determine an LTCH's star rating, the methods used for such calculations, and an anticipated timeline for implementation. Commenters strongly recommend that CMS engage with caregivers, providers, and patients in developing a LTCH Star Rating System to accurately capture and consider the complexities of LTCH. CMS notes that the agency will use this input to inform future star rating development efforts.

- **Medicare Promoting Interoperability Program (p. 1658)** – CMS finalizes an array of changes to the Medicare Promoting Interoperability Program. The agency describes the objectives and measures for EHR reporting in CY 2025 in Table IX.F.-01 on p. 1674.
  - CMS makes several changes to the Antimicrobial Use and Resistance Surveillance measure (p. 1658):
    - Separates the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures, an Antimicrobial Use (AU) Surveillance measure and an Antimicrobial Resistance (AR) Surveillance measure, beginning with the EHR reporting period in CY 2025;
    - Adds a new exclusion for eligible hospitals or critical access hospitals (CAHs) that do not have a data source containing the minimal discrete data elements that are required for AU or AR Surveillance reporting;
    - Modifies the applicability of the existing exclusions to either the AU or AR Surveillance measures, respectively; and
    - Treats the AU and AR Surveillance measures as new measures with respect to active engagement beginning with the EHR reporting period in CY 2025.
  - Incrementally increases the performance-based scoring threshold for eligible hospitals and CAHs reporting under the Medicare Promoting Interoperability Program from 60 points to 70 points beginning with the EHR reporting period in CY 2025 and from 70 to 80 points beginning CY 2026 (p. 1690)
  - Adopts two new eCQMs that hospitals can select as one of their three self-selected eCQMs beginning with the CY 2026 reporting period: the Hospital Harm – Falls with Injury eCQM and the Hospital Harm – Postoperative Respiratory Failure eCQM (p. 1702)
  - Increases the number of mandatory eCQMs eligible hospitals and CAHs would be required to report on beginning with the CY 2026 reporting period with slight modifications: hospitals must report eight eCQMs for CY 2026, nine eCQMs for CY 2027, and eleven eCQMs for CY 2028 (p. 1705)
  - Modifies one eCQM, the Global Malnutrition Composite Score eCQM beginning with the CY 2026 reporting period (p. 963)

CMS describes the future goals of the Promoting Interoperability program related to Fast Healthcare Interoperability Resources® (FHIR) application programming interfaces (APIs), cybersecurity, and prior authorization beginning on p. 1712.

- ***Other Provisions Included in this Final Rule (p. 1716)*** –

  - **Transforming Episode Accountability Model (TEAM) (p. 1716-2447)** – Despite many commenters requesting a delay to the start date, the agency finalizes its proposal for a new mandatory, episode-based payment model, Transforming Episode Accountability Model (TEAM), to begin on January 1, 2026, and end on December 31, 2030 in select CBSAs (see Table X.A.-07 on p. 1885 for the list of mandatory CBSAs). However, it does not finalize all provisions and notes that it will address some elements in future rulemaking.

    CMS finalizes its definition of model participant as proposed with a modification to allow hospitals that participate in the Bundled Payments for Care Improvement Advanced (BPCI Advanced) and Comprehensive Care for Joint Replacement (CJR) models to voluntarily opt into TEAM. The agency also permits hospitals to participate in both the TEAM and the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model. Maryland hospitals are excluded. CMS does not finalize a policy to permit AHEAD participants to voluntarily opt out of TEAM. Similar to its approach to TEAM and ACO overlap, it also does not finalize payment adjustments to account for the same beneficiaries being attributed to both models. More detailed overlap policies for TEAM and AHEAD will be considered in future rulemaking.

    CMS finalizes episode categories for TEAM as proposed but notes it will take stakeholders' feedback into consideration if it expands the number of episodes in the future, which it says would be done through notice-and-comment rulemaking. Table X.A.-08 details the final TEAM episode categories and billing codes.

    The agency finalizes its proposal to hold TEAM participants financially accountable for episodes as proposed. CMS makes several modifications to Tracks 1 and 2, including lengthening Track 1 up to 3 performance years for safety net hospitals, as well as changing Track 2 to have 5 percent stop-gain and stop-loss limits. The agency does not finalize the length of the lookback period or its low volume hospital policy, noting that these policies will be proposed through notice-and-comment rulemaking within the next year.

    Due to concerns regarding too much financial risk, CMS says it is finalizing its trend proposal with slight modifications to include a 3 percent capped retrospective trend factor adjustment

applied during reconciliation to construct reconciliation target prices. The agency also slightly modifies its proposed discount factors by incorporating a discount factor of 1.5 percent for CABG and Major Bowel episode categories and a discount factor of 2 percent for LEJR, SHFFT, and Spinal Fusion episode categories. The agency finalizes its risk adjustment methodology with some changes as well, see discussion starting on p. 2097 for details.

CMS estimates that testing TEAM will result in $481 million in savings for the Medicare program over the model's five performance years.

- **Provider Reimbursement Review Board (PRRB) (p. 2448)** – CMS finalizes its proposal to require Board Members be knowledgeable about provider payment under Medicare Part A and establishes a limit of three 3-year consecutive terms. The agency does not finalize a policy that would modify the number of consecutive terms the Chairperson may serve. Changes are effective January 1, 2025.

- **Materny Care Request for Information (RFI) (p. 2455)** – In the proposed rule, CMS requested stakeholder feedback on differences between hospital resources required to provide inpatient pregnancy and childbirth services to Medicare patients as compared to non-Medicare patients. CMS sought feedback on the extent to which non-Medicare payers or insurers may be using the IPPS as a basis for determining payment rates, and the impact of using the IPPS as the basis for payment. CMS reports that commenters generally appreciated the request and provided a wide range of feedback on adequacy of payment rates, the extent to which other payers use Medicare payment to set rates, and other suggestions to improve payment and health outcomes. CMS will consider the feedback in its ongoing efforts to reduce maternal health disparities.

- **Proposal to Establish Ongoing Reporting for COVID-19, Influenza, and RSV (p. 2470)** – CMS is finalizing the proposal to update the infection prevention and control and antibiotic stewardship program standards for hospitals and Critical Access Hospitals (CAHs). Starting November 1, 2024, these facilities must electronically report data on COVID-19, influenza, and RSV to the CDC through NHSN or other CDC-supported systems. The reporting will include:
  - Confirmed respiratory illness cases among hospitalized patients;
  - Hospital bed census and capacity, categorized by setting and population group (adult or pediatric); and
  - Limited patient demographic information, including age.

This rule revises previous COVID-19 and influenza reporting requirements by reducing the frequency of reporting to weekly (except during a declared public health emergency). The changes

aim to streamline data collection while maintaining situational awareness and minimizing reporting burdens.