April 11, 2024

CMS Issues FY 2025 Proposed Medicare Inpatient and Long-Term Care Hospital Payment Rule

On Wednesday (April 10), the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2025 proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System. In a press release, CMS Administrator Chiquita Brooks-LaSure said, "CMS is proposing changes that will create a more equitable and resilient health care system," adding, "Our proposals around payment and quality focus on rewarding better outcomes and supporting hospitals in their efforts to reach underserved communities and meet their needs."

The rule proposes to increase FY 2025 acute care hospital operating payments by about 2.6%, compared with FY 2024. CMS estimates the overall impact of the rule would result in an increase of about $3.2 billion in payments to acute care hospitals paid under the IPPS in FY 2025. Medicare uncompensated care payments to disproportionate share hospitals would increase by about $560 million in FY 2025, and additional payments for inpatient cases involving new medical technologies would increase by $94 million. In the rule, CMS noted that the Consolidated Appropriations Act of 2024 extended additional payments for Medicare-Dependent Hospitals (MDHs) and the temporary change in payments for low-volume hospitals through December 31, 2024. CMS estimated if Congress does not act and allows the funding to expire, payments to those hospitals would decline by $0.4 billion in FY 2025.

CMS expects the LTCH standard payment rate to increase by 2.8% and LTCH PPS payments for discharges paid the LTCH standard payment rate to increase by approximately 1.2% or $26 million.

Throughout the rule, CMS proposes several ways to increase health equity and improve maternal health, an ongoing priority for the Biden administration. CMS also proposes updates to hospital quality and value-based payment programs, among other changes. In addition, CMS proposes a new mandatory CMS Innovation Center model, the Transforming Episode Accountability Model (TEAM), that would provide bundled payment for certain surgical procedures. CMS will accept public comments on the proposed rule through June 10.

- Press Release, Fact Sheet, Proposed Rule, Fact Sheet on TEAM

Summary of key provisions

FY 2025 hospital payment rates. CMS proposes increasing FY 2025 acute care hospital operating payments by about 2.6%, compared with FY 2023, for hospitals that are meaningful users of electronic health records and submit quality measure data. This 2.6% payment update is the summation of a 3.0% hospital market basket increase and a 0.4 percentage point productivity cut. CMS estimates proposed changes to operating and capital payments would result in a $2.9 billion increase in FY 2025 IPPS payments, compared with FY 2024. However,

CMS estimated that the rule's cumulative changes would lead to an increase of about $3.2 billion in payments to acute care hospitals in FY 2025.

Table: Proposed FY 2025 Percentage Increases for the IPPS

	Hospital Submitted Quality Data and Is a Meaningful EHR User	Hospital Submitted Quality Data and Is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	3.0	3.0	3.0	3.0
Proposed Productivity Adjustment	-0.4	-0.4	-0.4	-0.4
Proposed Quality Data Adjustment	0.0	0.0	-0.75	-0.75
Proposed Meaningful EHR User Adjustment	0.0	-2.25	0.0	-2.25
Proposed Percentage Change to FY 2023 Standardized Amount	**2.6**	**.35**	**1.85**	**-0.4**

Individual hospital payment rates will vary further based on hospitals' participation in the Hospital Readmissions Reduction Program (HRRP), the Hospital-Acquired Condition (HAC) Reduction Program, and the Hospital Value-Based Purchasing (VBP) Program.

For FY 2025, CMS expects the LTCH standard payment rate to increase by 2.8% and LTCH PPS payments for discharges paid the LTCH standard payment rate to increase by approximately 1.2% or $26 million due primarily to a projected 1.3% decrease in high-cost outlier payments as a percentage of total LTCH PPS standard Federal payment rate payments. CMS is seeking comment on the proposed methodology used to determine the LTCH PPS outlier threshold for discharges paid the LTCH standard Federal payment rate, as well as an alternative methodology that would generate a lower outlier threshold.

DSH and uncompensated care payments

CMS projects Medicare uncompensated care payments to disproportionate share hospitals would increase by about $560 million in FY 2025, compared with FY 2024. CMS proposes several updates to its estimates of the three factors used to determine uncompensated care payments. As finalized in previous rules, CMS proposed using the three most recent years of data (FY 2019, FY 2020, and FY 2021) from Worksheet S-10 to calculate uncompensated care payments for FY 2025.

New Technology Add-on Payments (NTAP)

CMS proposed several updates to NTAPs. For FY 2025, CMS proposes to increase the NTAP percentage to 75%, up from 65%, for a gene therapy that is indicated and used specifically for sickle cell disease treatment for the 2-

to 3-year newness period of the gene therapy. CMS said the proposed change reflects CMS commitment to addressing sick cell disease, in its Sickle Cell Disease Action Plan.

Effective FY 2026, CMS proposes to use October 1, instead of April 1, to determine eligibility whether a technology is within its 2- to 3-year newness period for NTAP. Beginning with applications for NTAP for FY 2026, CMS also proposes to no longer consider an FDA marketing authorization hold status to be an inactive status when determining NTAP eligibility.

Buffer stock of essential medicines

CMS proposes to establish a separate payment under IPPS to small, independent hospitals with 100 or fewer beds to help offset the costs of directly establishing and maintaining a 6-month buffer stock of essential medicines. The additional payment would be calculated per hospital based on their reported costs but would not include the cost of the drug itself. Medicare under the proposal would pay about 11% of those costs and payments would not be made in a budget neutral manner. CMS estimates that 493 hospitals would qualify for the new payment and estimates that it would cost those hospitals a total of $2.8 million to establish buffer stocks of essential medicines, of which Medicare would pay about 11%, or $3 million.

Eligible drugs would be limited to the Advanced Regenerative Manufacturing Institute's list of 86 medicines deemed critical for minimum patient care in acute settings or important for acute care with no comparable alternatives. CMS says the proposal is based in part on consideration of the comments received in a request for information (RFI) included in the CY 2024 Outpatient Prospective Payment System proposed rule. In response to concerns that such a policy could exacerbate existing shortages, CMS proposes that hospitals that newly establish a buffer stock of an essential medicine listed as "currently in shortage" on the FDA Drug Shortages Database would not be eligible for the payment during the shortage. Hospitals that had already established a buffer stock of a medicine that becomes "currently in shortage" would continue to be eligible. CMS in the proposed rule includes several new RFIs including other potential costs to consider in calculating payments.

Low Wage Index updates

For FY 2025, CMS proposed to further extend temporary policies finalized in the FY 2020 IPPS rule to address wage index disparities between high and low wage hospitals, citing the need for more time to collect useable data to determine the policy's impact. CMS suggests the policy could remain in place until FY 2028 rulemaking, when the first full fiscal year of wage data after the COVID-19 PHE (FY 2024 wage data) is available.

Health equity and SDOH

CMS proposes to change the severity level designation of seven ICD-10-CM diagnosis codes related to homelessness from non-complication or comorbidity (Non-CC) to complication or comorbidity (CC), for FY 2025. The designation would increase IPPS payments for those codes to reflect the higher average resource costs of caring for individuals experiencing housing insecurity. In addition, the proposed rule also would take steps to implement section 4122 of the Consolidated Appropriations Act, 2023, which requires that at least half of the 200 new graduate medical education slots made available in 2026 under the law go towards psychiatry or psychiatry subspecialties. Further, CMS proposes to prioritize health professional shortage areas.

Transforming Episode Accountability (TEAM) Model

CMS in the rule proposes a new mandatory payment model to test episode-based payments for five surgical procedures: Lower Extremity Joint Replacement, Surgical Hip Femur Fracture Treatment, Spinal Fusion, Coronary Artery Bypass Graft, and Major Bowel Procedure. Hospitals would be selected for participation based on geographic regions. Selected hospitals would be required to participate in the five-year model, set to begin in January 2026, and to refer patients to primary care services to improve post-surgical care quality. The model would have three tracks ranging from no downside risk to higher levels of risk and reward.

Quality payment program updates

CMS' proposed rule also includes other key updates to hospital quality reporting programs, as well as a request for information on ways to better measure patient safety and outcomes across hospital quality programs.

Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes to add seven new measures to the IQR program, including two new eCQMs, one claims-based measure, two structural measures, and two healthcare-associated infection (HAI) measures:

- Hospital Harm – Falls with Injury eCQM, with inclusion in the eCQM measure set beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Hospital Harm – Post-operative Respiratory Failure eCQM, with inclusion in the eCQM measure set beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) claims-based measure beginning with the July 1, 2023 – June 30, 2025 reporting period, which impacts the FY 2027 payment determination.
- Patient Safety Structural Measure beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Age Friendly Hospital structural measure beginning with the CY 2025 reporting period/FY 2027 payment determination.
- Catheter-Associated Urinary Tract Infection Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination.
- Central Line-Associated Bloodstream Infection Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination.

CMS also proposes to remove four IQR measures beginning with the FY 2026 payment determination, and one measure, CMS PSI-04 Death Among Surgical Inpatients with Serious Treatable Complications, beginning with the FY 2027 payment determination. The four measures that would be removed for the FY 2026 payment determination are:

- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI Payment).
- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure (HF Payment).

- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia (PN Payment).
- Hospital-level, Risk-Standardized Payment Associated with a 30-day Episode of Care for Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA Payment).

CMS also proposes to modify two measures, increase the total number of eCQMs reported from six to eleven over two years, and updates the data validation requirements. CMS estimates that the proposed changes would increase hospitals' total information collection burden by 40,019 hours at a cost increase of $1,274,980 over a 3-year period.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

For the PCHQR, CMS proposed to add one new measure and modify an existing measure. The rule also proposes to accelerate the start date for publicly displaying hospital performance on the Hospital Commitment to Health Equity measure to January 2026 or "as soon as feasible thereafter."

Hospital Readmissions Reduction (HRR) and Hospital-Acquired Condition (HAC) Programs

CMS did not propose any changes to the HRR or HAC programs.

Hospital Value-based Purchasing Program

CMS proposes to adopt the Patient Safety Structural measure beginning with the CY 2025 reporting period, modify an existing HCAHPS Survey measure and accelerate the start date for publicly displaying hospital performance on the Hospital Commitment to Health Equity measure to January 2026 or "as soon as feasible thereafter."

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

CMS proposes to add four new Social Determinants of Health (SDOH) items, modify one SDOH item, and modify one administrative requirement for the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set. CMS also included RFIs on future measure concepts and a future star ratings program.

Promoting Interoperability Updates

CMS proposed several updates to the Promoting Interoperability program. Beginning with the EHR reporting period in CY 2025, CMS proposes to split the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures, add a new exclusion for eligible hospitals or CAHs that lack discrete electronic access to data elements that are required for AU or AR Surveillance reporting and modify existing exclusions. CMS also proposes to add two new eCQMs related to hospital harm beginning with the CY 2026 reporting period and align the eCQM data reporting and submission requirements with the Hospital IQR Program.

CMS also proposes to increase the performance-based scoring threshold for eligible hospitals and CAHs reporting to the PI Program from 60 points to 80 points beginning with the EHR reporting period in CY 2025.

Other proposed updates (non-exhaustive)

The proposed rule also would:

- Update several MS-DRGs, including reevaluating the post-acute care transfer policy status for MS-DRGs 459 and 460 and adding MS-DRGs 426-428, 447, and 448 to the list of MS-DRGs subject to the post-acute care transfer policy. (View proposed list of MS-DRG changes on page 608 on the proposed rule);
- Modify and make permanent the Condition of Participation requiring hospitals and critical access hospitals to report certain data on acute respiratory illnesses. Specifically, beginning October 1, 2024, CMS would require hospitals and CAHs to report data once per week on confirmed infections of COVID-19, influenza and respiratory syntactical virus among hospitalized patients, hospital capacity, and certain patient demographic information, including age; and
- Seek public comments on instances in which non-Medicare payers use Medicare IPPS payments for maternity care and the potential requirements and structure for an obstetrical services Conditions of Participation for hospitals.

If you have questions, please contact Heather Meade or Heather Bell.