Illinois Health and Hospital Association

RULE SUMMARY

APRIL 2024

FY 2025 MEDICARE INPATIENT PROSPECTIVE PAYMENT SYSTEM PROPOSED RULE (CMS-1808-P)

Overview and Resources

On April 10, 2024, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2025 proposed rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed 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 proposed in this rule:

- Utilizing FY 2023 Medicare Provider and Review (MedPAR) and FY 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 payments in FY 2025 being based on audited FYs 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 and related requests for information;
- Implementation of the Transforming Episode Accountability Model (TEAM) which would test whether financial accountability for five procedures would 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 would be effective for discharges on or after Oct. 1, 2024, unless otherwise noted. CMS estimates the overall impact of this proposed rule update to be an increase of approximately $3.2 billion in aggregate payments for acute care hospitals in FY 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.

An online version of the proposed rule will be available on May 2, 2024 here. Comments on the proposed rule are due to CMS by June 10, 2024.

IPPS Payment Rates

CMS proposed a 3.0% market basket update. After taking all adjustments, including the .4 percentage point productivity decrease, into effect, the net increase is 2.59% for federal operating/hospital specific rates, and 2.50% for federal capital rates.

The table below lists the federal operating and capital rates proposed for FY 2025 compared to the rates currently in effect for FY 2024. These rates include all market basket increases and reductions as well as the application of proposed 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 FY 2024	Proposed FY 2025	Percent Change
Federal Operating Rate	**$6,497.77**	**$6,666.10**	**+2.59%**
Federal Capital Rate	**$503.83**	**$516.41**	**+2.50%**

Hospitals that fail to meet Inpatient Quality Reporting (IQR) or Electronic Health Record (EHR) requirements will receive a 25% and 75% reduction to the full market basket, respectively.

Outlier Payments

On March 28, 2024, CMS issued Change Request 13566 which expands the criteria for identifying cost reports which 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 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 would be in addition to the previously adopted methodology that incorporates historic cost report outlier reconciliations to develop the outlier threshold. Therefore, for FY 2025, CMS proposes to incorporate total outlier reconciliation dollars from the FY 2019 cost reports into the outlier model using a similar methodology to what was finalized in FY 2020, modified to reflect the additional cost reports identified due to the new criteria. Since the new criteria are not effective until the FY 2025 cost reports, CMS proposes to apply the criteria to FY 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 to account for the criteria not being present in the FY 2019 cost reports.

An analysis done by CMS using this new proposed methodology determined outlier payments at 5.14% of total IPPS payments. CMS is proposing an outlier threshold of $49,237 for FY 2025, which includes a charge inflation factor calculated using the Dec. 2022 MedPAR file for FY 2022 charge data and the Dec. 2023 MedPAR file of FY 2023 charge data. This threshold is 15.2% higher than the current (FY 2024) outlier threshold of $42,750.

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 proposing to adopt the newest OMB delineations for the FY 2025 IPPS wage index.

If CMS adopts this proposal, 54 counties and 33 hospitals that are currently part of an urban CBSA would be considered located in a rural area. Providers who would lose their urban status due to these proposals would 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 would have their DSH payments adjusted to be one-third of the difference between their previous urban DSH payments and current rural DSH payments.

Additionally, adopting this proposal would 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 would have a two-year transition period that begins from the date the redesignation becomes effective and must reclassify as rural during this transition period in order to retain their CAH status after the transition ends. Also, 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 would cause some urban counties to shift between new or existing urban CBSAs. In some cases, this would change the name or numbers of certain CBSAs.

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 FY 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 FY and will be applied to the final wage index a hospital would have on the last day of the prior FY. 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 FY with no cap applied, because a new IPPS will not have a wage index in the prior FY. This policy would be implemented in a budget neutral manner with a proposed net budget neutrality factor of 0.99752, after backing out the effects of the FY 2024 adjustment.

Out-Migration Adjustments

For FY 2025 and onward, CMS is proposing to update out-migration adjustments to be based on a custom tabulation of the American Community Survey utilizing data from 2016-2020. This is consistent with methodology used for determining FY 2012 out-migration adjustments. Proposed out-migration adjustments can be found in Table 2 released with this proposed rule.

Addressing Wage Index Disparities between High and Low Wage Index Hospitals

CMS had noted that many comments from the Wage Index Request for Information in the FY 2019 IPPS proposed rule reflected *"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 FY 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 FY 2024) in order to be properly reflected in the Medicare cost report for future years. CMS believes that the effects of the COVID-19 public health emergency (PHE) has complicated their ability to evaluate how successful this low wage index hospital policy was for increasing employee compensation. As such, CMS proposes to 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 would be in effect for at least three more years, beginning in FY 2025, so that the policy would 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 pending 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. This court decision involves only FY 2020, is not final, and has been appealed by CMS.

CMS proposes to 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 FY 2025 is proposed to be 0.8879, and the net budget neutrality adjustment would be 1.0001 after backing out the effects of the FY 2024 adjustment.

Occupational Mix Adjustment

CMS proposes the use of the calendar year (CY) 2022 Occupational Mix Survey for the calculation of the wage index for FY 2025. The FY 2025 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS is proposing a FY 2025 occupational mix adjusted national average hourly wage of $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 FY 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 proposing that §412.103 reclassifications would 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 proposed cancellation would 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 proposing to update 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.

Rural Emergency Hospitals (REH)

CMS believes that REHs should be treated similarly to CAHs when calculating the wage index, since hospitals which converted to REH status do not provide acute care inpatient services. As such, CMS proposes to exclude REHs from the calculation of the wage index.

Labor-Related Share

The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FY 2025, CMS proposes to continue to apply a labor-related share of 67.6% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

A complete list of the proposed wage indexes for payments in FY 2025 is available on the CMS website.

DSH Payments

DSH dollars available to hospitals under the ACA's payment formula are proposed to increase by $0.560 billion in FY 2025 relative to FY 2024 due to an increase in the pool from projected DSH payments.

CMS is projecting that 2,422 hospitals would be eligible for DSH payments in FY 2025 based on audited FY 2019, FY 2020, and FY 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.

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 would become rural under the proposed CBSA updates would be 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 which would lose their urban status due to these proposals are proposed to 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 are proposed to 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 FY 2026. Each qualifying hospital that is approved for these positions would receive an increase to their resident limit, would be notified of the positions distributed to them by Jan. 31, 2026, and would have the increase effective as of July 1, 2026.

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.

CMS proposes that, for FY 2026, the application deadline for these positions would be March 31, 2025, with March 31 of each subsequent year being the deadline for applications starting the following FY.

Also in this proposed 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)
360090	McLaren St Luke's Hospital	Maumee, OH	45780	5/9/2023	14.93	14.93
260210	South City Hospital	St. Louis, MO	41180	11/18/2023	67.54	74.00

The IME adjustment factor is proposed to remain at 1.35 for FY 2025.

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. For IPPS rate-setting, CMS typically uses the MedPAR claims data file that contains claims from discharges two years prior to the fiscal year that is the subject of rulemaking. For hospital Cost Report data, CMS traditionally uses the dataset containing cost reports beginning three years prior to the fiscal year under study. Therefore, CMS proposes to utilize FY 2023 MedPAR IPPS claims data and FY 2022 HCRIS data to calculate FY 2025 rates.

There are proposed to be 771 payable DRGs for FY 2025 (compared to 764 for FY 2024), with 78.4% of DRG weights changing by less than +/- 5%, 16.0% changing at least +/-5% but less than +/- 10%, 5.6% changing +/-10% or more, 4.7% that are affected by the relative weight cap on reductions, and 1.3% being new MS-DRGs. The five MS-DRGs with the greatest proposed year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	MS-DRG Title	Final FY 2024 Weight	Proposed FY 2025 Weight	Percent Change
010	PANCREAS TRANSPLANT	4.8136	8.0365	66.95%
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	3.0320	4.3126	42.24%
770	ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7987	1.0969	37.34%
509	ARTHROSCOPY	1.3661	1.7550	28.47%
599	MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	0.6728	0.8486	26.13%

The full list of the proposed FY 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..

Cap for Relative Weight Reductions

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 proposes to continue this policy and apply a budget neutrality adjustment of 0.999617 to the operating rate and 0.9996 to the capital rate for all hospitals in FY 2025.

Changes to the Calculation of the IPPS Add-On Payment for Certain End-State Renal Disease (ESRD) Discharges

CMS is proposing that, effective for cost reporting periods beginning on or after Oct. 1, 2024, the ESRD add-on would be calculated using the annual CY ESRD PPS base rate multiplied by three, for eligible discharges. Under this proposal, payments to hospitals would 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.

Social Determinants of Health (SDOH) Diagnosis Codes

CMS is proposing a change to the severity level for the following diagnosis codes regarding inadequate housing and homelessness from NonCC to CC for FY 2025:

- Z59.10 - Inadequate housing, unspecified
- Z59.11 - Inadequate housing environmental temperature
- Z59.12 - Inadequate housing utilities
- Z59.19 - Other inadequate housing
- Z59.811 - Housing instability, housed, with risk of homelessness
- Z59.812 - Housing instability, housed, homelessness in past 12 months
- Z59.819 - Housing instability, housed unspecified

Low-Volume Hospital Adjustment

The CAA of 2023 extended the current criteria through FY 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 would 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.

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 FY 2025 beginning Oct. 1-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 proposing 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-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 FY 2024 may continue to receive the adjustment for FY 2024 without reapplying if it meets both the proposed discharge and mileage criteria for Oct. 1-Dec. 31, 2024, as well as the criteria for Jan. 1, 2024-Sept. 30, 2025.

Sole Community Hospitals (SCH) Status

For SCH applications received on or after Oct. 1, 2023 where a hospital's SCH approval is dependent on a merger with another nearby hospital and the applying hospital meets other SCH classification requirements, CMS is adopting that the SCH and payment adjustment will be effective as of the approved merger effective date if the MAC receives the complete application within 90 days of CMS' written notification to the hospital of the approval of the merger. If the MAC does not receive this complete application within 90 days, the SCH classification will be effective as of the date the MAC receives the application. The effective date of the rural reclassification of these hospitals would be effective on the same day as the SCH classification.

Medicare-Dependent, Small Rural Hospital (MDH) Program

The MDH program was extended through a portion of FY 2025, ending Dec. 31, 2024, as granted by the CAA of 2024. 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 would no longer have MDH status and would be paid based on the IPPS federal rate. Hospitals which would lose this status may apply for SCH status in advance of the expiration of the MDH program. Such hospitals would 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 proposing 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 would be:

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

This model is proposed to be mandatory and would last for 5 years, beginning on Jan. 1, 2026. Hospitals with required participation will be determined by CBSA, with CMS selecting CBSAs using a stratified random sampling methodology from a list of 803 eligible CBSAs. Table X.A.-02 in the proposed rule lists these CBSAs, of which approximately 25% would be chosen for this model. Hospitals required to participate would continue to bill Medicare FFS but would receive beneficiary risk-adjusted target prices by episode type and region, subject to a quality performance adjustment, based on historic Medicare episode spend and a 3% discount factor.

IPPS Payments for Establishing and Maintaining Access to Essential Medicines

CMS is proposing for cost reporting periods beginning on or after Oct. 1, 2024, a separate payment would 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 could be provided biweekly or as a lump sum at cost report settlement.

In an effort to mitigate this proposed policy from either exacerbating existing shortages or contributing to hoarding, CMS proposes that 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 proposing to revise 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 proposed to be 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.

Currently, reporting requirements on respiratory illness end on April 30, 2024, with this proposal going into effect on Oct. 1, 2024. CMS encourages providers to voluntarily report on these data in the interim. CMS also proposes that, outside of a declared national PHE for an acute respiratory illness, hospitals and CAHs would have to report this data on a weekly basis through a Centers for Disease Control and Prevention (CDC)-owned or supported system. The following proposals would 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 invites comments on if there should be any limits to the data that CMS can require without notice and comment rulemaking and how stakeholder feedback should be gathered during a PHE. CMS also seeks comment as to whether race/ethnicity demographic information should be included as part of the reporting beginning on Oct. 1, 2024. Finally, CMS is requesting 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 proposing to adopt the following measures beginning with the CY 2025 reporting period/FY 2027 payment determination:

- Patient Safety Structural measure;
- 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 proposing to adopt the following measures for the CY 2026 reporting period/FY 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 proposing to remove Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) for the CY 2025 reporting period/FY 2027 payment determination.

CMS is also proposing to remove four clinical episode-based payment measures beginning with the FY 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/FY 2028 payment determination, CMS is proposing to modify 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 proposing to increase the number of mandatory eCQMs in order to support CMS' commitment to better safety practices over two years. Specifically, CMS proposes to include the five Hospital Harm eCQMs as mandatory. Beginning with CY 2026 reporting period/FY 2028 payment determination, CMS is proposing to require hospitals to report on:

- Hospital Harm - Severe Hypoglycemia eCQM;
- Hospital Harm - Severe Hyperglycemia eCQM; and
- Hospital Harm - Opioid-Related Adverse Events eCQM.

Beginning with CY 2027 reporting period/FY 2028 payment determination, CMS is proposing to require hospitals to report on:

- Hospital Harm - Pressure Injury eCQM; and
- Hospital Harm - Acute Kidney Injury eCQM.

CMS is also proposing to modify the eCQM validation scoring beginning with CY 2025 eCQM data/FY 2028 payment determination to use accuracy rather than just completeness. Specifically, eCQM validation scores would 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 would be used to compute an agreement rate and an associated confidence interval. The upper bound of the two-tailed 90 percent confidence interval would be used as the final eCQM validation score for the hospital. A minimum score of 75 percent accuracy would be required for the hospital to pass the eCQM validation requirement. With this, CMS is proposing to 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 would be replaced by two separate validation scores, one for chart-abstracted measures and one for

eCQMs, equally weighted at 50% each. Hospitals would 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/FY 2026 payment determination, CMS is proposing that hospitals would 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/FY 2027 payment determination, CMS is proposing to modify the HCAHPS Survey measure to include 32 questions that would have a total of eleven sub-measures, with seven of the sub-measures being multi-question sub-measures. Seven of the sub-measures would remain unchanged from the current survey (four multi-question and three single-question).

The proposed 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 would also remove 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 would no longer be reported starting Jan. 2026. The existing “Responsiveness of Hospital Staff” sub-measure would 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 would begin public reporting Jan. 2025.

Seven new questions to address aspects of hospital care identified by patients would be 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 proposing to remove the following questions. The first is proposed to be removed because the hospital call button has been replaced by other mechanisms and the other questions are proposed to be 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 would 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 would only consist of the eight unchanged sub-measures in the current HCAHPS survey until four quarters of the updated data are available. This would be the case for the Jan. 2026, April 2026, and July 2026 public reporting on Care Compare.

CMS is also proposing to modify 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.

Quality-Based Payment Adjustments

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

In the Aug. 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 FY 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 FY 2025 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.7 billion). Hospitals can earn back some, all, or more than their individual 2.0% reduction.

  While the data applicable to the FY 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 FY 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 proposed rule are available in Table 16A on the CMS website.

  CMS anticipates making actual FY 2024 VBP adjustment factors available in the fall of 2024. Details and information on the program are available on CMS' QualityNet website.

- RRP: The FY 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 FY 2025 RRP program is still being reviewed and corrected by hospitals, and therefore CMS have not yet posted factors for the FY 2025 program in Table 15. CMS expects to release the final FY 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 FY 2024 HAC reduction program will evaluate hospital performance on six measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of 10 individual HAC measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio, Methicillin-resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC reduction program is not budget neutral; hospitals with a total HAC score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score.

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

  Details and information on the HAC currently are available on CMS' QualityNet website.

Quality-Based Payment Policies—FYs 2026 and Beyond

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

- VBP Program: CMS had already adopted VBP program rules through FY 2025 and some program policies and rules beyond FY 2025. CMS is proposing further program updates through FY 2030, described below.

  New baseline periods, performance periods, and performance standards are proposed for a subset of measures for the FYs 2026-2030 programs.

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

  With the proposal to adopt the updated HCAHPS Survey measure, CMS is proposing to modify the scoring of the HCAHPS survey beginning FY 2030 to account for the proposed 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 proposed 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 would still range from 0 to 80 points.
- The Consistency Points would still range from 0 to 20 points, calculated on the nine dimensions.

Since CMS is proposing the same HCAHPS Survey measure updates to VBP as to the Hospital IQR program beginning FY 2027, CMS is proposing to modify the scoring of the HCAHPS survey for FYs 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 would still range from 0 to 80 points.
- The Consistency Points would still range from 0 to 20 points but be calculated solely on the six unchanged dimensions.

Separately, beginning with the FY 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", where the maximum points would be 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 FY 2026 program, this will be FY 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 would 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 propose any changes to RRP.
- HAC Reduction Program: CMS did not propose 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 proposing 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 proposing 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 proposing to adopt active engagement for both the proposed measures as well where eligible hospitals and CAHs would 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 is proposing to 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 would increase from five to six measures.

For EHR reporting periods of CY 2025 and onwards, CMS is proposing to increase the minimum scoring threshold from 60 points to 80 points in order to encourage higher levels of performance.

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

Proposed Performance-Based Scoring Methodology Beginning with the CY 2025 EHR Reporting Period			
Objectives	**Measures**	**2023: 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 **(proposed)** • AR Surveillance Reporting **(proposed)**	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 is also proposing to modify one eCQM from the Hospital IQR measure set beginning with CY 2026 reporting. These measures are listed in the IQR section of this brief.

Request for Information – Public Health Reporting and Data Exchange

CMS believes that decision-making and prioritization about policy change should adhere to four goals:

- The meaningful use of CEHRT enables continuous improvement in the quality, timeliness, and completeness of public health data being reported.
- The meaningful use of CEHRT allows for flexibility to respond to new public health threats and meet new data needs without requiring new and substantial regulatory and technical development.
- The meaningful use of CEHRT supports mutual data sharing between public health and healthcare providers.
- Reporting burden on eligible hospitals and CAHs is significantly reduced.

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