CHAMBER HILL

INSIGHTS

CMS Proposes FY 2025 Hospital Inpatient Prospective Payment Rule

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On April 10, 2024, the Centers for Medicare and Medicaid Services (CMS) released their proposed Inpatient Hospital payment rule for 2025. The proposed changes are a mixed bag for the nation's inpatient hospitals and some of the provisions will need to be monitored before the rule is finalized. Under the proposed rule, the hospital market basket percentage would increase by 3.0% (with a 0.4 % reduction for productivity). The update is in line with last year's update of 2.8%, although it is much lower than MedPAC's recommendation of 4.5%. The American Hospital Association and the Federation of American Hospitals have both declared that this increase is insufficient due to hospital cost inflation and labor shortages. The update is much lower than MedPAC's recommendation of 4.5%.

All comments are due June 10, 2024.

PAYMENT FOR MAINTAINING ESSENTIAL MEDICINE STOCKPILE

CMS is proposing a new, additional payment for small, independent hospitals to enable these providers to establish and maintain a buffer stock of medicines. CMS is defining "small" as less than 100 beds. Payment amounts would be determined by the Medicare Administrative Contractor (MAC) based on existing costs and would be paid out either biweekly or as a lump sum.

UPDATED WAGE INDEX AREAS

As they do every year, CMS is recalculating all hospital wage index areas. The difference this year is that the Office of Management and Budget (OMB) has rolled out their new Core Based Statistical Area (CBSA) market definitions, and those changes are being incorporated into the wage index calculations. These new definitions could have a significant impact on individual hospitals. The table of changes can be found here: https://www.cms.gov/files/zip/fy2025-ipps-nprm-wage-index-puf.zip.

LOW-WAGE HOSPITAL POLICY

The proposed rule extends the temporary policy put in place in 2020 that makes upward adjustments to the wage indices of hospitals with a wage index value below the 25th percentile. While the policy was set to expire this year, CMS is proposing to extend it until 2028 when the first round of wage index data from the post-pandemic era (i.e. FY 2024 wage information) will be available.

DISTRIBUTION OF GME RESIDENCY SLOTS

Responding to Congressional mandate, an additional 200 Medicare-funded residency slots are created in this rule to train new physicians. Half of those slots are earmarked for psychiatry or psychiatry sub-specialists. CMS will notify hospitals receiving these new slots by January 31, 2026.

Residency slots will be distributed based on hospital-capacity for residents. In addition, certain types of hospital will be targeted, including rural hospitals, hospitals in health professional shortage areas (HPSA) areas, and hospitals with new medical schools. Each hospital that applies will receive at least one slot before any other hospital receives multiple slots. The maximum number of slots a hospital can receive is ten. The application deadline to request these slots is March 31, 2025.

SOCIAL DETERMINANTS OF HEALTH (SDOH) DIAGNOSIS CODES

CMS is proposing to use seven ICD-10 diagnosis codes pertaining to inadequate housing or housing instability to create a higher payment designation. These codes will move diagnoses to a higher category of complication or comorbidity (CC) based on the higher average resource costs of these cases. These codes are: Z59.10, Z59.01, z59.12, z59.19, z59.811, z59.812, z59.819.

DSH PAYMENT ADJUSTMENT

CMS is updating the three factors used to calculate the uncompensated care portion of the disproportionate share hospital (DSH) payment. CMS is using the Office of the Actuary's uninsured estimates while adding more recently available data to calculate Factor 2. CMS is also going to use the three most recent years of audited data for uncompensated costs for Factor 3, which will include FY 2019, 2020, and 2021.

QUALITY UPDATES

CMS is once again making major changes to hospital quality reporting in this proposed rule. Below see the different sections that are being updated.

Hospital Inpatient Quality Reporting (IQR) Program

CMS is proposing adoption of seven new measures for IQR. They are:

1. **Patient Safety Structural measure** beginning CY2025 (beginning Oct. 1, 2024);
2. **Age Friendly Hospital measure** beginning CY 2025 (beginning Oct. 1, 2024);

3. Catheter-Associated Urinary Tract Infection **(CAUTI) Standardized Infection Ratio Stratified for Oncology Locations** beginning CY 2026 (beginning Oct. 1, 2025);
4. Central Line-Associated Bloodstream Infection **(CLABSI) Standardized Infection Ratio Stratified for Oncology Locations** beginning CY 2026 (beginning Oct. 1, 2025);
5. **Hospital Harm - Falls** with Injury eCQM beginning CY 2026 (beginning Oct. 1, 2025);
6. **Hospital Harm - Postoperative Respiratory Failure** eCQM beginning CY 2026 (beginning Oct. 1, 2025); and
7. **Thirty-day Risk-Standardized Death Rate among Surgical Inpatients** with Complications (Failure-to-Rescue) measure beginning with the July 1, 2023 – June 30, 2025 reporting period.

The first measure, **patient safety**, is proposed to be an attestation-based measure to see whether hospitals have a structure and culture that prioritizes safety. The measure will have five parts:

1. Leadership commitment to eliminating preventable harm;
2. Strategic planning and organizational policy;
3. Culture of safety and learning health system;
4. Accountability and transparency; and
5. Patient and family engagement.

CMS is removing five measures:

1. **Death Among Surgical Inpatients with Serious Treatable Complications** (CMS PSI 04) measure beginning with the July 1, 2023 – June 30, 2025 reporting period;
2. Hospital-level, Risk-Standardized **Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) measure** beginning with the July 1, 2021 – June 30, 2024 reporting period
3. Hospital-level, Risk-Standardized P**ayment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) measure** beginning with the July 1, 2021 – June 30, 2024 reporting period
4. Hospital-level, Risk-Standardized **Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN) measure** beginning with July 1, 2021 – June 30, 2024 reporting period; and

5. Hospital-level, Risk-Standardized **Payment Associated with a 30-Day Episode-of-Care for Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)** measure beginning with the April 1, 2021 – March 31, 2024 reporting period.

CMS is also increasing the number of eCQMs that a hospital must report on annually from 4 to 7 for FY2025. The new requirements are for Severe Hypoglycemia, Severe Hyperglycemia, and Opioid-Related Adverse Events. For 2026, the number will rise to nine eCQMs (6 specified, and 3 self-selected). See table below

Reporting Period/ Payment Determination	**Total Number of eCQMs Reported**	**eCQMs Required to be Reported**
CY 2024/FY 2026 and CY 2025/FY 2027	Six	• Three self-selected eCQMs; and • Safe Use of Opioids - Concurrent Prescribing eCQM; and • Cesarean Birth eCQM; and • Severe Obstetric Complications eCQM
Proposed: CY 2026/FY 2028	Nine	• Three self-selected eCQMs; and • Safe Use of Opioids - Concurrent Prescribing eCQM; and • Cesarean Birth eCQM; and • Severe Obstetric Complications eCQM; and • Hospital Harm - Severe Hyperglycemia eCQM; and • Hospital Harm - Severe Hypoglycemia eCQM; and • Hospital Harm - Opioid-Related Adverse Events eCQM
Proposed: CY 2027/FY 2029 (and for subsequent years)	Eleven	• Three self-selected eCQMs; and • Safe Use of Opioids - Concurrent Prescribing eCQM; and • Cesarean Birth eCQM; and • Severe Obstetric Complications eCQM; and • Hospital Harm - Severe Hyperglycemia eCQM; and • Hospital Harm - Severe Hypoglycemia eCQM; and • Hospital Harm - Opioid-Related Adverse Events eCQM; and • Hospital Harm - Pressure Injury eCQM; and • Hospital Harm - Acute Kidney Injury eCQM

Source: CMS

CMS is also adding Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data to IQR this year.

New Transforming Episode Accountability (TEAM) Model

CMS is proposing a new 5-year **mandatory bundled payment program** for all acute-care hospitals in a yet-as-unnamed CBSA. (A list of eligible CBSAs is included on page 1119 of the rule.) The model would begin January 1, 2026 and end December 31, 2030.

Under this model, CMS would begin by focusing on lower extremity joint replacement, surgical hip femur fracture treatment, spinal fusion, coronary artery bypass graft, and major bowel procedures. Providers would bill as normal (MS-DRGs for inpatient, HCPCs for physician, etc.) for their procedures – but would receive target prices for episodes prior to each performance year. Performance for providers would be measured by spending as well as performance on three quality measures.

Once assessed, TEAM participants would be paid by CMS if their spending is below the target price, or they would need to repay CMS if spending is over the target price.

Report Acute Respiratory Illnesses

Under current conditions of participation, hospitals must report to CMS weekly on COVID-19 and influenza cases. CMS is amending this list to also include reporting of RSV. This change would go into effect on October 1, 2024. CMS estimates that for the 6,384 hospitals and critical access hospitals (CAHs), this would result in 248,976 hours of additional work and a total cost of $19,420,128 for the weekly reporting, which is $3,042 per facility annually.

There were no changes to value-based purchasing or the Hospital-Acquired Condition (HAC) reduction programs.

CMS has estimated that $1.7 billion is available in FY 2025 for value-based incentive payments.

DRG GROUPER CHANGES

CMS made several grouper coding changes based on feedback. See table below for details.

Code(s)	Currently	Moved to for FY 2025
0DB83ZZ, 0DBA3ZZ, 0DBA4ZZ, 0DBB3ZZ, 0DBB4ZZ, 0DBC0ZZ, 0DBC3ZZ, 0DBC4ZZ	MS-DRGs 347, 348, and 349 (Anal and Stomal Procedures)	MS-DRGs 329, 330, and 331 (Major Small and Large Bowel Procedures)
M43.8X4, M43.8X5, M43.8X6, M43.8X7, and M43.8X8	Spinal Curvature/ Malignancy/ Infection list	Adding to the OR Secondary Diagnosis" logic list
Deleting MSDRGS (Spinal Fusion)	MS-DRGs 453, 454, and 455	Creating eight new Spinal Fusion DRGs
NEW MS-DRG 426, 427, 428, 402, 429, 430, 447, and 448 for spinal Fusion	Spinal Fusion	Code logic can be found here: https://www.cms.gov/files/zip/fy2025-ipps-nprm-tables-6a-6j-6p.zip
Adding new code 0FBG4ZX	Surgeries	Adding to MS-DRGs 628, 629, 630, 405, 406,406, 907-9, and 957-959
MS-DRGs 606, 607, 795, 595, 596, 794		Adding 0DTF0ZZ and 0DTF4ZZ
MS-DRGs 834, 835, 836, 837, 838, and 839		Removing Q81.0, Q81.1, Q81.2, Q81.8, and Q81.9
MS-DRGs 834, 835, and 836		Removing C94.20, C94.21, C94.22, C94.40, C94.41, and C94.42 from MS-DRGs 823, 824 and 825
NEW MS-DRG 850		Adding C94.20, C94.21, C94.22, C94.40, C94.41, and C94.42 from MS-DRGs 823, 824 and 825
MS-DRGs 264, 329, 330, 331, 820-2, 826-8, 907-9, 957-9		Adding procedure codes: 0FBG4ZX, 0DBG4ZX, 0DBL4ZX, 0DBM4ZX and 0DBN4ZX
MS-DRGs 411-3, 417-9, 820-2, 826-8, 907-9, 957-9		Adding procedure code 0FB44ZX
MS-DRGs 405-7, 628-30, 907-9, 957-9		Adding procedure code 0FBG4ZX

In addition, CMS made many changes to severity levels in codes – those changes can be found here: https://www.cms.gov/files/zip/fy2025-ipps-nprm-tables-6a-6j-6p.zip.

POST- ACUTE TRANSFER POLICY

CMS is proposing to add and remove MS-DRGs from post-acute transfer payment treatment in this rule.

CMS is proposing to add MS-DRGs 317, 402 (new code), 426-30 (new codes), 447 (new code), and 448 (new code), 426-8 (new codes), 447, 448,

CMS is proposing to remove MS-DRG 453, 454, 455, 459, 460.

FEEDBACK

CMS is also asking for input on many aspects of the rule from stakeholders. Below we highlight some of their requests for feedback:

- For SDOH, how to further foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to more accurately reflect each health care encounter and improve the reliability and validity of the coded data including in support of efforts to advance health equity.
- For readmissions, CMS wants to hear how they could further encourage hospitals to improve discharge processes, such as by introducing measures currently in quality reporting programs into value-based purchasing to link outcomes to payment incentives. They want input on adopting measures to better represent the range of outcomes of interest to patients, including unplanned returns to the ED and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.
- For quality, CMS would like to hear feedback from providers regarding the new measures being proposed under the IQR.
- For mandated disease reporting, CMS seeks provider input on CMS involvement with the Center for Disease Control and Prevention's (CDC's) National Syndromic Surveillance Program (NSSP)

We trust you found this summary useful. Please reach out to us with any questions.