Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2024

MEDICARE IPPS FINAL RULE

On Aug. 1, 2024, the Centers for Medicare & 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 Oct. 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 Jan. 1, 2025.

A copy of the final rule and other resources related to the IPPS are available on the CMS website.

IPPS Payments Rates

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.

<table>
<tr><th></th><th>Federal Operating Rate</th><th>Hospital Specific Rate</th><th>Federal Capital Rate</th></tr>
<tr><td>Market Basket/Capital Input Price Index update</td><td colspan="2">+3.4%
(proposed at +3.0%)</td><td>+2.6%
(proposed at +2.5%)</td></tr>
<tr><td>ACA-Mandated Productivity Adjustment</td><td colspan="2">-0.5 percentage points (PPTs)
(proposed at -0.4 PPTs)</td><td>—</td></tr>
<tr><td>Forecast Error Adjustment</td><td colspan="2">—</td><td>+0.5 PPTs
(as proposed)</td></tr>
<tr><td>Lowest Quartile Wage Index Adjustment</td><td>-0.02%
(proposed at +0.01%)</td><td>—</td><td rowspan="2">-0.06%
(proposed at -0.21%)</td></tr>
<tr><td>Wage Index Cap Policy</td><td>-0.05%
(proposed at -0.25%)</td><td>—</td></tr>
<tr><td>MS-DRG Weight Cap Policy</td><td colspan="2">-0.01%
(proposed at -0.04%)</td><td>-0.01%
(proposed at -0.04%)</td></tr>
<tr><td>All Other Annual Budget Neutrality Adjustments</td><td>-1.11%
(proposed at +0.27%)</td><td>-0.28%
(proposed at +0.29%)</td><td>-1.65%
(proposed at -0.24%)</td></tr>
<tr><td>Net Rate Update</td><td>+1.67%
(proposed at +2.59%)</td><td>+2.6%
(proposed at +2.26%)</td><td>+1.33%
(proposed at +2.50%)</td></tr>
</table>

Effects of the IQR and EHR MU Incentive Programs: 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: On March 28, 2024, CMS issued Change Request 13566, available here, 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 Oct. 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.

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.

Wage Index

Updated CBSA Delineations: On July 21, 2023, the OMB issued OMB Bulletin No. 23-01 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. 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. 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 Oct. 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.

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.

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."

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 lists the eligible CBSAs that hospitals in CBSAs in the situation above could instead reclassify to. Table Y shows all providers subject to this policy.

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: 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: 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 the 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: 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) 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: 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: 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)."

Labor-Related Share: 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. By law, the labor-related share for hospitals with a wage index less than or equal to 1 will remain at 62%.

A complete list of the final wage indexes for payments in FFY 2025 is available here.

DSH Payments

The ACA mandates the implementation of Medicare DSH calculations and payments 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 Payment: 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 here.

Impact on Traditional DSH Payment Adjustments due to CBSA Delineation Updates: 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

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 Jan. 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; and
- 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.

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.

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.

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): 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 requested specific information on new residency program modifications. Based on comments received, CMS is not finalizing its proposals and is initiating another RFI seeking comment on the appropriate criterion regarding newness of residents.

Updates to the MS-DRGs

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%

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. For comparison purposes, the final FFY 2024 DRGs are available in Table 5 on the CMS website

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: 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-Stage Renal Disease (ESRD) Discharges: CMS is finalizing that, effective for cost reporting periods beginning on or after Oct. 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: 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 Oct. 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; and
- 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: 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; and
- Z59.819 - Housing instability, housed unspecified

Low-Volume Hospitals Adjustment

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 Dec. 31, 2024. On Jan. 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.

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 Oct. 1, 2024–Dec. 31, 2024. The MAC must receive a written request by Sept. 1, 2024 in order for the adjustment to be applied to payments for its discharges beginning on or after Oct. 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 Jan. 1, 2025-Sept. 30, 2025 to their MAC no later than Dec. 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 Oct. 1, 2024-Dec. 31, 2024, as well as the criteria for Jan. 1, 2024-Sept. 30, 2025.

Rural Referral Center (RCC) Status

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

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 Dec. 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 Sept. 30, 2024 will continue to be classified as an MDH as of Oct. 1, 2024, without the need to reapply. Beginning Jan. 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 Dec. 2, 2024 to apply for SCH status effective Jan. 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)

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 Jan. 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. Table X.A.-05 lists 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

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 Oct. 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.

CoP Requirements for Hospitals and CAHs to Report Respiratory Illness

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 Oct. 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 Oct. 1, 2024, but did not adopt any policies to include these data for reporting beginning on Oct. 1, 2024. Finally, CMS sought information on health care reporting to the National Syndromic Surveillance Program (NSSP).

Updates to the IQR Program and Electronic Reporting Under the Program

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; and
- 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; and
- 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); 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) (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 Oct. 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 Jan. 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 Jan. 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.

The updated HCAHPS Survey measure will be implemented for IQR beginning with patients discharged between Jan. 1, 2025-Dec. 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 Jan. 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.

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: 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 Adjustment

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 Jan. 1, 2020-June 30, 2020 will be used in calculations for the any of the three quality programs.

VBP Program: 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% 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% 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.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.

RRP: 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%.

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.

HAC Reduction Program: 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% 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.

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: 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: CMS did not adopt any changes to RRP.

HAC Reduction Program: CMS did not adopt any changes to the HAC reduction program.

Promoting interoperability Program

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 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.

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