FFY 2025 IPPS Proposed Rule Overview

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Vice President, Federal Policy
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Megan Howard
Vice President, Federal Policy
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May 15, 2024

Questions

We have built in time at the end of the presentation for Q&A.

Please submit your questions using the Q&A box (usually located at the bottom of your screen) as they come to you throughout the presentation.

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Speaker

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Vice President, Federal Policy
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Chad Mulvany is responsible for providing leadership on federal hospital reimbursement issues and contributes on other federal regulatory matters. Based in CHA's Washington, DC Office, Chad collaborates with CHA's federal and state advocacy colleagues and national hospital associations on analysis and policy development for advocacy purposes.

Speaker

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Vice President, Federal Policy
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As Vice President, Federal Policy for CHA, Megan Howard is responsible for providing leadership on federal regulatory issues related to health care finance, quality and patient safety, and hospital and post-acute provider related issues. Based in CHA's Washington, DC Office, Megan collaborates with CHA's federal and state advocacy colleagues and national hospital associations on analysis and policy development for advocacy purposes.

Agenda & Objectives

- Provide an overview of the federal fiscal year (FFY) 2025 inpatient prospective payment system (IPPS) proposed rule issued by the Centers for Medicare & Medicaid Services (CMS) including:
  - Payment Update
  - Medicare DSH Updates
  - Area Wage Index Proposals
  - TEAM
  - Other Payment Proposals
  - Value Based Quality Programs and Hospital Inpatient Quality Reporting Program
  - Promoting Interoperability Program
- Solicit member feedback on proposed changes for CHA's comment letter
- Comments are due to CMS by 2 p.m. (PT) on June 10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 411, 412, 419, 488, 489, and 495

[CMS–1795–P]

RIN 0938–AV08

Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would: revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals; make changes relating to Medicare graduate medical education (GME) for teaching hospitals; update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs); and make other policy-related changes.

DATES: To be assured consideration, comments must be received at one of the addresses provided in the ADDRESSES section, no later than 5 p.m. EDT on June 9, 2023.

ADDRESSES: In commenting, please refer to file code CMS–1795–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may (and we encourage you to) submit electronic comments on this regulation to https://www.regulations.gov. Follow the instructions under the "submit a comment" tab.
2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1795–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1795–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, we refer readers to the beginning of the SUPPLEMENTARY INFORMATION section.

FOR FURTHER INFORMATION CONTACT: Donald Thompson, and Michele Hudson, (410) 786–4487 or DAC@cms.hhs.gov, Operating Prospective Payment, MS–DRG Relative Weights, Wage Index, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Sole Community Hospitals (SCHs), Medicare-Dependent Small Rural Hospital (MDH) Program, Low-Volume Hospital Payment Adjustment, and Inpatient Critical Access Hospital (CAH) Issues.

Emily Lipkin, and Jim Mildenberger, DAC@cms.hhs.gov, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Adina Hersko, NewTech@cms.hhs.gov, New Technology Add-On Payments and New COVID–19 Treatments Add-on Payments Issues.

Mady Hue, marilu.hue@cms.hhs.gov, and Andrea Hazeley, andrea.hazeley@cms.hhs.gov, MS–DRG Classifications Issues.

Siddhartha Mazumdar, siddhartha.mazumdar@cms.hhs.gov, Rural Community Hospital Demonstration Program Issues.

Jeris Smith, jeris.smith@cms.hhs.gov, Frontier Community Health Integration Project (FCHIP) Demonstration Issues.

Lang Le, lang.le@cms.hhs.gov, Hospital Readmissions Reduction Program—Administration Issues.

Ngozi Uzokwe, ngozi.uzokwe@cms.hhs.gov, Hospital Readmissions Reduction Program—Measures Issues.

Jennifer Tate, jennifer.tate@cms.hhs.gov, Hospital-Acquired Condition Reduction Program—Administration Issues.

Ngozi Uzokwe, ngozi.uzokwe@cms.hhs.gov, Hospital-Acquired Condition Reduction Program—Measures Issues.

Julia Venanzi, julia.venanzi@cms.hhs.gov, Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program—Administration Issues.

Melissa Hager, melissa.hager@cms.hhs.gov and Ngozi Uzokwe, ngozi.uzokwe@cms.hhs.gov—Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues.

Elizabeth Goldstein, elizabeth.goldstein@cms.hhs.gov, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Ora Dawedeit, ora.dawedeit@cms.hhs.gov, PPS-Exempt Cancer Hospital Quality Reporting—Administration Issues.

Leah Domino, leah.domino@cms.hhs.gov, PPS-Exempt Cancer Hospital Quality Reporting Program—Measure Issues.

Ariel Cress, ariel.cress@cms.hhs.gov, Lorraine Wicklser, Lorraine.Wicklser@cms.hhs.gov, Long-Term Care Hospital Quality Reporting Program—Data Reporting Issues.

Jessica Warren, jessica.warren@cms.hhs.gov and Elizabeth Holland, elizabeth.holland@cms.hhs.gov, Medicare Promoting Interoperability Program.

Jennifer Milby, jennifer.milby@cms.hhs.gov and Sara Brico-Payne, sara.brico-payne@cms.hhs.gov, Special Requirements for Rural Emergency Hospitals (REHs).

Lisa O. Wilson, Lisa.Wilson2@cms.hhs.gov, Physician-Owned Hospital Issues.

Frank Whelan, Frank.Whelan@cms.hhs.gov, Disclosure of Ownership.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: https://www.regulations.gov. Follow the search instructions on that website to view public comments.

Tables Available on the CMS Website

The IPPS tables for this fiscal year (FY) 2024 proposed rule are available on the CMS website at https://

Payment Update

Proposed Rate Update

	Final FFY 2024	Proposed FFY 2025	Percent Change
Operating Rate	$6,497.77	$6,666.10	+2.59%
Capital Rate	$503.83	$516.41	+2.50%

	Federal Operating/ Hospital Specific Rate	Federal Capital Rate
Market Basket/Capital Input Price Index Update	+3.0%	+2.5%
ACA-Mandated Productivity Adjustment	-0.4 percentage point (PPT)	—
Forecast Error Adjustment	—	+0.5%
Lowest Quartile Wage Index Adjustment	+0.01%	-0.21%
Wage Index Cap Policy	-0.25%	
MS-DRG Weight Cap Policy	-0.04%	-0.04%
All Other Annual Budget Neutrality Adjustments	+0.27%	-0.24%
Net Rate Update	+2.59%	+2.50%

FFY 2025 Update with Electronic Health Records (EHR) Incentive and Inpatient Quality Reporting (IQR) Programs

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket (MB) Update (3.0% MB less 0.4 PPT productivity adjustment)	+2.6%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.0%)	—	-0.75 PPT	—	-0.75 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.0%)	—	—	-2.25 PPT	-2.25 PPT
Adjusted Net Market Basket Update (prior to other adjustments)	+2.6%	+1.85%	+0.35%	-0.4%

Fixed Loss Outlier Threshold

- CMS targets outlier payments at 5.11%
- Current FFY 2024 threshold is **$42,750**
- Proposes a fixed loss outlier threshold of **$49,237** for FFY 2025
- CMS proposes using “normal” datasets to calculate the fixed loss outlier threshold

Estimated California Impact

California

Group Impact Summary	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2024 IPPS Payments	$12,630,534,500		$937,289,200		$13,567,823,600	
Estimated FFY 2025 IPPS Payments	$12,690,840,400		$940,313,900		$13,631,154,300	
Total Estimated Change FFY 2024 to FFY 2025	$60,305,900	0.5%	$3,024,700	0.3%	$63,330,700	0.5%

Group Impact Detail	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Provider Type Changes	$0	0.0%	$0	0.0%	$0	0.0%
> Transitional DSH Payment	*$0*	*0.0%*	*N/A*	*N/A*	*$0*	*0.0%*
Change in Hospital Specific Rate Payment Status	$0	0.0%	N/A	N/A	$0	0.0%
Market Basket Update (Includes BN)	$378,345,300	3.0%	$20,001,100	2.1%	$398,346,400	2.9%
ACA-Mandated Market Basket Reduction	($46,311,400)	-0.4%	N/A	N/A	($46,311,400)	-0.3%
Forecast Error Adjustment	N/A	N/A	$4,424,300	0.5%	$4,424,300	0.0%
MS-DRG Weight 10% Reduction Cap BN	($4,714,200)	0.0%	($377,500)	0.0%	($5,091,700)	0.0%
WI/GAF (Wage Data and Reclassification)	($326,655,700)	-2.6%	($22,809,600)	-2.4%	($349,465,400)	-2.6%
> Removal of Previous Rural Floor BN	*$207,746,500*	*1.6%*	*$14,334,000*	*1.5%*	*$222,080,500*	*1.6%*
> Removal of Previous Rural Floor WI	*($958,276,200)*	*-7.6%*	*($69,156,100)*	*-7.4%*	*($1,027,432,400)*	*-7.6%*
> Change due to WI and LS (Prior to Rural Floor)	*($301,850,100)*	*-2.4%*	*($21,307,900)*	*-2.3%*	*($323,158,000)*	*-2.4%*
> Current Rural Floor WI	*$857,748,800*	*6.8%*	*$62,536,200*	*6.7%*	*$920,285,000*	*6.8%*
> Current Rural Floor BN	*($132,024,700)*	*-1.1%*	*($9,215,800)*	*-1.0%*	*($141,240,500)*	*-1.0%*
> Change in LS (Isolated from Previous Breakouts)	*$0*	*0.0%*	*N/A*	*N/A*	*$0*	*0.0%*
WI/GAF (Other Changes)	($18,112,200)	-0.1%	($1,231,800)	-0.1%	($19,344,000)	-0.1%
> Expiration of Previous 5% Stop Loss BN	*$4,354,200*	*0.0%*	*$406,300*	*0.0%*	*$4,760,500*	*0.0%*
> Expiration of Previous 5% Stop Loss WI	*$5,362,400*	*0.0%*	*$352,400*	*0.0%*	*$5,714,700*	*0.0%*
> Current 5% Stop Loss WI	*$5,837,900*	*0.1%*	*$396,600*	*0.0%*	*$6,234,500*	*0.1%*
> Current 5% Stop Loss BN	*($34,831,000)*	*-0.3%*	*($2,850,400)*	*-0.3%*	*($37,681,400)*	*-0.3%*
> Removal of Previous Bottom Quartile BN	*$31,948,500*	*0.3%*	*$2,982,900*	*0.3%*	*$34,931,500*	*0.3%*
> Removal of Previous Bottom Quartile WI	*$0*	*0.0%*	*$0*	*0.0%*	*$0*	*0.0%*
> Current Bottom Quartile Increase	*$0*	*0.0%*	*$0*	*0.0%*	*$0*	*0.0%*
> Current Bottom Quartile BN	*($30,784,300)*	*-0.2%*	*($2,519,600)*	*-0.3%*	*($33,303,900)*	*-0.3%*
DSH: UCC Payment Changes	$44,247,400	0.4%	N/A	N/A	$44,247,400	0.3%
> DSH UCC Distribution Factor Change	*$5,868,500*	*0.1%*	*N/A*	*N/A*	*$5,868,500*	*0.0%*
Change in Hospital Specific Rate	$0	0.0%	N/A	N/A	$0	0.0%
MS-DRG Updates	$54,021,400	0.4%	$4,127,600	0.4%	$58,149,000	0.4%
Quality Based Payment Adjustments	($4,354,700)	0.0%	($38,400)	0.0%	($4,393,100)	0.0%
> VBP	*($3,553,400)*	*0.0%*	*N/A*	*N/A*	*($3,553,400)*	*0.0%*
> RRP	*($3,700)*	*0.0%*	*N/A*	*N/A*	*($3,700)*	*0.0%*
> HAC	*($797,700)*	*0.0%*	*($38,400)*	*0.0%*	*($836,100)*	*0.0%*
Net Change due to Low Volume Adjustment	($16,160,000)	-0.1%	($1,071,000)	-0.1%	($17,231,000)	-0.1%

The values shown in the table above do not include the 2.0% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. It is estimated that sequestration will reduce FFY 2025 IPPS-specific payments by: $272,623,100

Source: CHA DataSuite

MS-DRGS: Significant Weight Change

MS-DRG	MS-DRG Title	Final FFY 2024 Weight	Proposed FFY 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%

More Detail

- Table 5 FFY 2025: Provides full list of the proposed DRGs, DRG weights, and flags for those subject to the post-acute care transfer policy.
- For comparison purposes, the final FFY 2024 DRGs are available in Table 5 on the CMS website.

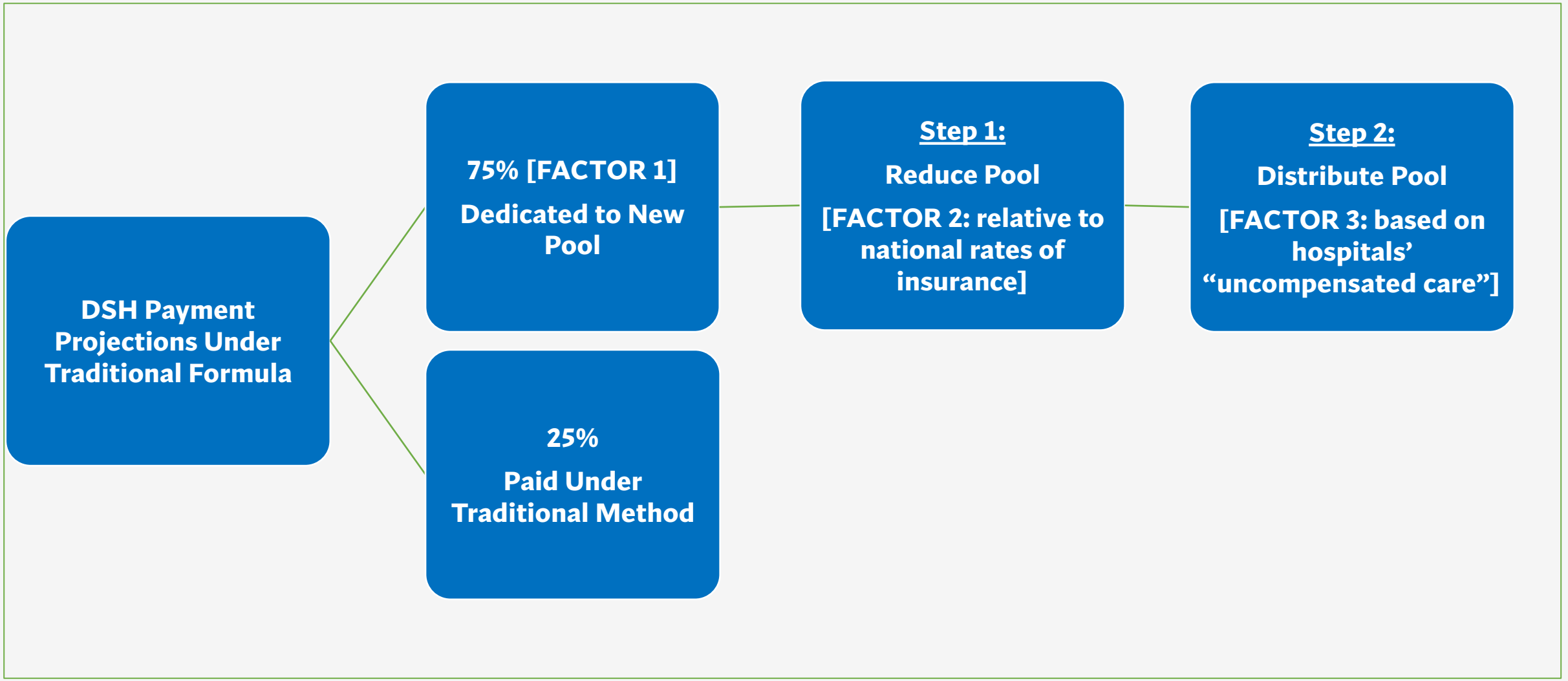
Inadequate Housing Proposed as a Complication or Comorbidity (CC)

CMS is proposing to change the severity level for the following diagnosis codes regarding inadequate housing from Non-CC 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
- Z59.819 – Housing instability, housed unspecified

Medicare Disproportionate Share Hospital (DSH)

Medicare DSH



Uncompensated Care (UCC) DSH

Increases in Factor 1 and Factor 2 drives an increase in the total UCC DSH pool.

Factors 1 and 2: Comparison of FFYs Proposed 2025 vs. Final 2024

$, Billions

Factor	FFY 2025	FFY 2024	Change from Prior Year
1: Base Funding	$10.457	$10.015	$0.442
2: Available Pool	$6.498	$5.938	$0.560

Factor 1 – Projected DSH Inputs

Increases in the "Other Category" drive increases in Factor 1.

Difference in Factors between FFY 2024 Final and FFY 2025 Proposed IPPS Rules

FY	Update	Discharges	Case Mix	Other	Total	Est DSH Pmt $, Billions
2022	0.000	0.005	0.000	(0.000)	0.005	0.304
2023	0.000	(0.014)	(0.015)	0.016	(0.015)	0.126
2024	0.000	(0.005)	0.000	0.019	0.013	0.300

Factor 2 – Projected Change in Uninsured Rate

The proposed rule likely underestimates the increase in the uninsured due to Medicaid redeterminations.

FFY 2025 Est. Factor 2 Calculation: Uninsured Rate

	2024	2025	FFY 2025 Uninsured Rate
Baseline Uninsured	28.6	29.8	
PHE Uninsured**	3.9	2.7	
Total Uninsured	32.5	32.5	
Total Population*	336.47	338.64	
Uninsured Rate	9.66%	9.59%	
Weighting	25.00%	75.00%	
Weighted Uninsured Rate	2.41%	7.20%	9.61%

Estimated Uninsured Rate Appears to Exclude Some Medicaid Beneficiaries Who Lost Coverage

Sources:
*Table 17 - Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years, 2013-2031
**CHA Analysis - Coverage Loss Due to Redetermination

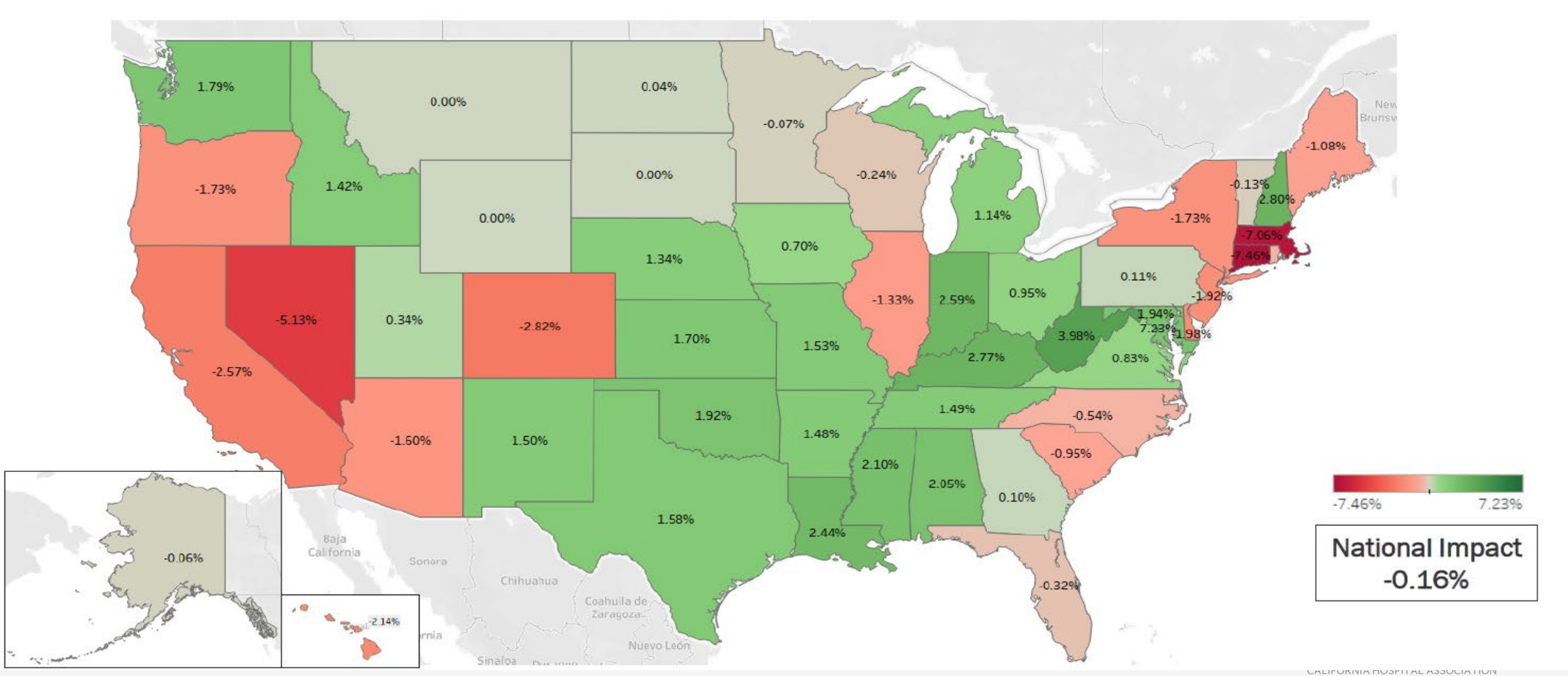
Factor 3 – UCC Per Discharge Amounts

- CMS proposes to use a hospital's 3-year average discharges to estimate interim UCC payments per discharge.
  - Proposes using FFYs 2019, 2020, and 2021
- Would be reconciled at cost report settlement as in past years

Area Wage Index Proposals

Impact of Standard Wage Index Changes

Wages in the rest of the country grew faster than in California. That coupled with the implementation of the new occ mix survey depressed AWI values in California.



Low Wage Index Policy

- For FFY 2025 through 2027, CMS proposes to continue the following policies:
  - Hospitals in the bottom quartile will have their wage index increased by half of the difference between the hospital's pre-adjustment wage index and the 25th percentile wage index value across all hospitals
  - Apply a budget neutrality adjustment and reduce the market basket by -0.25% for this policy
- Rationalized continuing the policy because it cannot evaluate its effectiveness due to insufficient data
- CHA continues to pursue separate litigation on behalf of its members.

Labor Related Share

- Hospitals with a wage index of 1 or greater will continue to have a labor-related share of 67.6%
- Hospitals with a wage index less than or equal to 1.0 will continue to have a labor-related share of 62.0%
- Updating cost-of-living adjustments (COLA) for facilities in Alaska and Hawaii

Other Wage Index

- Occupational Mix
  - Using the 2022 survey for FFYs 2025-2027
- Core Based Statistical Area (CBSA) Changes
  - Adopting the newest OMB delineations (OMB Bulletin No. 23-01) for the FFY 2025 IPPS wage index
  - Only one California CBSA is impacted
  - FFY 2024 CBSA 31460 (Madera County) would be subsumed by FFY 2025 CBSA 23420 (Fresno, CA)

Other Payment Proposals

Low-Volume Adjustment (LVA)

- The Consolidated Appropriations Act (CAA) of 2023 extended the more generous Balanced Budget Act of 2018 criteria through FFY 2024.
- For FFY 2025, hospitals will need to meet the more restrictive criteria:
  - Be located more than 25 road miles from another subsection (d) hospital
  - Have fewer than 200 total discharges (all payer) during the fiscal year
- A hospital that qualified for the LVA for FFY 2024 may continue to receive the adjustment for FFY 2025 without reapplying if it meets both the criteria.
- LVA applications for hospitals currently not receiving it are due to Noridian by September 1, 2024.

Medicare Dependent Hospitals (MDH)

- The CAA of 2023 extended the MDH program through FFY 2024.
- Discharges on/after January 1, 2025, do not qualify for the MDH payment methodology and are to be paid under the IPPS.
- CMS encourages MDH hospitals to explore Sole Community Hospital (SCH) status.

Sole Community Hospital (SCH) Status

- CMS regulations allow SCH status to begin the day following expiration of MDH status.
- MDH must apply for SCH status at least 30 days before the expiration of the MDH program, or by December 2, 2024.
- If the deadline is missed, the SCH status begins on the date Noridian receives the complete application.

Indirect Medical Education(IME)/Graduate Medical Education (GME)

- CMS proposes the IME adjustment factor to remain at 1.35 for FFY 2025.
- Specifications in the CAA of 2023 for awarding additional residents are similar those in the CAA of 2021 that required CMS to distribute an additional 1,000 resident positions.
  - Statute requires at least half of the slots (100) be distributed for psychiatric training programs
- New Residency Training Program Criteria: CMS “clarifies” policy related to “newness” criteria.
  - New Residents
  - New Program Director
  - New Teaching Staff

Mandatory Bundled Payment Model – TEAM

CMS proposes the "Transforming Episode Accountability Model" (TEAM) in select markets.

Key Features

- Runs from Jan. 1, 2026 to Dec. 2030
- Participants are acute care hospitals
- 30-day episode of care
- Services paid for under fee-for-service
- Episode retrospectively reconciled to a target price
- Target price covers almost all Part A and B spending during episode

Selected IP/OP Procedures

- *CABG*: Coronary Artery Bypass Graft
- *LEJR - (IP/OP):* Lower Extremity Joint Replacement
- *Major Bowel Procedure*
- *SHFFT*: Surgical Hip/Femur Fracture Treatment
- *Spinal Fusion - (IP/OP)*

A recording of CHA's detailed discussion of the TEAM Model is available.

TEAM Pricing Methodology

Services delivered by all providers are still separately billed to Medicare FFS.

Savings/Losses

- Hospitals share savings/losses with CMS if actual spending is below/above target price
- Savings/losses adjusted downward based on three quality measures
- May share savings/losses with other providers based on formal agreements
- Reconciliation occurs six months after end of performance year

Pricing Detail

- Based on average regional spend from three years rolling baseline, trended forward
- Risk-adjusted for beneficiary age, social factors and HCC count
- CMS takes 3% discount
- Rural and “safety-net” hospitals eligible for lower risk track
- No low volume exclusion

Potential California TEAM CBSAs

Under the proposed CBSA selection methodology, California would be over-represented.

California CBSA	Selection Probability	California CBSA	Selection Probability
31080 Los Angeles-Long Beach-Anaheim	1/2	33700 Modesto	1/4
40140 Riverside-San Bernardino-Ontario	1/2	37100 Oxnard-Thousand Oaks-Ventura	1/4
41860 San Francisco-Oakland-Fremont	1/2	39820 Redding	1/4
17020 Chico	1/3	40900 Sacramento-Roseville-Folsom	1/4
42200 Santa Maria-Santa Barbara	1/3	41500 Salinas	1/4
47300 Visalia	1/3	41740 San Diego-Chula Vista-Carlsbad	1/4
49700 Yuba City	1/3	41940 San Jose-Sunnyvale-Santa Clara	1/4
46380 Ukiah	1/4	42100 Santa Cruz-Watsonville	1/4
21700 Eureka-Arcata	1/4	42220 Santa Rosa-Petaluma	1/4
25260 Hanford-Corcoran	1/4	44700 Stockton-Lodi	1/4
39780 Red Bluff	1/4	18860 Crescent City	1/5
20940 El Centro	1/4	46020 Truckee-Grass Valley	1/5
32900 Merced	1/4	43760 Sonora	1/5
46700 Vallejo	1/4	34900 Napa	1/5
12540 Bakersfield-Delano	1/4	42020 San Luis Obispo-Paso Robles	1/5
23420 Fresno	1/4		

Establishing and Maintaining Access to Essential Meds

- Proposes separate IPPS payment for independent hospitals w/100 or fewer beds
- Covers the Medicare inpatient portion of the estimated additional resource cost of voluntarily maintaining access to 6-month buffer stocks of “essential medicines”
  - “Essential medicines” defined as the 86 currently included on the Advanced Regenerative Manufacturing Institute’s (ARMI) Next Foundry for American Biotechnology
- Begins on or after October 1, 2024
- Payments could be provided biweekly or as a lump sum at cost report settlement

Other Proposed Payment Policies

- Add-on payment calculation for certain end-stage renal disease
- Proposed change to the calculation of the new technology add-on payment for gene therapies indicated for sickle cell disease

Request for Info – Maternity Care

- CMS requests information on the differences between hospital resources required to provide inpatient pregnancy and childbirth services to Medicare patients as compared to non-Medicare patients.
- CMS is interested to know which non-Medicare payers may be using the IPPS as a basis for determining their payment rates for these services.
- Selected RFI Questions:
  - What policy options could improve maternal health outcomes?
  - How can CMS support hospitals in improving maternal health outcomes?
  - What payment models have impacted maternal health outcomes?
  - What payment models have been effective in improving maternal health outcomes, especially in rural areas?
  - What factors influence the number of vaginal deliveries and cesarean deliveries?

Hospital Quality Reporting and Value Programs

Hospital Inpatient Quality Reporting (IQR) and Hospital Value Based Purchasing (VBP) Programs

IQR Program: Proposed Measures

CMS proposes seven new measures for the IQR program:

1) Patient Safety Structural Measure (CY 2025 reporting/FFY 2027 payment)
2) Age-Friendly Hospital Structural Measure (CY 2025 reporting/FFY 2027 payment)
3) Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (CY 2025 reporting/FFY 2027 payment)

HAI Measures for Inpatient Oncology Locations (CY 2026 reporting/FFY 2028 payment)

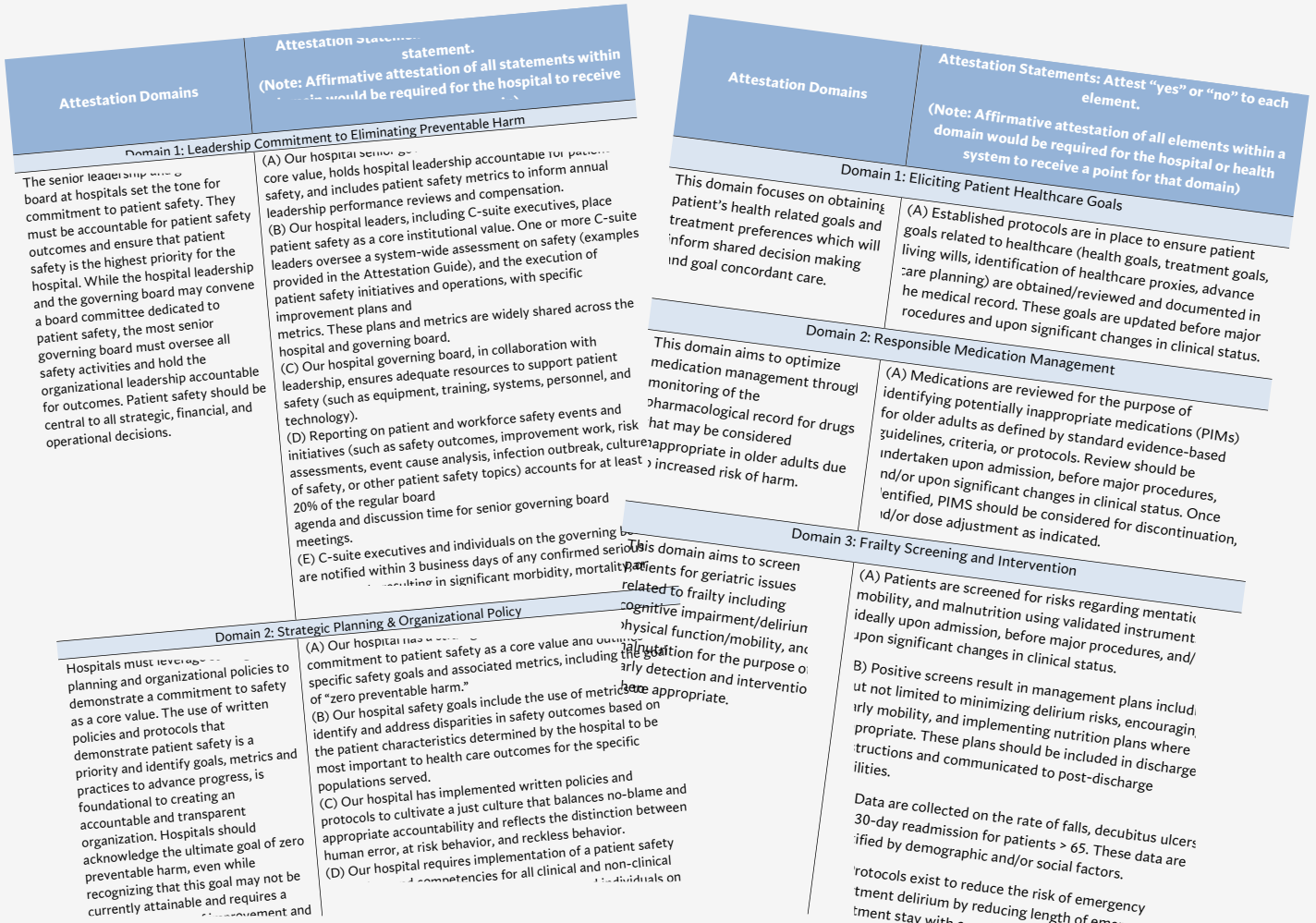
4) Catheter Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations (CAUTI-Onc)
5) Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations (CLABSI-Onc)

Hospital Harm Electronic Clinical Quality Measures (CY 2026 reporting/FFY 2028 payment)

6) Hospital Harm – Falls with Injury eCQM
7) Hospital Harm – Postoperative Respiratory Failure eCQM

Proposed Structural Measures

- **Patient Safety** and **Age-Friendly Hospital Structural Measures** are attestation based
- Each measure has 5 domains; each domain may have several attestation statements
  - Hospitals must be able to attest to each statement under a domain to receive one point for the domain
  - Both measures are scored 0-5/5
  - CMS will publicly report measure scores



Attestation Domains	Attestation Statements: Attest "yes" or "no" to each element. (Note: Affirmative attestation of all elements within a domain would be required for the hospital or health system to receive a point for that domain)
Domain 1: Leadership Commitment to Eliminating Preventable Harm	
The senior leadership and the board at hospitals set the tone for commitment to patient safety. They must be accountable for patient safety outcomes and ensure that patient safety is the highest priority for the hospital. While the hospital leadership and the governing board may convene a board committee dedicated to patient safety, the most senior governing board must oversee all safety activities and hold the organizational leadership accountable for outcomes. Patient safety should be central to all strategic, financial, and operational decisions.	(A) Our hospital senior [illegible] core value, holds hospital leadership accountable for patient safety, and includes patient safety metrics to inform annual leadership performance reviews and compensation. (B) Our hospital leaders, including C-suite executives, place patient safety as a core institutional value. One or more C-suite leaders oversee a system-wide assessment on safety (examples provided in the Attestation Guide), and the execution of patient safety initiatives and operations, with specific improvement plans and metrics. These plans and metrics are widely shared across the hospital and governing board. (C) Our hospital governing board, in collaboration with leadership, ensures adequate resources to support patient safety (such as equipment, training, systems, personnel, and technology). (D) Reporting on patient and workforce safety events and initiatives (such as safety outcomes, improvement work, risk assessments, event cause analysis, infection outbreak, culture of safety, or other patient safety topics) accounts for at least 20% of the regular board agenda and discussion time for senior governing board meetings. (E) C-suite executives and individuals on the governing board are notified within 3 business days of any confirmed serious [illegible] resulting in significant morbidity, mortality, or
Domain 2: Strategic Planning & Organizational Policy	
Hospitals must leverage [illegible] planning and organizational policies to demonstrate a commitment to safety as a core value. The use of written policies and protocols that demonstrate patient safety is a priority and identify goals, metrics and practices to advance progress, is foundational to creating an accountable and transparent organization. Hospitals should acknowledge the ultimate goal of zero preventable harm, even while recognizing that this goal may not be currently attainable and requires a [illegible] improvement and	(A) Our hospital has a [illegible] commitment to patient safety as a core value and [illegible] specific safety goals and associated metrics, including the [illegible] of "zero preventable harm." (B) Our hospital safety goals include the use of metrics [illegible] identify and address disparities in safety outcomes based on the patient characteristics determined by the hospital to be most important to health care outcomes for the specific populations served. (C) Our hospital has implemented written policies and protocols to cultivate a just culture that balances no-blame and appropriate accountability and reflects the distinction between human error, at risk behavior, and reckless behavior. (D) Our hospital requires implementation of a patient safety [illegible] competencies for all clinical and non-clinical [illegible] individuals on

Attestation Domains	Attestation Statements: Attest "yes" or "no" to each element. (Note: Affirmative attestation of all elements within a domain would be required for the hospital or health system to receive a point for that domain)
Domain 1: Eliciting Patient Healthcare Goals	
This domain focuses on obtaining [illegible] Patient's health related goals and treatment preferences which will inform shared decision making and goal concordant care.	(A) Established protocols are in place to ensure patient goals related to healthcare (health goals, treatment goals, living wills, identification of healthcare proxies, advance care planning) are obtained/reviewed and documented in the medical record. These goals are updated before major procedures and upon significant changes in clinical status.
Domain 2: Responsible Medication Management	
This domain aims to optimize medication management through [illegible] monitoring of the pharmacological record for drugs that may be considered appropriate in older adults due to increased risk of harm.	(A) Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMS should be considered for discontinuation, and/or dose adjustment as indicated.
Domain 3: Frailty Screening and Intervention	
This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium physical function/mobility, and [illegible] for the purpose of early detection and intervention [illegible] are appropriate.	(A) Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instrument ideally upon admission, before major procedures, and/or upon significant changes in clinical status. B) Positive screens result in management plans including but not limited to minimizing delirium risks, encouraging early mobility, and implementing nutrition plans where appropriate. These plans should be included in discharge instructions and communicated to post-discharge facilities. Data are collected on the rate of falls, decubitus ulcers, 30-day readmission for patients > 65. These data are stratified by demographic and/or social factors. Protocols exist to reduce the risk of emergency [illegible] treatment delirium by reducing length of emergency [illegible] treatment stay with a goal of transferring a targeted

*Review CHA summary for detailed domain and attestation statements; Pages 47-51 for Patient Safety and 51-53 for Age-Friendly Hospital

Electronic Clinical Quality Measure (eCQM) Reporting Requirements

Reporting Period	Payment Determination	Total Number of eCQMs Required	eCQM Reporting Requirements
CYs 2024 and 2025	FFYs 2026 and 2027	6	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications
CY 2026	FFY 2028	9*	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications • Hospital Harm – Severe Hyperglycemia* • Hospital Harm – Severe Hypoglycemia* • Hospital Harm – Opioid-related adverse events*
CY 2027	FFY 2029	11*	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications • Hospital Harm – Severe Hyperglycemia* • Hospital Harm – Severe Hypoglycemia* • Hospital Harm – Opioid-related adverse events* • Hospital Harm – Pressure Injury* • Hospital Harm – Acute Kidney Injury*

*Indicates proposal

IQR Program: Proposed Measure Removals

CMS proposes to remove five measures from the IQR program:

1) Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) (CY 2025 reporting/FFY 2027 payment determination)
    - Proposal is contingent on CMS finalizing new Failure-to-Rescue measure

- Four Clinical Episode-Based Payment Measures (FFY 2026 payment determination)

2) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI) (CBE #2431) (AMI Payment)
3) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure (HF) (CBE #2436) (HF Payment)
4) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia (PN) (CBE #2579) (PN Payment)
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) (CBE #3474) (THA/TKA Payment)

IQR Program: Proposed Measure Modification

CMS proposes to modify one existing eCQM:

- Global Malnutrition Composite Score (CY 2026 reporting/FFY 2028 payment determination)
  - Measure would be modified to expand the population from hospitalized adults 65 or older to hospitalized adults 18 or older
  - Measure would remain as an option for hospitals to self-select to meet eCQM reporting requirements

Proposed Modifications to HCAHPS Survey: IQR & VPB

- Beginning with Jan. 1, 2025, CMS proposes several changes to HCAHPS patient experience survey:
  - **Care coordination**: CMS would remove the current care transition sub-measure and replace with three new survey questions under Care Coordination:

    1) How often hospital staff were informed and up-to-date on a patients' care; 2) how well hospital staff worked together to care for the patient; and 3) whether hospitals worked with patients, families or caregivers in making post-hospitalization care plans.
  - **Restfulness of the hospital environment**: In addition to current quietness question, would include two new questions on whether hospitals provide a restful, healing environment.
  - **Information about symptoms**: New question intended to assess whether patients and families receive information about what symptoms they should watch for post-hospitalization.
  - **Responsiveness of hospital staff**: Proposed replacement of the current HCAHPS question focused on responsiveness to call bells with a more general question assessing whether patients received help when needed.

Proposed Modifications to HCAHPS Survey: VBP Scoring

- CMS proposes to adopt the updated HCAHPS sub-measures for the VBP program beginning with FFY 2030
  - Baseline period for updated HCAHPS measure would be CY 2026
  - Performance period for updated HCAHPS measures would be CY 2028
- For FFYs 2027-2029, CMS would exclude the current care transition and responsiveness of hospital staff sub-measures from scoring to ensure hospitals are scored on only those parts of the HCAHPS that would remain unchanged from the current survey.

Other CMS Hospital Quality Programs

- CMS proposes no changes to:
  - Hospital Readmissions Reduction Program (HRRP)
  - Hospital Acquired Conditions (HAC) Reduction Program
- PPS-Exempt Cancer Hospital Quality Reporting Program
  - Proposed adoption of Patient Safety Structural Measure
  - Proposed modifications to HCAHPS survey
  - Proposal to revise public reporting of Hospital Commitment to Health Equity Measure to January 2026

Promoting Interoperability Program

Proposed Modification to AUR Surveillance Measure

- CMS proposes to separate the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures beginning with CY 2025 EHR reporting:
  - **Antimicrobial Use (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.
  - **Antimicrobial Resistance (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.

Proposed Modification to AUR Surveillance Measure (cont'd)

- **Proposed Exclusions:**
  - Exclusion 1: During the reporting period, the hospital does not have any patients in any patient care location for which data are collected by NHSN.
  - Exclusion 2: During the reporting period, the hospital does not have an electronic medication administration record/bar-coded medication administration (eMAR/BCMA) records or electronic admission discharge transfer (ADT) system.
  - Exclusion 3: During the reporting period, the hospital does not have an electronic LIS or electronic ADT system.

Proposed Scoring Methodology

- Beginning with the CY 2025 reporting period, CMS proposes to **increase** the minimum scoring threshold **from 60 to 80 points**
- Other scoring policies remain the same:
  - Report on all the required measures across all four objectives, unless an exclusion applies
  - Report "yes" on all required yes/no measures, unless an exclusion applies
  - Attest to completing the actions included in the Security Risk Analysis measure
  - Meet eCQM reporting requirements
    - Aligned with IQR proposals

Performance-Based Scoring Methodology Beginning with the CY 2025 EHR Reporting Period

Objectives	Measures	Maximum Points	Redistribution if Exclusion Claimed
Electronic Prescribing	e-Prescribing	10 points	10 points to HIE Objective
	Query of PDMP	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	No exclusion
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* • AR Surveillance*	25 points	If an exclusion is claimed for all 6 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)	

Note: The Security Risk Analysis measure, SAFER Guides measure, and information blocking attestations required by section 106(b)(2)(B) of MACRA are required but will not be scored. eCQM measures are required but will not be scored.

See pages 61-62 in CHA summary.

Condition of Participation (CoP) Proposals and Requests for Information

Proposed CoP for Data Reporting of Respiratory Illnesses

- CMS previously finalized CoPs requiring hospitals and CAHs to report certain data elements related to COVID-19 and other respiratory illnesses (i.e., influenza); these reporting requirements expired April 30, 2024.
- CMS proposes to make permanent the CoP requiring hospitals and CAHs to report weekly certain data on acute respiratory illnesses, beginning Oct. 1, 2024:
  - Confirmed infections of COVID-19, influenza and respiratory syntactical virus (RSV) among hospitalized patients
  - Hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric])
  - Limited patient demographic information, including age
- CMS also proposes that during public health emergencies, additional data elements could be added and/or reporting frequency increased
- CMS seeks comments on including race/ethnicity data as part of its patient demographic data reporting requirements

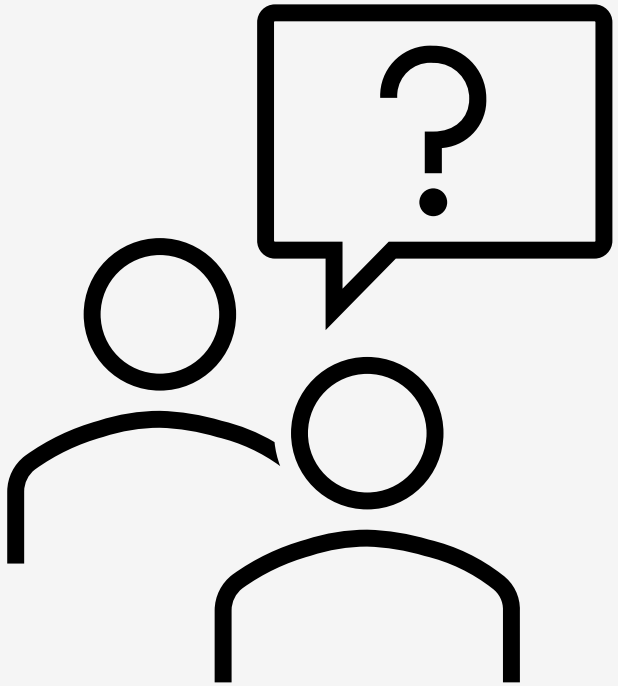
RFI on Obstetrical Services CoPs for Hospitals, CAHs and REHs

- CMS states that it plans to propose baseline health and safety standards for obstetrical (OB) services in the calendar year 2025 OPPS proposed rule; Comments are solicited ahead of proposal:
  - What should be the overarching requirement, scope, and structure for an obstetrical services CoP?
  - What types of facilities and care settings should such a CoP apply to (e.g., hospitals, hospitals with/without OB units, hospitals with/without emergency services, CAHs, outpatient settings)?
  - Should the CoP be structured as:
    - Optional services CoP specific to obstetrical services?
    - Modeled after infection prevention and control stewardship program CoPs, inlcuding requirements relating to service organization and policies, leadership responsibilities, and application to multi-hospital systems?
    - Requiring hospitals to develop standard processes for managing pregnant, birthing, and postpartum patients with or at risk for: (1) obstetric hemorrhage (a leading cause of maternal mortality); and (2) severe hypertension (a common pregnancy complication)?

RFI on Obstetrical Services CoPs for Hospitals, CAHs, and REHs

- CMS also seeks comments on questions related to staff training, including:
  - Should minimum OB staff training requirements (both initial and ongoing) be included in an obstetric services CoP?
  - Given the rate of OB unit closures, should CMS require a minimum obstetrical training standard for hospital/CAH non-OB unit, emergency department, REH, or other non-OB staff that may care for pregnant, birthing, and postpartum patients to improve maternal health outcomes?
  - Should such additional staff training include separate training on methods for providing respectful care for pregnant, birthing, and postpartum patients in an effort to improve maternal health outcomes?
  - Should staff also be trained on implicit bias, trauma-informed care, or other specific training topics aimed at addressing bias and reducing disparities in maternity care?
  - Should additional staff training include separate training on the screening, assessment, treatment, and referral for maternal depression and related behavioral health disorders by staff?
- Full discussion and set of questions available on pages 36498-36502 of the proposed rule

Questions



Contact

Please contact us if you have questions we were not able to address today.

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Thank You

Thank you for participating in today's webinar.

For education questions, contact education@calhospital.org.