SUMMARY OF PROPOSED RULE – MAY 2024

FFY 2025 Inpatient Prospective Payment System

In the May 2 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule describing federal fiscal year (FFY) 2025 policies and rates for Medicare's inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS). If finalized, the policy and payment provisions in the proposed rule will be effective for FFY 2025 discharges, beginning Oct. 1, 2024.

The following is a comprehensive summary of the proposed rule's acute care hospital provisions. Payment and policy changes for the FFY 2025 LTCH PPS proposed rule are addressed in a separate summary.

To Comment

Comments are due to CMS on June 10 by 2 p.m. (PT) and can be submitted electronically; search the site for "CMS-1808-P."

For Additional Information

Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742 or mhoward@calhospital.org, or Chad Mulvany, vice president of federal policy, at (202) 270-2143 or cmulvany@calhospital.org. Facility-specific CHA DataSuite analyses were sent under separate cover. Questions about CHA DataSuite should be directed to Alenie Reth, data analytics coordinator, at areth@calhospital.org.

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Proposed FFY 2025 Payment Changes

The table below lists the federal operating and capital rates proposed for FFY 2025 compared to the rates currently in effect for FFY 2024. These rates include all market basket (MB) increases and reductions as well as the application of annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g., penalty for non-compliance under the Inpatient Quality Reporting (IQR) Program and Electronic Health Records (EHR) Meaningful Use Program, quality penalties/payments, disproportionate share hospitals, etc.).

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

The standardized amount does not include the 2% Medicare sequester reduction that began in 2013 and continues under current law. The sequester reduction is applied as the last step in determining the payment amount for submitted claims and does not affect the underlying methodology used to calculate MS-DRG weights or standardized amounts.

The following table provides details for the proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2025.

	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%**	**+2.51%**

Effects of the Inpatient Quality Reporting and Electronic Health Records Incentive Programs

The IQR MB penalty imposes a 25% reduction to the full MB, and the EHR Meaningful Use penalty imposes a 75% reduction to the full MB; therefore, the entirety of the full MB update is at risk between these two penalty programs. A table displaying the various proposed update scenarios for FFY 2025 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket 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%***

CMS estimates that 91 hospitals will not receive the full MB rate of increase because they failed the quality data submission process or chose not to participate in IQR; 87 hospitals will not receive it because they are not meaningful EHR users; and 26 hospitals are estimated to be subject to both reductions.

Impact Analysis — California

The CHA DataSuite analysis estimates that California hospitals will experience an increase of 0.5% overall Medicare hospital inpatient payments if the FFY 2025 policies are finalized as proposed, as compared to FFY 2024.

IPPS FFY 2025 Proposed Rule Analysis
Estimated Change in Medicare Payments
FFY 2025 Proposed Rule Compared to FFY 2024 Final Rule with Correction Notice

California

Group Impact Summary	Operating Dollar Impact	Operating % Change	Capital Dollar Impact	Capital % Change	Total Dollar Impact	Total % 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 Dollar Impact	Operating % Change	Capital Dollar Impact	Capital % Change	Total Dollar Impact	Total % 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.

However, the impact will vary based on the type of hospital. CMS' detailed impact estimates are displayed in Table I of the proposed rule (page 670), which is partially reproduced below.

Hospital Type	All Proposed Rule Changes
All Hospitals	2.4%
Urban	2.4%
Urban Pacific	1.2%
Rural	1.9%
Rural Pacific	1.5%

Outlier Payments

CMS proposes an outlier threshold for FY 2025 of $49,237 – an increase of 15.2% and $6,487 from the FY 2024 amount ($42,750). CMS projects that the proposed outlier threshold for FY 2025 will result in outlier payments equal to 5.1% of operating DRG payments and 4.23% of capital payments. Accordingly, CMS is applying adjustments of 0.949 to the operating standardized amounts and 0.957708 to the capital federal rate to fund operating and capital outlier payments, respectively.

As it has historically, for FY 2025, CMS will use the latest year of claims data (December 2023) update to the FY 2023 Medicare Provider Analysis and Review File and the latest cost report data from the December 2023 update of the Provider-Specific File to set the fix-loss outlier threshold and update MS-DRG weights.

Medicare Disproportionate Share Hospital (DSH) — Uncompensated Care DSH

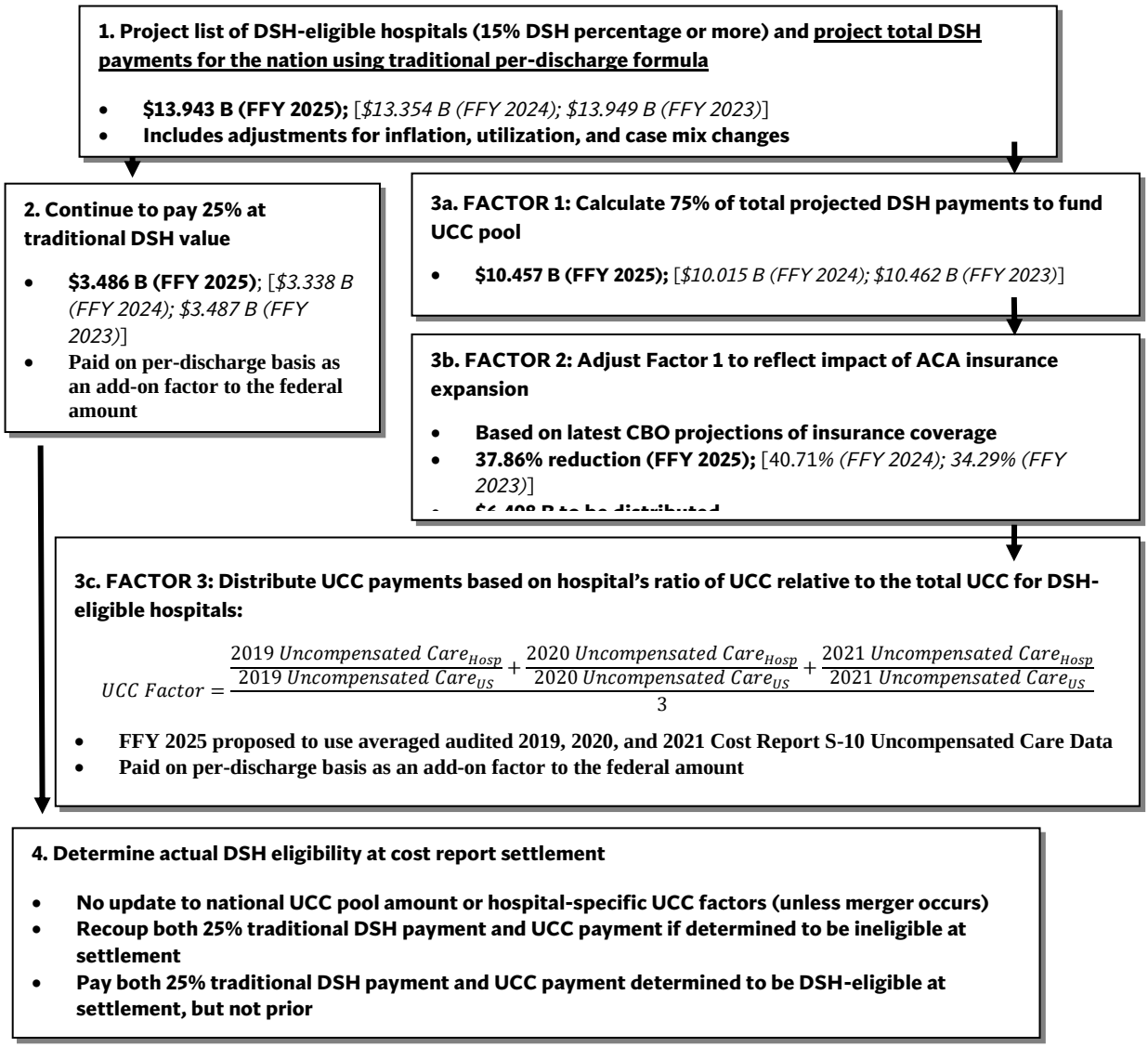
Medicare makes DSH and UCC payments to IPPS hospitals that serve a number of low-income patients above a certain threshold. Low income is defined as Medicare-eligible patients who also receive supplemental security income, and Medicaid patients who are not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC, the proportion of inpatient days for each of these subsets of patients is used.

Prior to 2014, CMS made only DSH payments. Beginning in FFY 2014, the Affordable Care Act (ACA) required that DSH payments equal 25% of the statutory formula and UCC payments equal the product of three factors:

- Factor 1: 75% of aggregate DSH payments that would be made under Section 1886(d)(5)(F) without application of the ACA
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to ACA implementation
- Factor 3: A hospital's UCC costs for a given period relative to UCC costs over the same period for all hospitals that receive Medicare DSH payments

The statute precludes administrative or judicial review of the secretary's estimates of the factors used to determine and distribute UCC payments. UCC payments are made only to hospitals eligible to receive DSH payments that are paid using the national standardized amount. Therefore, sole community hospitals (SCH) paid on the basis of hospital-specific rates and hospitals not paid under the IPPS are ineligible to receive UCC payments.

The schematic below describes the DSH payment methodology mandated by the ACA, along with how CMS proposes to change the program from FFY 2024 to FFY 2025:



DSH dollars available to hospitals under the ACA's payment formula are proposed to increase by $560 million in FFY 2025 relative to FFY 2024 due to an increase in the pool from projected DSH payments.

The regulatory impact analysis presented in Appendix A of the proposed rule includes the estimated effects of the changes to UCC payments for FFY 2025 across all hospitals by geographic location, bed size, region, teaching status, type of ownership, and Medicare utilization percent.

CMS projects 2,422 hospitals would be eligible for DSH payments in FFY 2025. CMS has made a file available that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology.

Proposed FFY 2025 Factor 1

CMS estimates this figure based on the most recent data available. It is not adjusted later based on actual data. CMS used the Office of the Actuary's (OACT) January 2024 Medicare DSH estimates, which were based on the December 2023 update of the HCRIS and the FFY 2024 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's January 2024 Medicare estimate of DSH payments for FY 2025 is $13.943 billion. The proposed Factor 1 amount is 75% of this amount, or $10.457 billion. The proposed Factor 1 for 2025 is about $442 million more than the final Factor 1 for FY 2024.

Proposed FFY 2025 Factor 2

Factor 2 adjusts Factor 1 based on the percent change in the number of individuals who are uninsured from 2013 until the most recent period for which data are available. CMS uses uninsured estimates from the National Health Expenditure Accounts in place of Congressional Budget Office data as the source of change in the uninsured population.

For FFY 2025, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14%, and for calendar years (CYs) 2024 and 2025 is 8.5% and 8.8%, respectively. CMS calculates the proposed Factor 2 for FFY 2025 (weighting the portion of CYs 2024 and 2025 included in FFY 2025) as follows:

- Percent of individuals without insurance for CY 2013: 14%
- Percent of individuals without insurance for CY 2024: 8.5%
- Percent of individuals without insurance for CY 2025: 8.8%
- Percent of individuals without insurance for FFY 2025 (0.25 times 0.085) + (0.75 times 0.088): 8.7%

Proposed Factor 2 = 1-|((0.087-0.14)/0.14)| = 1 – 0.3786 = 0.6214 (62.14 percent)

CMS calculated Factor 2 for the FY 2025 proposed rule to be 0.6214 or 62.14 percent, and the uncompensated care amount for FY 2025 to be $10.457 billion x 0.6214 = $6.498 billion which is about $560 million more than the FY 2024 UCP total of about $5.938 billion; the percentage increase is 9.4 percent.

Proposed Factor 3 for FFY 2025

Factor 3 equals the proportion of hospitals' aggregate UCC attributable to each IPPS hospital. CMS continues to define UCC as the amount on line 30 of Worksheet S-10, which is the cost of charity care (line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29). The product of Factors 1 and 2 determines the total pool available for UCC payments. This result multiplied by Factor 3 determines the amount of the UCC payment that each eligible hospital will receive.

CMS proposes to determine Factor 3 for FFY 2025 using the average of the audited FFY 2019, FFY 2020, and FFY 2021 Worksheet S-10 reports.

Proposed Per Discharge Amount of Interim UCC Payments

CMS typically calculates a per-discharge amount of interim UCC by dividing the hospital's total UCC payment amount by its three-year average of discharges. This per-discharge payment amount is used to make interim UCC payments to each projected DSH-eligible hospital. These interim payments are reconciled following the end of the year.

For FY 2025 and subsequent fiscal years, CMS proposes to calculate the per-discharge amount for uncompensated care payments using the average of the most recent three years of discharge data. CMS proposes for FY 2025 to use an average of FY 2021, FY 2022, and FY 2023 historical discharge data.[1]

To reduce the risk of overpayments of interim UCC payments and the potential for unstable cash flows for hospitals, CMS continues its voluntary process through which a hospital may submit a request to its Medicare Administrative Coordinator (MAC) for a lower per-discharge interim UCC payment amount. It includes a reduction to zero, once before the beginning of the fiscal year and/or once during the fiscal year. The hospital would have to provide documentation to support a likely significant recoupment — for example, 10% or more of the hospital's total UCC payment, or at least $100,000. The only change made would be to lower the per-discharge amount either to the amount requested by the hospital or another amount determined by the MAC. This does not change how the total UCC payment amount will be reconciled at cost report settlement.

Proposed Process for Notifying CMS of Merger Updates and to Report Upload Issues

CMS publishes a table on its website, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules. The table contains a list of the mergers known to CMS and the computed UCC payment for each merged hospital. Hospitals have 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies.

Proposed Updates to 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. CMS proposes utilizing FFY 2023 IPPS claims data and FFY 2022 HCRIS data, without modifications, to calculate FFY 2025 rates.

The total number of payable MS-DRGs is proposed to be 771 (compared to 764 for FFY 2024), with 78.4% of DRG weights changing by less than +/- 5%, 14.7% changing at least +/-5% but less than +/- 10%, 5.6% changing more than +/-10%, 4.7% that are affected by the relative weight cap on reductions, and 1.3% being proposed as new MS-DRGs. The five MS-DRGs with the greatest year-to-year change in weight, taking into account the relative weight cap, are:

1 In FY 2024, CMS used two years of data (FY 2021 and FY 2022) because of concerns about using data from FY 2020 due to the effects of the COVID-19 pandemic on discharges.

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%

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

Proposed MS-DRG Changes

CMS proposes making changes to a number of MS-DRGs effective for FFY 2025. CMS specifically proposes to:

- Add ICD-10-PCS codes describing left atrial appendage closure (LAAC) procedures and cardiac ablation procedures to proposed new MS-DRG 317 (Concomitant Left Atrial Appendage Closure and Cardiac Ablation).
- Delete existing MS-DRGs 453, 454, and 455 (Combined Anterior and Posterior Spinal Fusion with MCC, with CC, and without CC/MCC, respectively) and to reassign procedures from the existing MS-DRGs, 453, 454, and 455 and MS-DRGs 459 and 460 (Spinal Fusion except Cervical with MCC and without MCC, respectively) to proposed new MS-DRG 402 (Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical), proposed new MS-DRGs 426, 427, and 428 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC, with CC, without MCC/CC, respectively), proposed new MS-DRGs 429 and 430 (Combined Anterior and Posterior Cervical Spinal Fusion with MCC and without MCC, respectively), and proposed new MS-DRGs 447 and 448 (Multiple Level Spinal Fusion Except Cervical with MCC, and without MCC, respectively). We note that we are also proposing to revise the title of MS-DRGs 459 and 460 to “Single Level Spinal Fusion Except Cervical with MCC and without MCC, respectively.
- Reassign cases that report a principal diagnosis of acute leukemia with an “other” O.R. procedure from MS-DRGs 834, 835, and 836 (Acute Leukemia without Major O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) to proposed new MS-DRG 850 (Acute Leukemia with Other O.R. Procedures). We note that we are also proposing to revise the title of MS-DRGs 834, 835, and 836 from “Acute Leukemia without Major O.R. Procedures with MCC, with CC, and without CC/MCC”, respectively to “Acute Leukemia with MCC, with CC, and without CC/MCC”.

The table on Display pages 608-609 details which of these new or revised MS-DRGs CMS proposes subjecting to the post-acute care transfer policy for FFY 2025. The table on Display

pages 609-610 details which of these new or revised MS-DRGs are proposed to be subject to MS-DRG special payment policy.

Social Determinants of Health (SDOH) Diagnosis Coding

CMS proposes changing the severity level for the following diagnosis codes regarding inadequate housing and homelessness from NonCC to CC for FFY 2025:

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

Cap for Relative MS-DRG Weight Reductions

Beginning in FFY 2023, CMS adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget-neutral manner. As such, CMS will continue this policy and proposes a budget-neutrality adjustment of 0.999617 to the operating rate and 0.9996 to the capital rate for all hospitals FFY 2025. The cap only applies if an MS-DRG retains its number from the prior year and would not apply to the relative weight for any new or renumbered MS-DRGs for the year.

CAR-T Cell Therapies

Beginning with FY 2021, CMS adopted a differential payment for clinical trial cases and expanded access (compassionate) use claims where the hospital does not incur the costs of the CAR-T product. For FY 2025, CMS proposes to continue its methodology for identifying clinical trial claims and expanded access use claims in MS-DRG 018 by excluding claims with the presence of condition code "90" and claims that contain ICD-10-CM diagnosis code Z00.6 without payer-only code "ZC."

CMS estimates that the average costs of cases assigned to MS–DRG 018 that are identified as clinical trial cases ($116,831) were 34% of the average costs of the cases assigned to MS–DRG 018 that are identified as non-clinical trial cases ($342,684). Accordingly, CMS proposes a payment adjustor of 0.34 to the applicable clinical trial and expanded access use immunotherapy cases. Additionally, CMS will use an adjusted case count for these cases in determining the calculation of the relative weights and for purposes of budget neutrality and outlier simulations. The data underlying these adjustments will be updated for the FY 2025 final rule.

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

Effective for cost reporting periods beginning on or after October 1, 2024, CMS proposes 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.

Post-Acute Transfer Policy

CMS proposes adding new MS-DRGSs 426, 427, 447 and 448 to the post-acute transfer list. These MS-DRGs would also qualify to receive the special payment methodology. MS-DRGs 459 and 460 are currently subject to the post-acute transfer policy but CMS proposes removing them from because the proposed revisions to the MS-DRGs would make them no longer qualify. All of these MS-DRG pertain to spinal fusion.

New Technology Payments

The table below lists the 24 technologies CMS proposes continuing new technology add-on payments for FY 2024 because the three-year anniversary date of entry into the U.S. market occurs on or after April 1, 2024. The complete table in the proposed rule also includes the proposed maximum NTAP amount for FY 2025, codes used to identify cases eligible for NTAP, and previous related final rule citations.

Proposed Continuation of Technologies Approved for FY 2024 New Technology Add-On Payments Still Considered New for FY 2025 Because 3-Year Anniversary Date Occurs on or After April 1, 2025

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto US Market
1	Thoraflex™ Hybrid Device	04/19/2022	10/1/2022	04/19/2025
2	ViviStim® Paired VNS System	04/29/2022	10/1/2022	04/29/2025
3	GORE® TAG® Thoracic Branch Endoprosthesis	05/13/2022	10/1/2022	05/13/2025
4	Cerament® G	05/17/2022	10/1/2022	05/17/2025
5	iFuse Bedrock Granite Implant System	05/26/2022	10/1/2022	05/26/2025
6	CYTALUX® (pafolacianine) (ovarian indication)	04/15/2022	10/1/2023	04/15/2025
7	CYTALUX® (pafolacianine) (lung indication)	06/05/2023	10/1/2023	06/05/2026
8	EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm)	05/19/2023	10/1/2023	05/19/2026
9	Lunsumio™ (mosunetuzumab)	12/22/2022	10/1/2023	12/22/2025
10	REBYOTA™ (fecal microbiota, live-jslm) and VOWST™ (fecal microbiota spores, live-brpk)	01/23/2023	10/1/2023	01/23/2026
11	SPEVIGO® (spesolimab)	09/01/2022	10/1/2023	09/01/2025

Proposed Continuation of Technologies Approved for FY 2024 New Technology Add-On Payments Still Considered New for FY 2025 Because 3-Year Anniversary Date Occurs on or After April 1, 2025				
	Technology	**Newness Start Date**	**NTAP Start Date**	**3-year Anniversary Date of Entry onto US Market**
12	TECVAYLI™ (teclistamab-cqyv)	11/09/2022	10/1/2023	11/09/2025
13	TERLIVAZ® (terlipressin)	10/14/2022	10/1/2023	10/14/2025
14	Aveir™ AR Leadless Pacemaker	06/29/2023	10/1/2023	06/29/2026
15	Aveir™ Dual-Chamber Leadless Pacemaker	06/29/2023	10/1/2023	06/29/2026
16	Ceribell Status Epilepticus Monitor	05/23/2023	10/1/2023	05/23/2026
17	DETOUR System	06/07/2023	10/1/2023	06/07/2026
18	DefenCath™ (taurolidine/heparin)	11/15/2023	1/1/2024	11/15/2026
19	EchoGo Heart Failure 1.0	11/23/2022	10/1/2023	11/23/2025
20	Phagenyx® System	04/12/2023	10/1/2023	04/12/2026
21	REZZAYO™ (rezafungin for injection)	03/22/2023	10/1/2023	03/22/2026
22	SAINT Neuromodulation System	09/01/2022	10/1/2023	09/01/2025
23	TOPS™ System	06/15/2023	10/1/2023	06/15/2026
24	XACDURO® (sulbactam/durlobactam)	05/23/2023	10/1/2023	05/23/2026

The table below lists the seven technologies CMS proposes discontinuing new technology add-on payments for FY 2024 because the three-year anniversary date of entry into the U.S. market occurs prior to April 1, 2024. The complete table in the proposed rule also includes the proposed maximum NTAP amount for FY 2025, codes used to identify cases eligible for NTAP, and previous related final rule citations.

Proposed Discontinuation of Technologies Approved for FY 2024 New Technology Add-On Payments No Longer Considered New for FY 2025 Because 3-Year Anniversary Date Occurs Prior to April 1, 2025				
	Technology	**Newness Start Date**	**NTAP Start Date**	**3-year Anniversary Date of Entry onto US Market**
1	Intercept® Fibrinogen Complex (PRCFC)	05/05/2021	10/1/2021	5/05/2024
2	Rybrevant® (amivantamab)	05/21/2021	10/1/2021	05/21/2024
3	StrataGraft®	06/15/2021	10/1/2021	06/15/2024
4	aprevo® Intervertebral Body Fusion Device (TLIF indication)	6/30/2021 (TLIF)	10/1/2021	6/30/2024 (TLIF)
5	Hemolung Respiratory Assist System (RAS) (non- COVID-19 related use)	11/15/2021 (other)	10/1/2022	11/15/2024 (other)
6	Livtencity™ (maribavir)	12/2/2021	10/1/2022	12/2/2024
7	Canary Tibial Extension (CTE) with Canary Health Implanted Reporting Processor (CHIRP) System	10/04/2021	10/1/2023	10/04/2024

CMS proposes new technology add-on payments for 12 technologies under the traditional pathway and 14 under alternative pathways. CMS previously conditionally approved one new technology (taurolidine/heparin) under the alternate pathway for FFY 2024 and is proposing to continue payments for this technology for FFY 2025.

Proposed Change to the Calculation of the New Technology Add-On Payment for Gene Therapies Indicated for Sickle Cell Disease (SCD)

CMS proposes that, subject to its review of the new technology add-on payment eligibility criteria, for certain gene therapies approved for new technology add-on payments in the FY 2025 final rule for the treatment of SCD, effective with discharges on or after October 1, 2024, and concluding at the end of the two- to three-year newness period, to increase the payment percentage from 65% to 75%. CMS notes that if finalized, this policy would be temporary; these payment amounts would only apply to any gene therapy indicated and used specifically for the treatment of SCD that CMS approves for FY 2025 new technology add-on payments.

CMS seeks comments on the proposal and whether it should make this proposed 75% add-on payment percentage available only to applicants that meet certain additional criteria, such as attesting to offering and/or participating in outcome-based pricing arrangements with purchasers (without regard to whether the specific purchaser availed itself of the outcome-based arrangement) or otherwise engaging in behaviors that promote access to these therapies at lower costs.

Proposed FFY 2025 Wage Index

CMS adjusts a portion of IPPS payments to account for area differences in the cost of hospital labor, an adjustment known as the area wage index. Additional details about this methodology can be found in the regulation. A complete list of the proposed wage indexes for payments in FFY 2025 is available in Table 2 on the CMS website.

Core-Based Statistical Areas (CBSAs) for the Proposed FFY 2025 Hospital Wage Index

Hospitals are assigned to labor market areas and the wage index reflects the weighted (by hours) average hourly wage reported on Medicare cost reports. CMS uses Office of Management and Budget (OMB) CBSA delineations as labor market areas.

On July 21, 2023, the OMB issued OMB Bulletin No. 23-01 that made a number of significant changes to the CBSA delineations. To align with these changes, CMS proposes adopting the newest OMB delineations for the FFY 2025 IPPS wage index.

While these changes are significant, only one California CBSA is impacted. In the rule, CMS proposes that FFY 2024 CBSA 31460 (Madera County) would be subsumed by FFY 2025 proposed CBSA 23420 (Fresno, CA).

Worksheet S-3 Wage Data

CMS calculates the proposed rule FFY 2025 wage index using data from FY 2021 submitted cost reports. CMS does not propose any changes to the categories of included and excluded costs for FY 2025 relative to prior years. CMS' proposed rule calculations of the FY 2025 wage index are based on wage data of 3,075 hospitals. The data file used to construct the wage index includes FY 2021 data submitted to CMS as of Jan. 26, 2024.

The wage index data used for the FY 2025 wage index spans the COVID-19 PHE. The proposed rule presents data showing a higher proportion of hospitals had an increase in their average hourly wage using the FY 2020 and FY 2021 data than in prior years. However, CMS indicates that it is not apparent whether any changes due to the COVID-19 PHE differentially impacted the wages paid by individual hospitals. Even if there were differential impacts, it is not clear how those changes could be isolated from changes due to other reasons and what an appropriate potential methodology might be to adjust the data.

General wage index policies are unchanged from prior years. CMS notes that it excluded 69 providers due to aberrant wage data that failed edits for accuracy from the proposed rule wage index calculation. However, if data aberrancies for these providers are resolved timely, CMS will include data from these providers to set the final rule FFY 2025 wage indexes. CMS calculates an unadjusted national average hourly wage of $54.80.

Occupational Mix Adjustment

CMS proposes using the calendar year (CY) 2022 Occupational Mix Survey to calculate the wage index for FFY 2025 through 2027. The FFY 2025 occupational mix adjusted wage index based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS proposes a FFY 2025 occupational mix adjusted national average hourly wage of $54.73.

Rural Floor

The rural floor prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS estimates the rural floor will increase the proposed rule FY 2025 wage index for 494 urban hospitals requiring a budget neutrality adjustment factor of 0.985868 (-1.41%) applied to hospital wage indexes.

CMS does not propose new policies with respect to calculation of the wage index when an urban hospital is reclassified as rural. It does note that an urban to rural reclassified hospital is considered to be geographically rural for calculation of the pre-reclassified wage index. If that urban to rural reclassified hospital further reclassifies under the Medicare Geographic Classification Review Board (MGCRB) reclassification provisions, the hold harmless provisions with respect to the rural wage index will apply.

Proposed Revisions to FFY 2025 Wage Index Based on Geographic Reclassifications

The MGCRB approved 610 hospitals for wage index reclassifications starting in FFY 2025. Because reclassifications are effective for three years, there are a total of 1,163 hospitals reclassified for FFY 2025 (248 hospitals reclassified back to their home area).

The deadline for withdrawing or terminating a wage index reclassification for FY 2025 approved by the MGCRB is 45 days from the date of publication of the FY 2025 proposed rule in the *Federal Register* on May 2, 2024, making the deadline June 16, 2024.

For withdrawal or terminating FY 2026 reclassifications, CMS is proposing to change the deadline to 45 days from proposed rule display with the Office of Federal Register.

Lugar Hospitals and Counties

A “Lugar” hospital is located in a rural county adjacent to one or more urban areas that is automatically reclassified to the urban area from which the highest number of its workers commute. The out-migration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Out-migration adjustments are fixed for three years. A hospital can either be reclassified or receive the out-migration adjustment, but not both. Lugar status is automatic. A Lugar hospital must decline its reclassification using the same process as other hospitals to receive the out-migration adjustment (e.g., notify CMS by May 24, 2024, that it is declining its Lugar reclassification).

The proposed rule restates the following policies with respect to how Lugar hospitals may decline their urban status to receive the out-migration adjustment:

- Waiving deemed urban status results in the Lugar hospital being treated as rural for all IPPS purposes
- Waiving deemed urban status can be done once for the three-year period that the outmigration adjustment is effective
- If a Lugar hospital waives its reclassification for three years, it must notify CMS to reinstate its Lugar status within 45 days of the IPPS proposed rule publication for the following fiscal year

In some circumstances, a Lugar hospital may decline its urban reclassification to receive an out-migration adjustment that it would no longer qualify for once it is reclassified as rural. In these circumstances, CMS will decline the Lugar hospital's request and continue to assign it a higher urban wage index (which itself could result in the county requalifying for the out-migration adjustment based on data in the final rule).

Under the proposed new CBSA delineations, 22 Lugar counties will become urban and no longer be considered Lugar counties. In most cases, these counties are becoming part of an urban area or a substantially similar one to which they were previously deemed. Hospitals in these counties will now be considered urban for purposes of the wage index and all other IPPS purposes.

CMS is also proposing to use updated data from the 2020 Census to revise the commuting thresholds for determining whether a county is a Lugar county. Based on the revised data, CMS is proposing that 17 of 53 counties that that were previously urban qualify to be Lugar counties. CMS proposes to remove Lugar status for 33 rural counties (11 hospitals) where the counties no longer meet the commuting thresholds or adjacency criteria to qualify for Lugar status.

Out-migration Adjustment

CMS proposes to apply the same policies for the FFY 2025 out-migration adjustment that it has been using since FFY 2012. CMS estimates the out-migration adjustment will increase IPPS payments by $55 million to 196 hospitals in FFY 2025.

Reclassification from Urban to Rural

A qualifying IPPS hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB. Not later than 60 days after the receipt of an application from an IPPS hospital that satisfies the statutory criteria, CMS must treat the hospital as being located in the rural area of the state in which the hospital is located.

CMS restates policies adopted in earlier years regarding urban to rural reclassifications. It also notes that it is adopting a new policy with respect to the effective date for hospitals that qualify for urban to rural reclassification to become sole community hospitals (SCHs). This proposed change is discussed below in the SCH section.

Process for Requests for Wage Index Data Corrections

CMS details its established multistep, 15-month process for the review and correction of the hospital wage data used to create the IPPS wage index for the upcoming fiscal year. A hospital that fails to meet the procedural deadlines does not have a later opportunity to submit wage index data corrections or to dispute CMS' decision on requested changes.

CMS posts the wage index timetable for FFY 2025 on its website. It includes all the public use files made available during the wage index development process.

Proposed Labor-Related Share

CMS updates the labor-related share every four years. The labor-related share was last updated in the FFY 2022 final rule. CMS is currently using a national labor-related share of 67.6%. If a hospital has a wage index of less than 1.0, its IPPS payments will be higher with a labor-related

share of 62%. If a hospital has a wage index that is higher than 1.0, its IPPS payments will be higher using the national labor-related share of 67.6%. Consistent with the statute, CMS is not applying budget neutrality when using the lower 62% labor share when a hospital has a wage index less than 1.0.

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.

If an IPPS provider's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. If a hospital reclassifies as rural with an effective date after this day, the policy will apply to the reclassified wage index instead. Additionally, a new IPPS hospital is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS will not have a wage index in the prior FFY.

This policy would be implemented in a budget neutral manner with a proposed budget neutrality factor of -.284%.

Proposed Continuation of the Low-Wage Index Hospital Policy

Despite opposition from CHA and other stakeholders, in the FFY 2020 IPPS final rule CMS adopted a policy intended to address concerns that the current wage index system perpetuates and exacerbates the disparities between high- and low-wage index hospitals. CMS finalized the policies to be effective for a minimum of four years to be properly reflected in the Medicare cost report for future years. However, due to COVID-19 CMS proposes extending the policy (again) for FFY 2025 through 2027. Specifically, CMS proposes:

- Hospitals with a wage index value in the bottom quartile of the nation would 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
- For FFY 2025, the 25th percentile wage index value across all hospitals is 0.8879
- CMS is applying a budget-neutrality adjustment of -.25% for this policy

The low wage index hospital policy and the related budget neutrality adjustment are the subject of pending litigation. The rule specifically mentions *Bridgeport Hospital, et al., v. Becerra,* filed in the U.S. District Court for the District of Columbia. The district court in Bridgeport held that the Secretary did not have authority to adopt the low wage index hospital policy and remanded the policy to the agency. CMS has appealed the court's decision and oral argument was held on October 27, 2023. A decision from the D.C. Circuit is pending. CMS does not indicate what it would do in the final rule if the circuit court upholds the district court decision and finds the low wage index policy to be unlawful.

Additionally, in a legal challenge brought by CHA on behalf of its members, the U.S. District Court for the Central District of California issued a decision in favor of California's hospitals in *Kaweah Delta Health Care District, et al. v. Becerra* on December 22, 2022. The court found CMS'

reduction to the IPPS standardized amount violates the Medicare Act, consistent with the ruling in *Bridgeport Hospital, et al. v. Becerra (above*). In both cases, the court has remanded the case to the U.S. Department of Health and Human Services (HHS) to determine an appropriate remedy, and the government has appealed both rulings. The appeals were argued before the U.S. Courts of Appeal for the Ninth and District of Columbia Circuits and decisions are pending.

In addition to the 2020 litigation CHA is currently pursuing similar, separate litigation on behalf of its members for FFYs 2021, 2022, 2023, and 2024.

Rural Referral Center: Annual Updates to Case-Mix Index and Discharge Criteria

CMS provides updated criteria for determining Rural Referral Center (RRC) status, including updated minimum national and regional case-mix index (CMI) values, and updated minimum national and regional numbers of discharges. For FFY 2025, CMS proposes to use FFY 2023 data to set the CMI criteria.

To qualify for initial RRC status for cost reporting periods beginning on or after Oct. 1, 2024, a rural hospital must have 275 or more beds. Those with fewer than 275 beds available for use can obtain RRC status if they meet specific geographic criteria, and have:

- More than 5,000 discharges (3,000 for an osteopathic hospital) in their cost reporting period that began during FFY 2021
- A CMI greater than or equal to the lower of 1.7764 (national urban hospital CMI excluding teaching hospitals) or the CMI for the hospital's census region (Pacific Census Region, 1.7821)

The median regional CMIs in the final rule reflect the December update of the FFY 2023 MedPAR file, contains claims received through December 2022. A hospital seeking to qualify as an RRC should get its hospital-specific CMI value (not transfer-adjusted) from its MAC.

Low-Volume Hospital Adjustment

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The Consolidated Appropriations Act (CAA) of 2023 extended the current criteria through FFY 2024. The current payment adjustment formula for hospitals located more than 15 miles from another subsection (d) hospital, with between 500 and 3,800 total discharges is:

$$Low\ Volume\ Hospital\ Payment\ Adjustment = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

In FFY 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 both the following 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

Consistent with historical practice, for a hospital to receive low-volume status for FFY 2025 it must submit a written request to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for FFY 2025. The MAC must receive the request by Sept. 1, 2024, for the adjustment to be applied to payments for its discharges beginning on or after Oct. 1, 2024. If accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

A hospital that qualified for the low-volume hospital payment adjustment for FFY 2024 may continue to receive the adjustment for FFY 2025 without reapplying if it meets both the criteria.

Medicare-Dependent Small Rural Hospitals (MDH)

The MDH program was most recently extended through FFY 2024 by the CAA of 2023. Beginning with discharges occurring on or after January 1, 2025, all hospitals that previously qualified for MDH status will no longer be eligible for this special payment methodology. There are currently 173 MDHs, of which CMS estimates 114 have been paid under the blended payment of the Federal rate and hospital-specific rate while the remaining 59 would have been paid based on the IPPS Federal rate. With the expiration of the MDH program, all these providers will be paid based on the IPPS Federal rate beginning with discharges occurring on or after January 1, 2025.

While the MDH program was set to expire many times previously, it has always been extended by Congress. Nevertheless, at this time, CMS is advising hospitals of the MDH program expiration and the potential to ameliorate the associated reduction in payment through becoming an SCH.

Sole Community Hospital (SCH) Status

CMS in 2012 revised the SCH regulations to allow MDHs to apply for SCH status in advance of the expiration of the MDH program. These regulations allow SCH status to begin the day following the MDH program's expiration. For an MDH to receive SCH status effective January 1, 2025, the MDH must apply for SCH status at least 30 days before the expiration of the MDH program, or by December 2, 2024. The MDH also must request that, if approved, the SCH status be effective with the expiration of the MDH program. If the MDH does not apply by the deadline, the hospital would instead be subject to the usual effective date for SCH classification, which is the date the MAC receives the complete application.

Indirect and Direct Graduate Medical Education Costs

CMS proposes the indirect medical education (IME) adjustment factor remain at 1.35 for FFY 2025. Below is an overview of several IME/graduate medical education (GME) policies discussed in the FFY 2025 IPPS proposed rule.

Distribution of Additional Resident Positions Under Section 4122 of the CAA, 2023

The CAA, 2023 provides 200 additional residency positions effective July 1, 2026. At least 100 of the positions made available shall be distributed for psychiatry or psychiatry subspecialty residency training programs. Hospitals must be notified of the additional residents they are awarded by January 31, 2026. The specifications in CAA of 2023 for awarding additional residents

are similar those in the CAA, 2021 that required CMS to distribute an additional 1,000 resident positions.

CMS proposes an application deadline of March 31 of the prior fiscal year to the provision being effective—that is, March 31, 2025. The application must be submitted to CMS using the Medicare Electronic Application Request Information System™ (MEARIS™).

Demonstrated Likelihood. For a hospital to be eligible for additional residents, it must demonstrate a likelihood that it will fill the positions that it is awarded. A hospital may meet this criterion by showing it does not have sufficient room under its current FTE resident cap(s) to accommodate a planned new program or expansion of an existing program.

Qualifying Hospitals. The law requires at least 10% of the additional residents be awarded to hospitals in each of the following four categories. CMS proposes that a qualifying hospital must also be in at least one of these categories:

- Located or Treated as Being a Rural Area. The hospital must be either geographically rural under CMS' CBSA delineations or reclassified from an urban to a rural area prior to the application deadline of March 31, 2025.
- Reference Resident Level Exceeds the Hospital's Resident Limit. The "reference resident level" refers to unweighted count from the hospital's most recent cost reporting period ending on or before December 29, 2022. This criterion is met if the hospital's reference resident level exceeds its Direct Graduate Medical Education (DGME) cap (which is also unweighted).
- States with New Medical Schools, Additional Locations and Branch Campuses. This category consists of hospitals located in states that established new medical schools or additional locations and branch campuses on or after January 1, 2000. This category consists of 35 states (including California) and Puerto Rico.
- Hospital Serves Patients from Health Professional Shortage Areas (HPSA). Residents in the hospital's residency program must spend at least 50 percent of their training time in a primary care or mental-health-only geographic HPSA. For mental-health-only geographic HPSAs, the program must be a psychiatry program or a subspecialty of psychiatry.

Pro Rata Distribution and Limitation on Individual Hospitals. All qualifying hospitals will receive at least 1 (or a fraction of 1) additional resident before any hospital is awarded two residents. A single hospital may not be awarded more than 10 residents.

Prioritization of Applications by HPSA Score. Priority for awarding additional residents will be given to hospitals based on the HPSA score associated with the program for which each hospital is applying. CMS will request HPSA data from HRSA in November 2024 to be used for prioritizing applications based on HPSA score.

Requirement for Rural Hospitals to Expand Programs. CMS proposes any resident positions awarded to a rural hospital must be used to expand an existing residency that is no longer within its 5-year newness period.

Distributing At Least 10% of Positions to Each of the Four Categories. For the 1,000 residents (200 per year) distributed by the CAA, 2021, CMS has distributed residents for the first two years and found that it has not met the requirement to distribute at least 10% of the residents to hospitals in category 4. For distributing the remaining section 126 of the CAA, 2021 positions in years 4 and 5, CMS proposes to prioritize hospitals qualifying under category 4 regardless of HPSA score.

Hospital Attestation to National Culturally and Linguistically Appropriate Services (CLAS) Standards. Consistent with prior requirements, CMS proposes a hospital must attest to meeting the CLAS standards to be eligible to receive additional resident positions.

Medicare Payment for Additional Resident Positions. CMS proposes to use the per resident amount for all other residents to pay for additional residents awarded.

Affiliation Agreements. Hospitals may aggregate resident caps to facilitate cross training among multiple hospitals. However, the statute limits hospitals including residents awarded by the CAA, 2023 from being included in affiliation agreements for five years.

Other GME Provisions

New Medical Residency Training Program. When the Balanced Budget Act (BBA) of 1997 capped the number of residents a hospital may count for DGME and IME, it also provided authority for CMS to establish rules that allowed the caps to be adjusted for hospitals that had not previously trained residents and established "new medical residency training programs." In order to address a concern that hospitals could move an existing program to a new teaching hospital to train more residents at its own hospital, inconsistent with the BBA, 1997, CMS defined the term "new medical residency training program."

The three primary criteria are: 1) the residents are new, 2) the program director is new, and 3) the teaching staff are new. CMS is using the FY 2025 IPPS proposed rule to further clarify its policy on what it means for a medical residency training program to be "new."

a) Residents: CMS is proposing to further define "overwhelming majority" as meaning at least 90% of the individual residents (not FTEs) must not have previous training in the same specialty as the new program. If more than 10% of the trainees (not FTEs) transferred from another program at a different hospital/sponsor in the same specialty, even during their first year of training, CMS proposes this would render the program (but not the entire hospital or its other new programs, if applicable) ineligible for new cap slots.

b) Program Director and Faculty: CMS recognizes that a new medical residency program may want to recruit a director and faculty with prior experience so believes that a criterion of less than 90% should be applicable. CMS is not proposing a specific threshold but suggests that up to 50% of the faculty in a new program may come from an existing program in the same specialty but each of those staff members should come from a different previously existing program.

c) CMS has also been asked whether it would make a difference if a faculty member had previous teaching experience, but a certain amount of time has passed since they taught in the same specialty. The proposed rule indicates that in determining whether the presence of a faculty member might jeopardize the newness of a new residency program, it may make sense to consider whether a certain amount of time has passed since that faculty member last taught in another program in the same specialty. CMS is soliciting comments on this issue.

d) Similarly, CMS understands that a new teaching hospital may also want to recruit an experienced program director. The rule solicits comments on whether it would make sense to define a similar period of time (for example, 10 years or five years) during which an individual must not have been employed as the program director in a program in the same specialty in order to be considered a "new" program director.

Comingling of Residents. This issue is complex, but CMS is concerned about what happens when a program is new and eligible for a cap adjustment but rotates residents to a hospital with an existing program that is eligible for a cap adjustment by virtue of being treated as rural.[2] CMS appears to believe that this "comingling" of residents in a new and existing program allows an existing program to increase the number of residents even though it is not new. CMS requests comments on this issue.

One Hospital Sponsoring Two Programs in the Same Specialty. CMS has responded to questions about whether a single hospital can sponsor two programs in the same specialty by saying that if each program has separate program directors, and separate staff, and separately matched residents, then it is permissible for one hospital to sponsor two programs in the same specialty.

Notice of Closure of Teaching Hospital and Opportunity to Apply for Available Slots. Section 5506 of the Affordable Care Act authorizes the Secretary to redistribute residency slots after closure of a hospital that trained residents in an approved medical residency program.

CMS is notifying the public of the closure of McLaren St. Luke's Hospital Located in Maumee, OH (CCN 360090) and South City Hospital, located in St. Louis, MO (CCN 260210):

Available Resident Cap FTEs

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME Resident Cap	DGME Resident Cap
360090	McLaren St. Luke's Hospital	Maumee, OH	47580	May 9, 2023	14.93	14.93
260010	South City Hospital	St. Louis, MO	41180	November 18, 2023	67.54	74.00

2 This will only affect IME as the urban to rural reclassification provision only applies to section 1886(d) of the Act that includes IME and not section 1886(h) of the Act that applies to DGME.

Application Process for Available Resident Slots. The application period for hospitals to apply for slots under section 5506 is 90 days following notification to the public of a hospital closure. Therefore, hospitals must submit an application form to the CMS Central Office no later than July 9, 2024, to be eligible to receive slots from this closed hospital. CMS will only accept applications submitted via MEARIS™ (MEARIS™ (cms.gov)).

Reasonable Cost Payment for Nursing and Allied Health Education Programs

Medicare pays for provider-operated nursing and allied health education programs on a reasonable-cost basis. CMS is required to include Medicare Advantage (MA) utilization in determining the Medicare share of reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to MA utilization were funded through a reduction to analogous payments made to teaching hospitals for direct GME and limited to $60 million per year.

CMS uses cost reporting periods ending in the fiscal year that is two years prior to the current CY to determine each eligible hospital's share of the $60 million pool in a given year. Each hospital's payment is based on its relative share of national nursing and allied health education payments and MA utilization.

Proposal for 2023. CMS proposes using the 4th quarter 2023 update of the 2021 HCRIS projected forward two years to estimate 2023 payments. For 2023, CMS will be distributing $60 million in nursing and allied health education MA payments with an offset of 2.73% to MA DGME payments. These figures are the result of applying the statutory formula, which leads to capped payments of $60 million for nursing and allied health education MA payments.

Rate-of-Increase for TEFRA Hospitals

Hospitals subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) continue to be paid based on reasonable costs subject to a per-discharge limit updated annually. These hospitals include 11 cancer hospitals, children's hospitals, and hospitals located in the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Religious non-medical health care institutions are also paid reasonable costs subject to a limit. The FFY 2025 proposed annual update to the TEFRA limit is 3%.

Establishing and Maintaining Access to Essential Medicines

CMS proposes for cost reporting periods beginning on or after October 1, 2024, to establish a separate IPPS payment for small (100 beds or fewer), independent hospitals for the estimated additional resource cost of voluntarily establishing and maintaining access to six-month buffer stocks of "essential medicines." These payments could be provided biweekly or as a lump sum at cost report settlement.

To prevent this policy from either that newly exacerbating existing shortages or contributing to hoarding, CMS proposes that any hospital establishing a buffer stock of 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.

CMS proposes using a list of 86 essential medicines included on the Advanced Regenerative Manufacturing Institute's (ARMI) Next Foundry for American Biotechnology as those that would be eligible for the additional payment. The current list is available in the proposed rule (display pages 707-711). CMS also proposes that if the ARMI List is updated to add or remove any essential medicines, all medicines on the updated list would be eligible for separate payment as of the update date.

Transforming Episode Accountability Model (TEAM)

CMS proposes a mandatory five-year episode-based payment model (January 1, 2026 – December 31, 2030) using its 1115A waiver authority. TEAM includes five surgical episode categories:

- coronary artery bypass graft (CABG)
- lower extremity joint replacement (LEJR)
- major bowel procedure
- surgical hip/femur fracture treatment (SHFFT)
- spinal fusion

Provisions of Proposed Transforming Episode Accountability Model

Acute care hospitals paid under the IPPS are the only entities to initiate episodes under TEAM. Participation will be mandatory for selected hospitals.

While CMS proposes participation in TEAM be mandatory for selected hospitals, the agency seeks comment on whether to create a voluntary opt-in participation arm of the model.

CMS proposes that TEAM participants exclusively (and not other providers and suppliers involved in the care provided during an episode) bear financial accountability for performance under the model. In the case of episodes involving multiple hospitalizations, financial accountability would fall to the TEAM participant initiating the episode.

There would be three tracks in TEAM, defined by varying levels of potential risk and reward.

- Track 1 would be available only in PY 1 for all TEAM participants and would have only upside financial risk with quality adjustment applied to positive reconciliation amounts
- Track 2 would be available in PYs 2 through 5 to rural and safety net hospitals, and would have two-sided financial risk with quality adjustment to reconciliation amounts
- Track 3 would be available in PYs 1 through 5 for all TEAM Participants and would have two-sided financial risk with quality adjustment to reconciliation amounts

Because some participants are less able to take on substantial financial risk, CMS is proposing to allow rural and "safety net" TEAM participants[3] who start in Track 1 in PY 1 to elect Track 2 in PY 2 and remain in Track 2 for the duration of the model. Such hospitals could voluntarily elect to move into Track 3. Table X.A.-01, reproduced below, summarizes the proposed TEAM tracks.

3 Safety net hospitals, rural hospitals, Medicare-dependent hospitals (MDHs), Sole community hospitals (SCH), and essential access community hospitals as defined under 42 CFR 412.109.

TABLE X.A.-01 – SUMMARY OF PROPOSED TEAM PARTICIPATION TRACKS

Track	Performance Year (PY)	Team Participant Eligibility	Financial Risk
Track 1	PY 1	All TEAM participants	• Upside risk only (10% stop-gain limit)
Track 2	PYs 2-5	TEAM participants that meet one of following hospital criteria: • Safety net hospital • Rural hospital • Medicare Dependent Hospital • Sole Community Hospital • Essential Access Community Hospital	• Upside and downside risk (10% stop-gain/stop-loss limits) • CQS adjustment percentage of up to 10% for positive reconciliation amounts and CQS adjustment percentage of up to 15% for negative reconciliation amounts
Track 3	PYs 1-5	All TEAM participants	• Upside and downside risk (20% stop-gain/stop-loss limits) • CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts

CMS seeks comment on the proposals for the TEAM Participation Tracks, and on the proposal that TEAM participants who meet the eligibility criteria for Track 2 may self-select into Track 2 and change their track selection annually.

Proposed Approach to Select TEAM Participants and Statistical Power

CMS proposes identifying model participants by first selecting geographic areas, and then requiring all hospitals (except for those hospital types specifically excluded) in the geographic area to participate. Geographic areas would be defined on the basis of CBSAs.

OMB CBSA 2023	State	Sample Stratum
46380 Ukiah	CA	1
21700 Eureka-Arcata	CA	3
18860 Crescent City	CA	5
46020 Truckee-Grass Valley	CA	5
43760 Sonora	CA	6
34900 Napa	CA	8
42020 San Luis Obispo-Paso Robles	CA	8
17020 Chico	CA	12
42200 Santa Maria-Santa Barbara	CA	12
47300 Visalia	CA	12
49700 Yuba City	CA	12
25260 Hanford-Corcoran	CA	13
39780 Red Bluff	CA	13
20940 El Centro	CA	15
32900 Merced	CA	15
46700 Vallejo	CA	15
12540 Bakersfield-Delano	CA	16
23420 Fresno	CA	16
33700 Modesto	CA	16
37100 Oxnard-Thousand Oaks-Ventura	CA	16
39820 Redding	CA	16
40900 Sacramento-Roseville-Folsom	CA	16
41500 Salinas	CA	16
41740 San Diego-Chula Vista-Carlsbad	CA	16
41940 San Jose-Sunnyvale-Santa Clara	CA	16
42100 Santa Cruz-Watsonville	CA	16
42220 Santa Rosa-Petaluma	CA	16
44700 Stockton-Lodi	CA	16
31080 Los Angeles-Long Beach-Anaheim	CA	17
40140 Riverside-San Bernardino-Ontario	CA	17
41860 San Francisco-Oakland-Fremont	CA	17

CMS proposes stratifying CBSAs into groups based on:

- Average historical episode spending
- Number of hospitals
- Number of safety net hospitals
- CBSA's exposure to prior CMS bundled payment models

CMS proposes oversampling CBSAs that have limited previous participation in CMS' bundled payment models and those with a higher number of "safety net hospitals." CMS would stratify each of these categories into "high" and "low" groups, resulting in 16 unique combinations, but would create a 17th stratum to group CBSAs with a very high number of safety net hospitals. CMS anticipates selecting 25% of eligible CBSAs for participation.

Proposed Episodes

CMS proposes limiting the episodes in TEAM to those included in BPCI Advanced (BPCI-A) and consisting of high-expenditure, high-volume care delivered to Medicare beneficiaries. CMS is not proposing to include medical episodes in TEAM. The selected episode categories and billing codes are summarized in Table X.A.-04, reproduced below.

TABLE X.A.-04: PROPOSED EPISODE CATEGORIES AND BILLING CODES

Episode Category Billing Codes (MS-DRG/HCPCS)
LEJR: MS-DRG 469, 470, 521, 522. HCPCS 27447, 27130, 27702
SHFFT: MS-DRG 480, 481, 482
CABG: MS-DRG 231, 232, 233, 234, 235, 236
Spinal fusion: MS-DRG 453, 454, 455, 459, 460, 471, 472, 473. HCPCS 22551, 22554, 22612, 22630, 22633
Major bowel procedure: MS-DRG 329, 330, 331

CMS proposes defining TEAM episodes as consisting of all Part A and Part B services (with some exceptions), beginning with an inpatient admission ("anchor hospitalization" or outpatient procedure ("anchor procedure"), and ending 30 days after discharge or after the anchor procedure. These include physician services, hospital services, post-acute care, therapy, laboratory tests, durable medical equipment, most Part B drugs, and hospice.

Services excluded are the same for BPCI-A:

- Items and services clinically unrelated to the anchor hospitalization/procedure
- Hospital admissions and readmissions for specific categories of diagnoses, such as oncology, trauma medical admissions, organ transplant, and ventricular shunts determined by MS–DRGs, defined Major Diagnostic Categories (MDC);[4]
- New technology add-on payments for drugs, technologies and services identified by value code 77 on IPPS claims.

OPPS pass-through payments for certain medical devices, and drugs paid outside of the MS-DRG (such as hemophilia clotting factors) are also proposed to be excluded, as well as other low-volume, high-cost drugs.

Quality Measures and Reporting

CMS proposes three initial measures for TEAM. For all TEAM episodes:

- Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356)
- CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135)

Additionally, for LEJR episodes a Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618).

Reconciliation payments to participants would be adjusted based on performance on these measures.

4 MDC 02 (Diseases and Disorders of the Eye), MDC 14 (Pregnancy, Childbirth, and Puerperium), MDC 15 (Newborns), and MDC 25 (Human Immunodeficiency Virus).

CMS is also considering the future use of three measures on the 2023 Measures Under Consideration (MUC) list:[5]

- Hospital Harm – Falls with Injury (MUC2023-048)
- 30-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (MUC2023-049)
- Hospital Harm - Postoperative Respiratory Failure (MUC2023-050)

CMS seeks comment on the potential for these three measures to replace the CMS PSI 90 measure beginning in 2027.

CMS proposes that TEAM participants would use existing Hospital IQR program processes to report data for calculating these measures. Participants' performance on the measures would be publicly reported, with PY 1 measure scores reported in 2027, and each year's performance reported annually with a one-year lag thereafter for the duration of the model.

Pricing and Payment Methodology

CMS proposes using three years of baseline data, trended forward to the performance year, to calculate target prices at the level of MS-DRG/HCPCS episode type and region. CMS proposes to roll the three-year baseline forward for each year of the model and lays out the specific data used for each performance year.

Within each three-year baseline period, CMS adjusts spending for the first two years of the period to trend it forward to the most recent (3rd) year of the baseline period. Spending in the third year would be weighted at 50% in the calculation of target prices (spending in year one would be 17% and year two would be 33%). These baseline trend factor adjustments would be calculated at the MS-DRG/HCPCS episode type and region level.

The agency would group episodes from the baseline period by applicable MS-DRG for episode types that include only inpatient hospitalizations, and by applicable MS-DRG or HCPCS code for episode types that include both inpatient hospitalizations and outpatient procedures creating a site-neutral target price.

For episode types that include both inpatient hospitalizations (identified by MS-DRGs) and outpatient procedures (identified by HCPCS codes), HCPCS codes are combined for purposes of target pricing with the applicable MS-DRG representing an inpatient hospitalization without Major Complications and Comorbidities, as CMS expects those beneficiaries to have similar clinical characteristics and costs.

CMS proposes to cap high-cost outlier episodes at the 99th percentile for each of the 24 proposed MS-DRG/HCPCS episode types and nine regions (which CMS proposes to define as the nine U.S. census divisions).

5 Centers for Medicare & Medicaid Services. (December 1, 2023). 2023 Measures Under Consideration (MUC) List. Available at: https://mmshub.cms.gov/sites/default/files/2023-MUC-List.xlsx; see also Centers for Medicare & Medicaid Services. (December 2023). Overview of the List of Measures Under Consideration. Available at: https://mmshub.cms.gov/sites/default/files/2023-MUC-List-Overview.pdf

CMS proposes using average standardized spending for each MS-DRG/HCPCS episode type in each region as the benchmark price for that MS-DRG/HCPCS episode type for that specific region, resulting in 216 MS-DRG/HCPCS episode type/region-level benchmark prices. CMS proposes TEAM participants would be provided the regional prices as episode targets, rather than hospital-specific or a blend of regional/hospital-specific prices.

The agency proposes applying a prospective trend factor and a discount factor (3%) to benchmark prices (as well as a prospective normalization factor) to calculate preliminary target prices. The prospective trend factor would represent expected changes in overall spending patterns between the most recent calendar year of the baseline period and the performance year, based on observed changes in overall spending patterns between the earliest calendar year of the baseline period and the most recent year of the baseline period. The discount factor would represent Medicare's portion of potential savings from the episode.

CMS proposes to risk adjust episode-level target prices at reconciliation by:

- beneficiary age
- beneficiary's Hierarchical Condition Count
- social risk.

CMS proposes to calculate risk adjustment multipliers prospectively at the MS-DRG/HCPCS episode type level based on baseline data, and hold those multipliers fixed for the performance year. To ensure that risk adjustment does not inflate target prices overall, the agency further proposes calculating a prospective normalization factor based on the data used to calculate the risk adjustment multipliers. The prospective normalization factor would be applied, in addition to the prospective trend factor and discount factor described previously, to the benchmark price to calculate the preliminary target price for each MS-DRG/HCPCS episode type and region. CMS proposes that the prospective normalization factor would be subject to a limited adjustment at reconciliation based on TEAM participants' observed performance period case mix, such that the final normalization factor would not exceed +/- 5 percent of the prospective normalization factor.

CMS also proposes a low-volume threshold policy under TEAM for purposes of reconciliation. This low volume threshold would apply to total episodes across all episode categories in the 3-year baseline period for a given PY. If a TEAM participant did not meet the proposed low volume threshold of at least 31 total episodes in the baseline period for PY1, CMS would still reconcile their episodes, but the TEAM participant would be subject to the Track 1 stop-loss and stop-gain limits for PY1. If a TEAM participant did not meet the proposed low volume threshold of at least 31 total episodes in the applicable baseline periods for PYs 2-5, they would be subject to the Track 2 stop-loss and stop-gain limits for PY 2-5.

Risk Adjustment and Normalization. CMS will calculate risk adjustment coefficients at the MS-DRG/HCPCS episode type level. For beneficiary age, CMS proposes using the same age brackets as in CJR: less than 65 years, 65-75 years, 75-85 years, and 85 years or more, based on the beneficiary's age on the first day of the episode.

CMS also proposes to use an HCC count variable (TEAM HCC count), collecting HCCs from the FFS claims for each beneficiary starting 90 days before the anchor hospitalization/procedure.

Lastly, CMS proposes to use a variable to account for social risk composed of three elements: (1) fully dually eligible for Medicare/Medicaid, (2) position on the distribution of the beneficiary's geographic residence on the distribution of Area Deprivation Index (ADI) values (>the 80th percentile for national ADI, and the 8th decile for state ADI), and (3) whether or not the beneficiary qualifies for the Part D Low-Income Subsidy (LIS).

Proposed Process for Reconciliation. CMS proposes to conduct an annual reconciliation calculation that would compare performance year spending on episodes that ended during that PY with reconciliation target prices for those episodes to calculate a reconciliation amount for each TEAM participant. CMS would conduct the reconciliation six months after the end of the performance year.

Composite Quality Score. CMS proposes, as part of the annual reconciliation process, to adjust the difference between the TEAM participant's performance year spending and their reconciliation price (the reconciliation amount) by its Composite Quality Score, an approach similar to that used in CJR and BPCI-A.

CMS proposes to convert raw quality measure scores into scaled quality measure scores by comparing the raw quality measure score to the distribution of raw quality measure score percentiles among the national cohort of hospitals, which would consist of TEAM participants non-participants, in the CQS baseline period (CMS proposes CY 2025 as the baseline period for the duration of TEAM), so that each measure has a scaled quality measure score between 0 and 100 for each episode category.

Prior to calculating the CQS, the quality measures would be weighted based on the volume of episodes for a TEAM participant. A normalized weight would be calculated by dividing the TEAM participant's volume of episodes for a given quality measure by the total volume of all the TEAM participant's episodes. CMS proposes taking the quality measures normalized weights and combining them with the scaled quality measure scores to determine the weighted scaled score by multiplying each quality measure's scaled quality measure score by its normalized weight to create weighted scaled scores for a TEAM participant. The weighted scaled scores would then be added together to construct the CQS for the TEAM participant.

Calculating the Reconciliation Payment Amount or Repayment Amount. CMS proposes to retrospectively calculate a TEAM participant's actual episode performance based on the episode definition, after the completion of each performance year. Any performance year episode spending amount above the high-cost outlier cap would be set to the amount of the high-cost outlier cap. CMS would then compare each TEAM participant's performance year spending to its reconciliation target prices, and define the reconciliation amount as the dollar amount representing the difference between the reconciliation target price and performance year spending for each MS-DRG/HCPCS episode type, prior to adjustments for quality, stop-gain/stop-loss limits, and post-episode spending. The agency would adjust the reconciliation amount for quality performance, and then apply stop-loss and stop-gain limits to calculate the Net Payment Reconciliation Amount (NPRA).[6]

6 This amount would be adjusted by a post-episode spending calculation, discussed later in the proposed rule.

CMS proposes applying the CQS adjustment percentage to any reconciliation amount (positive or negative). The percentage adjustments would vary as a function of the model participant's Track, as indicated in Table X.A.-08 of the proposed rule, reproduced below.

TABLE X.A.-08 – TEAM PROPOSED CQS ADJUSTMENT PERCENTAGE FORMULAS

Track Reconciliation Amount CQS Adjustment Percentage Formula
Track 1 Positive Reconciliation Amount CQS adjustment percentage = (10%-10% * (CQS/100))
Track 2 Positive Reconciliation Amount CQS adjustment percentage = (10%-10% * (CQS/100))
Track 2 Negative Reconciliation Amount CQS adjustment percentage = (15% * (CQS/100))
Track 3 Positive Reconciliation Amount CQS adjustment percentage = (10%-10% * (CQS/100))
Track 3 Negative Reconciliation Amount CQS adjustment percentage = (10% * (CQS/100)

Limitations on NPRA. Track 1 TEAM participants would not be subject to downside risk in performance year 1, but would be subject to a stop-gain limit of 10 percent. Track 2 TEAM participants would be subject to downside and upside risk with symmetric stop-gain and stop-loss limits of 10% for PYs 2-5.

Since Track 3 would be designed for TEAM participants with prior experience in value-based care or those who are prepared to accept greater financial risk in the first year of TEAM, CMS proposes that TEAM participants who opt into Track 3 would be subject to both upside and downside risk, with symmetric stop-gain and stop-loss limits of 20% for all performance years.

Participant Responsibility for Increased Post-Episode Payments. CMS proposes to calculate total Part A and Part B spending in the 30-day period following the completion of each episode, whether or not the spending is related to the defined episode to monitor for cost-shifting outside of the episode window. Starting in PY1 for Track 3 TEAM participants, and PY2 for Track 2 TEAM participants, if the TEAM participant's average post-episode spending exceeds three standard deviations from the regional average 30-day post-episode spending, the amount above the threshold would be subtracted from the reconciliation amount or added to the repayment amount for that performance year. The amount above the threshold would not be subject to the stop-loss limits proposed elsewhere in the proposed rule.

Reconciliation Payments and Repayments. For the performance year 1 reconciliation process for Track 1 TEAM participants, CMS proposes combining a TEAM participant's NPRA and post-episode spending amount, and if positive, the TEAM participant would receive the amount as a one-time lump sum reconciliation payment from Medicare. If negative, the TEAM participant would not be responsible for repayment to Medicare.

For TEAM participants in Track 3 for PY 1, and Track 2 or Track 3 for PYs 2-5, if the amount is positive, the TEAM participant would receive the amount as a one-time lump sum reconciliation payment from Medicare. If the amount is negative, Medicare would hold the TEAM participant responsible for a one-time lump sum repayment. CMS would collect the one-time lump sum repayment in a manner that is consistent with all relevant federal debt collection laws and regulations.

Model Overlap

CMS proposes a beneficiary could be in an episode in TEAM by undergoing a procedure at a TEAM participant, and be attributed to a provider participating in a total cost of care or shared savings model or program. This proposal would allow savings generated on an episode in TEAM, and any contribution to savings in the total cost of care model, be retained by each respective participant. The episode spending in TEAM would be accounted for in the total cost of care model's total expenditures, but TEAM's reconciliation payment amount or repayment amount would not be included in the total cost of care model's total expenditures.

Health Equity

CMS for purposes of TEAM defines safety net hospitals and rural hospitals, and flexibilities that would be afforded to these providers.

For TEAM, CMS proposes to define "safety-net hospitals" as acute care and critical access hospitals whose patient mix of beneficiaries with dual eligibility or Part D LIS exceeds the 75th percentile threshold for all congruent facilities who bill Medicare.[7]

With respect to identifying rural hospitals, as proposed, because TEAM participants would be selected from CBSAs, by definition no rural hospitals would be explicitly included in TEAM. However, due to geographic reclassifications or rural referral center designations, CMS proposes to define rural hospitals for purposes of TEAM as an IPPS hospital that is located in a rural area as defined under §412.64; is located in a rural census tract defined under §412.103(a)(1); has reclassified as a rural hospital under §412.103; or is designated a rural referral center (RRC) under §412.96.

Beneficiary Social Risk Adjustment. CMS proposes to incorporate and equally weight the three social risk indicators discussed earlier in TEAM's target price methodology (state and national ADI indicators, the Medicare Part D LIS indicator, and Dual-eligibility status for Medicare and Medicaid). CMS seeks comment on this proposal.

Health Equity Plans and Reporting. CMS proposes that TEAM participants can voluntarily submit to CMS, in a form and manner and by the date(s) specified by CMS, a health equity plan for the first performance year. These plans would identify health disparities among the TEAM participant's beneficiary population, identify health equity goals, describe the health equity plan intervention strategy, and identify health equity plan performance measures. CMS proposes that these plans would be mandatory for TEAM participants beginning in PY2.

CMS similarly proposes that TEAM participants voluntarily submit demographic data (including data on race, ethnicity, language, disability, sexual orientation, gender identity, sex characteristics, and other demographics) to CMS in PY1, and that this would become mandatory in PY2 and subsequent years.

Beginning in PY1, CMS proposes TEAM participants would be required to screen attributed TEAM beneficiaries for at least the following four health-related social needs (HRSN) domains—

7 https://www.cms.gov/priorities/innovation/data-and-reports/2022/cmmi-strategy-refresh-imp-tech-report

food insecurity, housing instability, transportation needs, and utilities difficulty. (CMS also considered requiring TEAM participants to screen on a standardized set of HRSN domains.)

CMS also proposes that TEAM participants would need to report aggregated HRSN screening data and screened-positive data for each HRSN domain for TEAM beneficiaries that received screening to CMS in a form and manner and by date(s) specified by CMS beginning in PY1 and for all following performance years. As part of this reporting to CMS, TEAM participants would report on policies and procedures for referring beneficiaries to community-based organizations, social service agencies, or similar organizations that may support patients in accessing services to address unmet social needs.

Financial Arrangements

CMS believes it necessary to provide TEAM participants the ability to engage in financial arrangements to share reconciliation payment and repayment amounts. If the proposed arrangements are finalized, CMS expects to make a determination that the anti-kickback statute safe harbor for CMS-sponsored model arrangements is available to protect certain remuneration proposed in this section when arrangements with eligible providers and suppliers are in compliance with this rule.

CMS proposes that the following types of providers and suppliers that are Medicare-enrolled and eligible to participate in Medicare or entities that are participating in a Medicare ACO initiative may be TEAM collaborators:

- Skilled Nursing Facility (SNF)
- Home Health Agency (HHA)
- Long-Term Care Hospital (LTCH)
- Inpatient Rehabilitation Facility (IRF)
- Physician
- Nonphysician practitioner
- Therapist in a private practice
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Provider or supplier of outpatient therapy services
- Physician Group Practice (PGP)
- Hospital
- Critical Access Hospital (CAH)
- Non-physician provider group practice (NPPGP)
- Therapy group practice (TGP)
- Medicare ACO

Sharing Arrangements. CMS proposes certain financial arrangements between a TEAM participant and a TEAM collaborator be termed “sharing arrangements.” For purposes of the Federal anti-kickback statute safe harbor a sharing arrangement would be to share reconciliation payment amounts or repayment amounts. Payment from a TEAM participant to a TEAM collaborator is defined as a “gainsharing payment.” Payment from a TEAM collaborator to a TEAM participant is defined as an “alignment payment.”

A TEAM participant must not make a gainsharing payment or receive an alignment payment except in accordance with a sharing arrangement. CMS proposes that the TEAM participant and TEAM collaborator must document this agreement in writing and, per monitoring and compliance guidelines (§512.590), must make it available to CMS upon request. The written agreement must specify the following parameters of the arrangement:

- The purpose and scope of the sharing arrangement
- The identities and obligations of the parties, including specified TEAM activities and other services to be performed by the parties under the sharing arrangement
- The date of the sharing arrangement
- Management and staffing information, including type of personnel or contractors that will be primarily responsible for carrying out TEAM activities
- The financial or economic terms for payment, including the following:
    - Eligibility criteria for a gainsharing/alignment payment
    - Frequency of gainsharing/alignment payment
    - Methodology and accounting formula for determining the amount of a gainsharing payment that is solely based on quality of care and the provision of TEAM activities
    - Methodology and accounting formula for determining the amount of an alignment payment

The sharing arrangement must also require the TEAM collaborator to have a compliance program that includes oversight of the sharing arrangement and compliance with the requirements of the model. The agency proposes the board or other governing body of the TEAM participant have responsibility for overseeing the TEAM participant's participation in the model, its arrangements with TEAM collaborators, its payment of gainsharing payments, its receipt of alignment payments, and its use of beneficiary incentives in the model.

Lastly, CMS proposes that the sharing arrangement must not pose a risk to beneficiary access, beneficiary freedom of choice, or quality of care so that financial relationships between TEAM participants and TEAM collaborators do not negatively impact beneficiary protections under the model. CMS proposes to require the terms of the sharing arrangement must not induce the TEAM participant, TEAM collaborator, or any employees, contractors, or subcontractors of the TEAM participant or TEAM collaborator to reduce or limit medically necessary services to any beneficiary or restrict the ability of a TEAM collaborator to make decisions in the best interests of its patients, including the selection of devices, supplies, and treatments.

Gainsharing Payment and Alignment Payment Conditions and Limitations. Gainsharing payment eligibility for TEAM collaborators is conditioned on two requirements—(1) quality of care criteria; and (2) the provision of TEAM activities.

To satisfy the first requirement, the TEAM collaborator must meet quality of care criteria during the performance year for which the TEAM participant earned a reconciliation payment amount.

To satisfy the second requirement, a TEAM collaborator other than a PGP, NPPGP, or TGP must have directly furnished a billable item or service to a TEAM beneficiary during the same

performance year for which the TEAM participant earned a reconciliation payment amount or repayment amount.

CMS proposes establishing similar requirements for PGPs, NPPGPs, and TGPs that vary because these entities do not directly furnish billable services.

CMS proposes the amount of any gainsharing payments must be determined in accordance with a methodology that is solely based on quality of care and the provision of TEAM activities, and *not* the *amount* of TEAM activities provided.

CMS proposes for each performance year, the aggregate amount of all gainsharing payments derived from a reconciliation payment amount by the TEAM participant must not exceed the amount of the reconciliation payment amount and lays out other parameters governing the gainsharing payments.[8]

The agency also proposes alignment payments from a TEAM collaborator to a TEAM participant may be made at any interval that is agreed upon by both parties. Alignment payments must not be issued, distributed, or paid prior to the calculation by CMS of the repayment amount, and cannot be assessed in the absence of a repayment amount.

Distribution Arrangements. CMS proposes that certain financial arrangements between TEAM collaborators and other individuals or entities called "collaboration agents" be termed "distribution arrangements." A collaboration agent is an individual or entity that is not a TEAM collaborator and that is a PGP, NPPGP, or TGP member that has entered into a distribution arrangement with the same PGP, NPPGP, or TGP in which he or she is an owner or employee. For purposes of the federal anti-kickback statute safe harbor CMS proposes a distribution arrangement is a financial arrangement between a TEAM collaborator that is a PGP, NPPGP or TGP and a collaboration agent for the sole purpose of sharing a gainsharing payment received by the PGP, NPPGP, or TGP.

The requirements CMS proposes for distribution arrangements largely parallel those proposed for sharing arrangements and gainsharing payments described above—all distribution arrangements must be in writing and signed by the parties, contain the effective date of the agreement, and be entered into before care is furnished to TEAM beneficiaries under the distribution arrangement (and *not* conditioned on the volume of services provided). Participation must be voluntary and without penalty for nonparticipation, and the distribution arrangement must require the collaboration agent to comply with all applicable laws and regulations.

CMS proposes the TEAM collaborator may not enter into a distribution arrangement with any individual or entity that has a sharing arrangement with the same TEAM participant. Allowing

8 For example, CMS proposes certain limitations on alignment payments that are consistent with the CJR model. For a performance year, the aggregate amount of all alignment payments received by the TEAM participant from all of the TEAM participant's TEAM collaborators must not exceed 50% of the repayment amount. CMS believes it is important that the TEAM participant retain a significant portion of its responsibility for repayment amounts. In addition, the aggregate amount of all alignment payments from a TEAM collaborator to the TEAM participant for a TEAM collaborator other than an ACO may not be greater than 25% of the TEAM participant's repayment amount. The aggregate amount of all alignment payments from a TEAM collaborator to the TEAM participant for a TEAM collaborator that is an ACO may not be greater than 50% of the TEAM participant's repayment amount.

both types of arrangements for the same individual or entity for care of the same beneficiary during the performance year could also allow for duplicate counting of the individual or entity's contribution toward model goals and provision of TEAM activities in the methodologies for both gainsharing and distribution payments, leading to financial gain for the individual or entity that is disproportionate to the contribution toward model goals and provision of TEAM activities by that individual or entity.

Beneficiary Incentives. TEAM participants may provide in-kind patient engagement incentives to beneficiaries in an episode, which may include items of technology, subject to certain conditions. CMS expects to make a determination that the anti-kickback statute safe harbor for CMS-sponsored model patient incentives is available to protect the beneficiary incentives when the incentives are offered in compliance with the requirements established in the final rule and the conditions for use of the anti-kickback statute safe harbor at 42 CFR 1001.952(ii). The incentive must be reasonably related to the beneficiary's medical care.

With respect to technology, no item or service involving technology can exceed $1,000 for any TEAM beneficiary in any episode. CMS also proposes that items and services above $75 in retail value remain the property of the TEAM participant and must be returned[9] to the TEAM participant at the end of the episode.

CMS proposes that TEAM participants can offer their beneficiaries in-kind engagement incentives, as long as they are related to the beneficiary's care and do not represent inducements to seek care from specific entities. CMS proposes the incentives must advance one of four goals:

- Beneficiary adherence to drug regimens
- Beneficiary adherence to care plans
- Reduction of readmissions or complications from treatment
- Management of chronic conditions or diseases that may be affected by treatment of the TEAM clinical condition.

CMS proposes documentation requirements for all beneficiary incentives.

Fraud and Abuse Waiver and OIG Safe Harbor Authority. CMS is not proposing to issue any waivers of fraud and abuse provisions in conjunction with TEAM. However, as indicated previously, if the proposals herein are finalized, CMS expects to determine that the CMS-sponsored models safe harbor will be available to protect certain financial arrangements and incentives:

- TEAM sharing arrangement's gainsharing payments and alignment payments
- Distribution arrangement's distribution payments with TEAM collaborators and collaboration agents
- Downstream distribution arrangements and downstream distribution payments with collaboration agents and downstream collaboration agents
- TEAM beneficiary incentives

9 The CMS proposal is oddly detailed in describing the steps that a TEAM participant must take to retrieve technology from a TEAM beneficiary, including the documentation of steps taken to retrieve it (or failure to retrieve it), and penalties for the beneficiary in the event the item cannot be retrieved.

Proposed Waivers of Medicare Program Requirements

Homebound and "Incident-To" Rules. CMS does not propose removing requirements that a beneficiary be "homebound" in order to receive home health services. Nor is CMS proposing to waive the "incident to" rules, which allow physicians or a non-physician practitioner to bill for services furnished in the beneficiary's home, when the beneficiary does not meet the eligibility criteria for the home health benefit.

Telehealth. CMS proposes waiving geographic site requirements limiting telehealth payment to services furnished within specific types of geographic areas and originating site requirements specifying the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system.

CMS proposes creating a set of nine HCPCS G-codes to describe the E/M services furnished to TEAM beneficiaries in their homes via telehealth, with corresponding new payment rates that would be published in the CY 2026 Medicare Physician Fee Schedule.

SNF 3-Day Requirement. CMS proposes waiving the three-inpatient day stay requirement for TEAM beneficiaries. However, TEAM participants may only discharge a TEAM beneficiary to a SNF with a quality rating of three stars or higher.[10] TEAM participants could also discharge a beneficiary to a swing bed in an acute-care hospital or critical access hospital.

Monitoring and Beneficiary Protection

TEAM would not limit a beneficiary's ability to choose among Medicare providers or limit Medicare's coverage of items and services available to the beneficiary. While TEAM participants may recommend preferred providers to their beneficiaries, they may not limit beneficiaries to a preferred or recommended providers list that is not compliant with existing restrictions.

CMS proposes TEAM participants must require all ACOs, providers and suppliers who execute a Sharing Arrangement with a TEAM participant to share beneficiary notification materials (to be developed or approved by CMS) with the beneficiary prior to discharge from the anchor hospitalization, or prior to discharge from the anchor procedure for a Medicare FFS patient who would be included under the model.

CMS proposes TEAM participants must require every TEAM collaborator provide written notice, to be developed by CMS, to applicable TEAM beneficiaries of the existence of its sharing arrangement with the TEAM participant and the basic quality and payment incentives under the model.

Access to Records and Record Retention

CMS proposes the federal government would have a right to audit, inspect, investigate, and evaluate any documents and other evidence regarding implementation of TEAM. CMS proposes that the TEAM participant and its TEAM Collaborators must maintain and give the federal government access to all documents (including books, contracts, and records) and other evidence sufficient to enable the audit, evaluation, inspection, or investigation of the CMS Innovation Center model, including, without limitation, documents and other evidence regarding compliance,

10 https://www.medicare.gov/care-compare/?redirect=true&providerType=NursingHome

payments, quality measure information, utilization of services of the model, the ability of the TEAM participant to bear risk, patient safety, and any other program integrity issues.

Data Sharing

CMS proposes making certain beneficiary-identifiable claims data and regional aggregate data available to participants in TEAM regarding Medicare FFS beneficiaries who may initiate an episode and be attributed to them in the model. These data would only be made available pursuant to a formal signed TEAM data sharing agreement.

For the three-year baseline period, TEAM participants would only receive beneficiary-identifiable claims data for beneficiaries that initiated an episode in their hospital or hospital outpatient department in the three-year baseline period, and the beneficiary-identifiable claims data shared with the TEAM participant would be limited to the items and services included in the episode. Data would be shared at a granular (*e.g.*, claims) or aggregated level, as requested by the TEAM participant through formal specified processes.

CMS also proposes making three years of baseline data on Part A and Part B spending to TEAM participants for beneficiaries who would have been included in an episode had the model been implemented during the baseline period, and that this baseline data would be rolled forward and updated for each performance year of the model. These data would be shared with TEAM participants at least one month before the start of each performance year.

Decarbonization and Resilience Initiative

CMS discusses a proposal for a voluntary Decarbonization and Resilience Initiative within TEAM. The voluntary initiative would have two elements: technical assistance for all interested TEAM participants and a proposed voluntary reporting option to capture information related Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol (GHGP) framework,[11] with the potential to add Scope 3 in future years.

Technical Assistance. CMS indicates it would provide three types of support to interested TEAM participants:

- Developing approaches to enhance organizational sustainability and resilience
- Transitioning to care delivery methods that result in lower GHG emissions and are clinically equivalent to or better than previous care delivery methods (for example, switching from Desflurane to alternative inhaled anesthetics)
- Identifying and using tools to measure emissions and associated measurement activities

Voluntary Reporting. CMS proposes that TEAM participants could elect to report metrics and questions related to emissions to CMS on an annual basis following each performance year. TEAM participants that elect to report on all the initiative metrics and questions to CMS, in the form and manner required by CMS, would be eligible for benefits such as receiving individualized feedback reports and public recognition as well as potentially achieving operational savings. CMS proposes four areas for reporting:

11 Janet Ranganathan, Laurent Corbier, Pankaj Bhatia, Simon Schultz, Peter Gage, & Kjeli Oren. The Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (Revised Edition). World Business Council for Sustainable Development and World Resources Institute. 2004. https://ghgprotocol.org/sites/default/files/standards/ghg-protocol-revised.pdf

- Organizational Questions
- Building Energy Metrics
- Anesthetic Gas Metrics
- Transportation Metrics

CMS proposes specific metrics under each of these four areas. CMS also proposes a set of questions that TEAM participants opting into the Initiative would be required to answer.

- CMS proposes that TEAM participants electing to participate in the Decarbonization and Resilience Initiative would report information to CMS annually no later than 120 days after the end of each performance period, in a form and manner to be specified by CMS.
- CMS proposes that TEAM participants who elect to report all the metrics identified would receive individualized feedback reports and be eligible to receive public recognition for their commitment to decarbonization.

Termination of the TEAM

CMS indicates that the agency would provide written notice to TEAM participants specifying the grounds for termination and the effective date of such termination or ending. Termination of the model would not be subject to administrative or judicial review.

Request for Information – 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. Additionally, 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.

CMS requests feedback on the following questions:

- What policy options could help drive improvements in maternal health outcomes?
- How can CMS support hospitals in improving maternal health outcomes?
- What, if any, payment models have impacted maternal health outcomes, and how?
- What, if any, 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?
- To what extent do non-Medicare payers, such as state Medicaid programs, use the IPPS MS-DRG relative weights to determine payment for inpatient obstetrical services? What effect, if any, does the use of those relative weights by those payers have on maternal health outcomes?
- To what extent are Medicare claims and cost report data reflective of the differences in relative costs between vaginal births and cesarean section births for non-Medicare patients?
- Are there other data beyond claims and cost reports that Medicare should consider incorporating in development of relative weights for vaginal births and cesarean section births?
- What impact, if any, does the relatively lower numbers of births in Medicare have on the variability of the relative weights?

- What effect, if any, does potential variability in the relative weights on an annual basis have on maternal health outcomes?"

Request for Information – Obstetrical Services Standards for Hospitals, CAHs, and REHs

CMS plans to propose baseline health and safety standards, as well as a targeted obstetrical services Conditions of Participation (CoP) in the CY 2025 OPPS proposed rule. CMS is requesting comment on what types of facilities and care setting should a CoP apply to as well a list of CoP policy options to include. Possible options are listed on Display pages 1415-1419. CMS welcomes input on other options to include in the CoP not listed on these pages.

CMS is also interested in feedback on requiring additional training, protocols, or equipment for hospital non-OB units, emergency departments, CAHs, and REHs that treat pregnant and postpartum patients as a stop-gap measure. A list of questions regarding these topics can be found on Display pages 1421-1425 in the proposed rule.

CoP Requirements for Hospitals and CAHs to Report Respiratory Illness

CMS proposes revising the hospital and CAH infection prevention and control program and antibiotic stewardship program CoPs to extend a modified form of the current COVID-19 and influenza reporting requirements to include data for respiratory syncytial virus (RSV) and reduce the frequency of reporting for hospitals and CAHs.

The data elements 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])
- Limited patient demographic information, including age

Currently, reporting requirements on respiratory illness end on April 30, 2024, with this proposal going into effect on October 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 inquires 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 October 1, 2024.

Finally, CMS is requesting information on health care reporting to the National Syndromic Surveillance Program (NSSP). Specifically, CMS seeks input on the questions on Display pages 1445-1446 in the proposed rule.

Hospital Performance-Based Quality Programs

IPPS payments are adjusted for quality performance under the Hospital Readmissions Reduction Program (HRRP), the Hospital Value Based Purchasing (VBP) program, RRP, and the Hospital Acquired Conditions (HAC) Reduction Program.

In general, CMS has returned to each program's typical scoring methodology following the end of the COVID-19 PHE. However, CMS continues to exclude claims and chart-abstracted data reflecting services provided January 1-June 30, 2020, from calculations for each of the three quality programs. In this proposed rule, CMS does not make any changes to the HRRP or HAC programs. Additional details on each program is provided below.

Hospital Readmissions Reduction Program

The HRRP reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital subject to the HRRP receives an adjustment factor between 1 (no reduction) and 0.9700, for the greatest possible reduction of 3% of base operating diagnosis-related group (DRG) payments. As adopted in the FFY 2018 IPPS final rule, and as required by the 21st Century Cures Act, hospitals are assigned to one of five peer groups based on the proportion of Medicare inpatients who are dually eligible for full-benefit Medicare and Medicaid; the HRRP formula compares a hospital's performance to the median for its peer group.

The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio (ERR) to the median ERR for the hospital's peer group. "Payment" refers to base operating DRG payments, "dx" refers to an HRRP condition (i.e., acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), total hip arthroplasty/total knee arthroplasty (THA/TKA), chronic obstructive pulmonary disease (COPD), and coronary artery bypass grafting (CABG)), and "NMM" is a budget-neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}),0\})}{All\ payments}\}$$

CMS does not propose any changes to the HRRP in this proposed rule.

Hospital VBP Program

As required by law, the available funding pool for the hospital VBP Program is equal to 2% of the base operating DRG payments to all participating hospitals. CMS calculates a VBP incentive payment percentage for a hospital based on its Total Performance Score (TPS) for a specified performance period. The adjustment factor may be positive, negative, or result in no change in the payment rate that would apply absent the program. In the FFY 2024 IPPS final rule, CMS adopted changes to the scoring methodology to include a health equity adjustment and to increase the TPS maximum to 110 points, beginning with FFY 2026. CHA refers readers to our FFY 2024 IPPS final rule summary for more details.

In this proposed rule, CMS proposes changes to the hospital VBP scoring methodology to account for its related proposal (described in the IQR section of this summary) to adopt changes to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure in both the IQR and VBP programs. Table 2 in the appendix of this summary lists previously adopted and proposed measures for the program.

Proposed Changes to Scoring Methodology for HCAHPS Measure

In alignment with its proposal to adopt changes to the HCAHPS Survey measure for the IQR program (described in the IQR section of this summary), CMS proposes to adopt the same updates to the VBP program beginning FFY 2030. The measure would be modified in the IQR program beginning with FFY 2027. As a result, CMS proposes the following changes to the HCAHPS scoring methodology for FFYs 2027-2029:

- 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

Beginning with FFY 2030, CMS proposes to modify the scoring of the HCAHPS survey to account for the proposed modifications to the measure, which would include nine dimensions of the survey:

- 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

Performance and Baseline Periods

The table shows the baseline and performance periods for each measure for FFY 2026 through 2030:

Baseline and Performance (Perf.) Periods by Measure for the FYs 2026 Through 2030 Program Years										
Measure	Baseline Period 2026	Perf. Period 2026	Baseline Period 2027	Perf. Period 2027	Baseline Period 2028	Perf. Period 2028	Baseline Period 2029	Perf. Period 2029	Baseline Period 2030	Perf. Period 2030
Person and Community Engagement Domain										
HCAHPS	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23 *	1/1/25 - 12/31/25*	1/1/24-12/31/24 *	1/1/26 - 12/31/26*	1/1/25-12/31/25 *	1/1/27 - 12/31/27 *	1/1/26-12/31/26 *	1/1/28 - 12/31/28 *
Safety Domain										
CAUTI	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/26	1/1/28 - 12/31/28
CLABSI	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/26	1/1/28 - 12/31/28
SSI	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/26	1/1/28 - 12/31/28
CDI	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/26	1/1/28 - 12/31/28
MRSA	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/26	1/1/28 - 12/31/28
SEP-1	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/26	1/1/28 - 12/31/28
Clinical Outcomes Domain										
MORT-30-AMI	7/1/16–6/3/19	7/1/21 – 6/30/24	7/1/17-6/30/20 **	7/1/22 - 6/30/25	7/1/18-6/30/21 **	7/1/23 - 6/30/26	7/1/19-6/30/22 **	7/1/24 - 6/30/27	7/1/20-6/30/23	7/1/25 - 6/20/28
MORT-30-HF	7/1/16–6/3/19	7/1/21 – 6/30/24	7/1/17-6/30/20 **	7/1/22 - 6/30/25	7/1/18-6/30/21 **	7/1/23 - 6/30/26	7/1/19-6/30/22 **	7/1/24 - 6/30/27	7/1/20-6/30/23	7/1/25 - 6/20/28

Baseline and Performance (Perf.) Periods by Measure for the FYs 2026 Through 2030 Program Years										
Measure	Baseline Period 2026	Perf. Period 2026	Baseline Period 2027	Perf. Period 2027	Baseline Period 2028	Perf. Period 2028	Baseline Period 2029	Perf. Period 2029	Baseline Period 2030	Perf. Period 2030
MORT-30-COPD	7/1/16–6/3/19	7/1/21 – 6/30/24	7/1/17-6/30/20 **	7/1/22 - 6/30/25	7/1/18-6/30/21 **	7/1/23 - 6/30/26	7/1/19-6/30/22 **	7/1/24 - 6/30/27	7/1/20-6/30/23	7/1/25 - 6/20/28
MORT-30-CABG	7/1/16–6/3/19	7/1/21 – 6/30/24	7/1/17-6/30/20 **	7/1/22 - 6/30/25	7/1/18-6/30/21 **	7/1/23 - 6/30/26	7/1/19-6/30/22 **	7/1/24 - 6/30/27	7/1/20-6/30/23	7/1/25 - 6/20/28
MORT-30-PN	7/1/16–6/3/19	7/1/21 – 6/30/24	7/1/17-6/30/20 **	7/1/22 - 6/30/25	7/1/18-6/30/21 **	7/1/23 - 6/30/26	7/1/19-6/30/22 **	7/1/24 - 6/30/27	7/1/20-6/30/23	7/1/25 - 6/20/28
COMP-HIP-KNEE	4/1/16–3/31/19	4/1/21 – 3/31/24	4/1/17-3/31/20 **	4/1/22 - 3/31/25	4/1/18-3/31/21 **	4/1/23 - 3/31/26	4/1/19-3/31/22 **	4/1/24 - 3/31/27	4/1/20-3/31/23	4/1/25 - 3/31/28
Efficiency and Cost Reduction Domain										
MSPB	1/1/22–12/31/22	1/1/24 – 12/31/24	1/1/23-12/31/23	1/1/25 - 12/31/25	1/1/24-12/31/24	1/1/26 - 12/31/26	1/1/25-12/31/25	1/1/27 - 12/31/27	1/1/26-12/31/25	1/1/28 - 12/31/28

Source: Tables V.L.-03 through V.L.-07 in the rule, excerpted and combined by Health Policy Alternatives, Inc.
* In section IX.B.2.f of the proposed rule, CMS proposes that for the FY 2027, FY 2028, and FY 2029 program years, it would only score on the 6 dimensions of the HCAHPS Survey that would be unchanged from the current version. In section IX.B.2.g of the rule, CMS proposes to adopt the substantive updates to the HCAHP Survey beginning with the FY 2030 program year.
**These baseline periods are impacted by the Extraordinary Circumstances Exception (ECE) granted on March 22, 2020. Qualifying claims will be excluded from the measure calculations for January 1, 2020-March 31, 2020 (Q1 2020) and April 1, 2020-June 30, 2020 (Q2 2020) from the claims-based complication, mortality, and CMS PSI 90 measures. See the FY 2022 IPPS/LTCH PPS final rule (86 FR 45297-45299).

Performance Standards

For the previously established and newly estimated performance standards for the measures in the FY 2027, FY 2028, FY 2029, and FY 2030 program years, CHA refers readers to Tables V.L.-08 through V.L.-12 of the proposed rule.

Hospital-Acquired Conditions (HAC) Reduction Program

Under the HAC Reduction Program, which was implemented in FFY 2015, hospitals that fall in the worst-performing quartile are subject to a 1% reduction in IPPS payments. CMS does not propose any changes to the HAC reduction program. Table 3 in the appendix of this summary lists previously adopted measures for the HAC Reduction Program.

Hospital IQR Program

The hospital IQR Program is a pay-for-reporting program under which hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update. Additional information on the IQR measures and reporting processes is available online.

CMS proposes several changes to the IQR Program, including the addition of seven new measures, modifications to two existing measures, and the removal of five measures. CMS also proposes changes to the reporting and submission requirements for electronic clinical quality measures (eCQMs) and the validation process. Table 1 in the appendix to this summary shows the IQR Program the previously adopted and proposed measure set for FFY 2024 through FFY 2027.

Proposed Measures in the Hospital IQR Measure Set

CMS proposes seven new measures for the IQR program with a focus on patient safety measures and age friendly care. The proposed measure specifications and policies are described in detail below.

Patient Safety Structural Measure

CMS proposes to adopt the attestation-based Patient Safety Structural measure in the Hospital IQR program beginning with the CY 2025 reporting period/FFY 2027 payment determination. The measure is a structural measure that is intended to assess how well hospitals have implemented strategies and practices that demonstrate a structure, culture, and leadership commitment that prioritizes safety. The measure includes five domains ((i) Leadership commitment to eliminating preventable harms, (ii) Strategic planning and organization policy, (iii) Culture of safety and learning health systems, (iv) Accountability and transparency, and (v) Patient and family engagement), each containing a set of corresponding statements (or attestations).

Table IX.B.1-01 of the proposed rule, reproduced below, shows the five attestation domains and corresponding attestation statements.

Attestation Domains	Attestation Statements: Attest yes or no to each statement. (Note: Affirmative attestation of all statements within a domain would be required for the hospital to receive a point for the domain)
Domain 1: Leadership Commitment to Eliminating Preventable Harm	
The senior leadership and governing 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	(A) Our hospital senior governing board prioritizes safety as a 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, 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.	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 safety events resulting in significant morbidity, mortality, or other harm.
Domain 2: Strategic Planning & Organizational Policy	
Hospitals must leverage strategic 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 continual process of improvement and commitment. Patient safety and equity in care are inextricable, and therefore equity, with the goal of safety for all individuals, must be embedded in safety planning, goal-setting, policy, and processes.	(A) Our hospital has a strategic plan that publicly shares its commitment to patient safety as a core value and outlines specific safety goals and associated metrics, including the goal of “zero preventable harm.” (B) Our hospital safety goals include the use of metrics to 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 curriculum and competencies for all clinical and non-clinical hospital staff, including C-suite executives and individuals on the governing board, regular assessments of these competencies for all roles, and action plans for advancing safety skills and behaviors. (E) Our hospital has an action plan for workforce safety with improvement activities, metrics and trends that address issues such as slips/trips/falls prevention, safe patient handling, exposures, sharps injuries, violence prevention, fire/electrical safety, and psychological safety.
Domain 3: Culture of Safety & Learning Health Systems	
Hospitals must integrate a suite of evidence-based practices and protocols that are fundamental to cultivating a hospital culture that prioritizes safety and establishes a learning system both within and across hospitals. These practices focus	(A) Our hospital conducts a hospital-wide culture of safety survey using a validated instrument annually, or every2 years with pulse surveys on target units during non-survey years. Results are shared with the governing board and hospital staff and used to inform unit based interventions to reduce harm.

on actively seeking and harnessing information to develop a proactive, hospital-wide approach to optimizing safety and eliminating preventable harm. Hospitals must establish an integrated infrastructure (that is, people and systems working collaboratively) and foster psychological safety among staff to effectively and reliably implement these practices.	(B) Our hospital has a dedicated team that conducts event analysis of serious safety events using an evidence-based approach, such as the National Patient Safety Foundation's Root Cause Analysis and Action (RCA2). (C) Our hospital has a patient safety metrics dashboard and uses external benchmarks (such as CMS Star Ratings or other national databases) to monitor performance and inform improvement activities on safety events (such as: medication errors, surgical/procedural harm, falls, pressure injuries, diagnostic errors, and healthcare-associated infections). (D) Our hospital implements a minimum of 4 of the following high reliability practices: • Tiered and escalating (for example, unit, department, facility, system) safety huddles at least 5 days a week, with 1 day being a weekend, that include key clinical and non-clinical (for example, lab, housekeeping, security) units and leaders, with a method in place for follow-up on issues identified. • Hospital leaders participate in monthly rounding for safety on all units, with C-suite executives rounding at least quarterly, with a method in place for follow-up on issues identified. • A data infrastructure to measure safety, based on patient safety evidence (for example, systematic reviews, national guidelines) and data from the electronic medical record that enables identification and tracking of serious safety events and precursor events. These data are shared with C-suite executives at least monthly, and the governing board at every regularly scheduled meeting. • Technologies, including a computerized physician order entry system and a barcode medication administration system, that promote safety and standardization of care using evidence-based practices. • The use of a defined improvement method (or hybrid of proven methods), such as Lean, Six Sigma, Plan-Do-Study-Act, and/or high reliability frameworks. • Team communication and collaboration training of all staff. • The use of human factors engineering principles in selection and design of devices, equipment, and processes. (E) Our hospital participates in large-scale learning network(s) for patient safety improvement (such as national or state safety improvement collaboratives), shares data on safety events and outcomes with these network(s),and has implemented at least one best practice from the network or collaborative.
Domain 4: Accountability & Transparency	
Accountability for outcomes, as well as transparency around safety events	(A) Our hospital has a confidential safety reporting system that allows staff to report patient safety events, near misses,

and performance, represent the cornerstones of a culture of safety. For hospital leaders, clinical and non-clinical staff, patients, and families to learn from safety events and prevent harm, there must exist a culture that promotes event reporting without fear or hesitation, and safety data collection and analysis with the free flow of information.	precursor events, unsafe conditions, and other concerns, and prompts a feedback loop to those who report. (B) Our hospital reports serious safety events, near misses and precursor events to a Patient Safety Organization (PSO) listed by the Agency for Healthcare Research and Quality (AHRQ) that participates in voluntary reporting to AHRQ's Network of Patient Safety Databases. (C) Patient safety metrics are tracked and reported to all clinical and non-clinical staff and made public in hospital units (for example, displayed on units so that staff, patients, families, and visitors can see). (D) Our hospital has a defined, evidence-based communication and resolution program reliably implemented after harm events, such as AHRQ's Communication and Optimal Resolution (CANDOR) toolkit, that contains the following elements: • Harm event identification • Open and ongoing communication with patients and families about the harm event • Event investigation, prevention, and learning • Care-for-the-caregiver • Financial and non-financial reconciliation Patient-family engagement and on-going support (E) Our hospital uses standard measures to track the performance of our communication and resolution program and reports these measures to the governing board at least quarterly.
Domain 5: Patient & Family Engagement	
The effective and equitable engagement of patients, families, and caregivers is essential to safer, better care. Hospitals must embed patients, families, and caregivers as co-producers of safety and health through meaningful involvement in safety activities, quality improvement, and oversight.	(A) Our hospital has a Patient and Family Advisory Council that ensures patient, family, caregiver, and community input to safety related activities, including representation at board meetings, consultation on safety goal-setting and metrics, and participation in safety improvement initiatives. (B) Our hospital's Patient and Family Advisory Council includes patients and caregivers of patients who are diverse and representative of the patient population. (C) Patients have comprehensive access to and are encouraged to view their own medical records and clinician notes via patient portals and other options, and the hospital provides support to help patients interpret information that is culturally and linguistically appropriate as well as submit comments for potential correction to their record. (D) Our hospital incorporates patient and caregiver input about patient safety events or issues (such as patient submission of safety events, safety signals from patient complaints or other patient safety experience data, patient reports of discrimination). (E) Our hospital supports the presence of family and other designated persons (as defined by the patient) as essential members of a safe care team and encourages engagement in activities such as

	bedside rounding and shift reporting, discharge planning, and visitation 24 hours a day, as feasible.

The measure is scored similar to the existing "Hospital Commitment to Health Equity" measure. A hospital would be able to earn up to one point for each of the five domains, for a total of up to five points. To receive a point for a domain, a hospital would need to attest affirmatively to each of the statements that correspond to that domain. A hospital would not be able to receive partial points for a domain, and therefore would receive zero points for any domain for which it cannot attest affirmatively to each of the corresponding statements. If a hospital includes more than one acute care hospital facility reporting under the same CCN, all the facilities would need to satisfy these criteria for the hospital to affirmatively attest and receive points.

Hospitals would be required to submit information for the measure once annually using the CDC's data submission and reporting standard procedures for the National Healthcare Safety Network (NHSN). Beginning in fall 2026, CMS would publicly report the hospital's measure performance score (0 to 5 points) on an annual basis on *Care Compare*.

Age Friendly Hospital Measure

CMS proposes to adopt an attestation based structural measure – the Age Friendly Hospital measure – that is intended to ensure that hospitals are reliably implementing the "4 Ms". Developed by several organizations, including The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), in partnership with the American Hospital Association (AHA), the "4 Ms" refers to a framework of four evidence-based elements (What Matters, Medication, Mentation, and Mobility) to help organize care for older adults' wellness regardless of a person's culture, race, ethnicity, religious background, or chronic conditions.

The Age Friendly Hospital measure assesses hospital commitment to improving care for patients age 65 or older receiving services in the hospital, operating room (OR), or emergency department (ED). It consists of five attestation domains ((i) Eliciting Patient Healthcare Goals, (ii) Responsible Medication Management, (iii) Frailty Screening and Intervention, (iv) Social Vulnerability; and (v) Age-Friendly Care Leadership) and corresponding attestation statements shown in the table below:

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 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	(A) Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as

monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm.	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 malnutrition for the purpose of early detection and intervention where appropriate.	(A) Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instruments 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. (C) Data are collected on the rate of falls, decubitus ulcers, and 30-day readmission for patients > 65. These data are stratified by demographic and/or social factors. (D) Protocols exist to reduce the risk of emergency department delirium by reducing length of emergency department stay with a goal of transferring a targeted percentage of older patients out of the emergency department within 8 hours of arrival and/or within 3 hours of the decision to admit.
Domain 4: Social Vulnerability	
This domain seeks to ensure that hospitals recognize the importance of social vulnerability screening of older adults and have systems in place to ensure that social issues are identified and addressed as part of the care plan.	A) Older adults are screened for geriatric specific social vulnerability including social isolation, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse to identify those who may benefit from care plan modification. The assessments are performed on admission and again prior to discharge. (B) Positive screens for social vulnerability (including those that identify patients at risk of mistreatment) are addressed through intervention strategies. These strategies should include appropriate referrals and resources for patients upon discharge.
Domain 5: Age-Friendly Care Leadership	
This domain seeks to ensure consistent quality of care for older adults through the identification of an age friendly champion and/or interprofessional committee tasked with ensuring compliance with all components of this measure.	(A) Our hospital designates a point person and/or interprofessional committee to specifically ensure age friendly care issues are prioritized, including those within this measure. This individual or committee oversees such things as quality related to older patients, identifies opportunities to provide education to staff, and updates hospital leadership on needs related to providing age friendly care. (B) Our hospital compiles quality data related to the Age Friendly Hospital measure. These data are stratified by demographic and/or social factors and should be used to drive improvement cycles.

Similar to the proposed Patient Safety Structural measure, the measure consists of five domains and corresponding attestation statements. For each domain, to receive a point for the domain, hospitals would need to affirmatively attest to all of the statements within the domain for each

hospital reported under their CCN, with a total of five possible points (one per domain). Partial points would not be available. However, because the Hospital IQR Program is a pay-for-reporting program, hospitals would receive credit for reporting results regardless of their responses or points.

The measure would be reported once annually using a CMS-approved web-based data collection tool available within the HQR System. CMS proposes requiring reporting of the measure beginning with the CY 2025 reporting period/FY 2027 payment determination.

CAUTI Standardized Infection Ratio Stratified for Oncology Locations (CAUTI-Onc)
Beginning with the CY 2026 reporting period/FFY 2028 payment determination, CMS proposes this measure is to encourage best practices (set by the CDC) for the use of urinary catheters to reduce the incidence of CAUTIs for patients with cancer. Hospitals would need to verify that all locations, including those with oncology patients, are mapped in NHSN in order to report the measure.

The NHSN calculates the quarterly risk-adjusted standardized infection ratio (SIR) of CAUTIs among inpatients at acute care hospitals who are in oncology wards. The CDC calculates the SIR using all four quarters of data from the reporting period year, which CMS then uses for performance calculation and public reporting. The SIR compares the actual number of CAUTIs to the expected number. An oncology ward is defined by the CDC as an area for the evaluation and treatment of patients with cancer. The SIR of one facility is not meant to be compared to another facility, but to compare the facility's CAUTI rate to the national rate after adjusting for facility and patient risk factors.

> Numerator: Number of annually observed CAUTIs among acute care hospital inpatients in oncology wards.
> Denominator: Number of annually predicted CAUTIs among acute care hospital inpatients in oncology wards.
> Data Submission and Reporting: The measure would be collected through the CDC's NHSN. For purposes of the Hospital IQR Program requirements, hospitals would report data for the CAUTI-Onc measure quarterly. Hospitals would collect the numerator and denominator for the measure each month and submit data to the NHSN, and the data from all 12 months would be calculated into quarterly reporting periods. Currently, CAUTI data is reported to the NHSN monthly and the SIR is calculated on a quarterly basis.

CLABSI Standardized Infection Ratio Stratified for Oncology Locations (CLABSI-Onc)
Beginning with the CY 2026 reporting period/FFY 2028 payment determination, CMS proposes the CLABSI-Onc measure to encourage use of best practices for central line use, to promote CLABSI prevention activities, and to reduce incidence of CLABSIs for patients with cancer. Hospitals would need to verify that all locations, including those with oncology patients, are mapped in NHSN in order to report the measure.

The NHSN calculates the quarterly risk-adjusted SIR of CLABSIs among inpatients at acute care hospitals who are in oncology wards. The CDC calculates the SIR using all four quarters of data from the reporting period year, which CMS then uses for performance calculation and public reporting. The SIR compares the actual number of CLABSIs to the expected number. The SIR of

one facility is not meant to be compared to another facility, but to compare the facility's CLABSI rate to the national rate after adjusting for facility and patient risk factors.

Numerator: Number of annually observed CLABSIs among acute care hospital inpatients in oncology wards.
Denominator: Number of annually predicted CLABSIs among acute care hospital inpatients in oncology wards.
Data Submission and Reporting: The measure would be collected through the CDC's NHSN. For purposes of the Hospital IQR Program requirements, hospitals would report data for the CLABSI-Onc measure quarterly. Hospitals would collect the numerator and denominator for the measure each month and submit data to the NHSN, and the data from all 12 months would be calculated into quarterly reporting periods. Currently, CLABSI data is reported to the NHSN monthly, and the SIR is calculated on a quarterly basis.

Hospital Harm - Falls with Injury eCQM
CMS proposes to adopt the Hospital Harm – Falls with Injury measure, a risk-adjusted outcome eCQM, beginning with the CY 2026 reporting period/FFY 2028 payment determination. The measure is reported as the number of inpatient hospitalizations with falls with moderate or major injury per 1,000 patient days and is calculated as the product of the ratio of the numerator to the denominator multiplied by 1,000.

Numerator: Total number of encounters with falls with moderate or major injury; determined as inpatient hospitalizations for patients identified in the initial population (and not subject to exclusion) and who during the hospitalization had a fall that results in moderate injury or major injury.
Denominator: Total number of eligible hospital days; determined as inpatient hospitalizations for patients aged 18 and older with a length of stay less than or equal to 120 days that ends during the measurement period.
Exclusions: Diagnosis of a fall and of a moderate or major injury that was present on admission.
Data Submission and Reporting: The measure uses data collected through hospitals' EHRs and is designed to be calculated using certified electronic health record technology (CEHRT) and then submitted to CMS. CMS proposes to add the measure to the available eCQM measure set from which hospitals can self-select to report beginning with the CY 2026 reporting period/FFY 2028 payment determination.

Hospital Harm – Postoperative Respiratory Failure eCQM CMS proposes adoption of the Hospital Harm – Postoperative Respiratory Failure measure, a risk-adjusted outcome eCQM, beginning with the 2026 reporting period/FY 2028 payment determination. CMS acknowledges the postoperative respiratory failure related component (PSI 11) of the PSI 90 composite measure, but in comparison the agency believes the Hospital Harm – Postoperative Respiratory Failure eCQM would enable assessment of the rate of postoperative respiratory failure in a larger population and use more timely information from patients' electronic medical records (EMRs) instead of administrative claims data.

The measure would be calculated as the product of 1,000 multiplied by the ratio of the number of encounters in the numerator to the number of encounters in the denominator.

Numerator: Elective inpatient hospitalizations for patients with postoperative respiratory failure.
Denominator: Elective inpatient hospitalizations that end during the measurement period for patients at least 18 years of age without an obstetrical condition and for whom at least one surgical procedure was performed within the first three days of the encounter.
Risk Adjustment: Accounts for 10 comorbidities present at admission (weight loss, deficiency anemias, heart failure, diabetes with chronic complications, moderate to severe liver disease, peripheral vascular disease, pulmonary circulation disease, valvular disease, and ASA categories 3-5) and lab values for oxygen, leukocytes, albumin, BUN, bilirubin, and pH of arterial blood.
Data Submission and Reporting: The measure would be calculated by the hospital's certified EHR technology using the patient-level data collected through hospitals' EHRs and then submitted by hospitals to CMS. CMS proposes to add the measure to the available eCQM measure set from which hospitals can self-select to report beginning with the CY 2026 reporting period/FFY 2028 payment determination.

Thirty-Day Risk-Standardized Death Rate Among Surgical Inpatients with Complications (Failure-to-Rescue) Measure

CMS proposes to adopt the Failure-to-Rescue measure, which is a risk-standardized measure of death after hospital-acquired complication, beginning with the July 1, 2023, through June 30, 2025, performance period affecting the FY 2027 payment determination. The Failure-to-Rescue measure is designed to improve upon the Death Rate Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) measure in the Hospital IQR Program and would replace that measure contingent on adoption of this Failure-to-Rescue measure.

The measure uses Medicare FFS Part A inpatient claims data, Medicare Inpatient Encounter data for MA enrollees, and validated death data from the Medicare Beneficiary Summary File or resources equivalent to such File.

Numerator: Patients who died within 30 days from the date of their first OR procedure, regardless of site of death.
Denominator: Patients at least 18 years of age admitted for certain procedures in the general surgery, orthopedic, or cardiovascular MS-DRGs who upon admission were Medicare beneficiaries with no documented complication present.
Exclusions: Excludes patients whose relevant complications preceded their first inpatient OR procedure and broadens the definition of denominator-triggering complications to include other complications that may predispose to death.
Data Submission and Reporting: The measure uses administrative claims data routinely generated and submitted to CMS; therefore, hospitals would not be required to report additional data. The measure would be calculated and publicly reported on an annual basis using a rolling 24 months of prior data, consistent with what is currently used for CMS PSI 04 and PSI 90 (the Patient Safety and Adverse Events Composite measure).

Proposed Refinements to Current IQR Program Measures

CMS proposes to make refinements to two measures: the Global Malnutrition Composite Score (GMCS) eCQM beginning with the CY 2026 reporting period/FFY 2028 payment determination; and the HCAHPS Survey measure beginning with the CY 2025 reporting period/FFY 2027 payment determination.

HCAHPS Survey Measure

Beginning with the CY 2025 reporting period/FFY 2027 payment determination, CMS proposes 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. CMS also proposes to adopt these changes for the hospital VBP program under which the questions would make up nine dimensions. 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 October 2026:

- the multi-item "Care Coordination"
- the multi-item "Restfulness of Hospital Environment"
- 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 January 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. CMS would begin publicly reporting the modified measure in January 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 proposes 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."

CMS also proposes to modify the "About You" section of the survey with the following changes:

- Replacing the existing Emergency Room Admission question with a new, Hospital Stay Planned in Advance question because the new question is believed to be better understood
- Reducing the number of response options for the existing Language Spoken at Home question to include only English, Spanish, Chinese, or Some Other Language as options
- Alphabetizing the response options for the existing ethnicity question
- Alphabetizing the response options for the existing race question

Neither patient race nor ethnicity is used to adjust HCAHPS Survey results but questions are instead included in the survey for congressionally-mandated reports. These modifications would not be included in public reporting of the survey, nor would they affect scoring under the HVBP Program. The "Hospital Stay Planned in Advance" question would be used in the patient-mix adjustment of responses.

Global Malnutrition Composite Score (GMCS) eCQM

In the FFY 2023 IPPS final rule, CMS adopted the GMCS measure to assess the percentage of hospitalizations for patients 65 and older with a length of stay of at least 24 hours who received optimal malnutrition care during the current inpatient hospitalization. CMS proposes to modify the measure by expanding the patient cohort to all patients 18 and older.

Proposed Measure Removals for the IQR Program

CMS proposes to remove the following five measures from the IQR Program, including one claims-based measure and four clinical episode-based payment measures.

Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04)

CMS proposes to remove the Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) claims-based measure beginning for the FFY 2027 payment determination (and corresponding July 1, 2023, through June 30, 2025 reporting period). This proposal is contingent on finalizing the new Failure-to-Rescue measure described earlier in this summary.

Proposed Removal of Four Clinical Episode-Based Payment Measures Beginning with FY 2026 Payment Determination

CMS proposes to remove the following four clinical episode-based payment measures beginning for the FFY 2026 payment determination due to the availability of a more broadly applicable measure (the Medicare Spending Per Beneficiary (MSPB) in the Hospital VBP program):

- The Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI Payment) measure, beginning with the July 1, 2021–June 30, 2024, reporting period
- The Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF Payment) measure, beginning with the July 1, 2021–June 30, 2024, reporting period
- The Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN Payment) measure, beginning with the July 1, 2021–June 30, 2024, reporting period
- The 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) (THA/TKA Payment) measure, beginning with the April 1, 2021–March 31, 2024, reporting period

Form, Manner, and Timing of Quality Data Submission

CMS is not proposing changes to most policies related to quality data submission, collection, and reporting requirements, including the requirement that EHRs be certified to all available eCQMs, the file format for EHR data, the submission deadlines for eCQM data, submission and reporting requirements for hybrid measures, sampling and case thresholds for chart-abstracted measures, and data submission and reporting requirements for CDC NHSN measures, structural measures, and PRO-PMs. However, CMS does propose changes to increase eCQM reporting, including specifying more mandatory measures.

Currently, hospitals must report four quarters of data for six eCQMs, three of which are mandatory (Safe Use of Opioids, Cesarean Birth, and Severe Obstetric Complications) and three that are self-selected from the available measure set. CMS proposes to progressively increase the number of mandatory eCQMs that a hospital must report beginning with the CY 2026 reporting period/FFY 2028 payment determination, so that by the 2027 reporting period, hospitals would report data for a total of 11 eCQMs, eight of which would be specified by CMS.

CMS proposes that beginning with the CY 2026 reporting period/FFY 2028 payment determination, hospitals would need to report on six mandatory and three self-selected eCQMs. In addition to the current three mandatory eCQMs, CMS proposes to require reporting on the following eCQMs: Hospital Harm - Severe Hypoglycemia eCQM; Hospital Harm - Severe Hyperglycemia eCQM; and Hospital Harm - Opioid-Related Adverse Events eCQM.

Beginning with the CY 2027 reporting period/FFY 2029 payment determination, hospitals would need to report on eight mandatory eCQMs and three self-selected. In addition to the current three mandatory eCQMs and the three eCQMs proposed to be mandatory beginning with the 2028 payment determination, the following would be included as mandatory eCQMs: Hospital Harm – Pressure Injury eCQM; and Hospital Harm – Acute Kidney Injury eCQM.

If a hospital does not have patients that meet the denominator criteria for an eCQM that would be required, the hospital would submit a zero-denominator declaration for the measure, which allows the hospital to meet the reporting requirements for that eCQM.

Validation of Hospital IQR Program Data
CMS previously finalized policies that will incorporate eCQMs into the existing validation process for chart-abstracted measures, such that there is one pool of up to 200 hospitals randomly selected and one pool of an additional 200 hospitals selected based on targeting criteria, for both chart-abstracted measures and eCQM. Under the existing validation policy, hospitals are scored on the completeness of eCQM medical record data submitted for the validation process; however, the accuracy of the data does not affect the validation score.

CMS proposes that, beginning with 2025 eCQM data affecting the FFY 2028 payment determination, eCQM validation scoring will be based on the accuracy of the data. In addition, the agency proposes to remove the requirement that hospitals submit 100% of the requested eCQM medical records to pass the validation requirement and that missing eCQM medical records be treated as mismatches (consistent with the practice for chart-abstracted measure validation). eCQM validation scores would be determined using the same methodology that is currently used to score chart-abstracted measure validation.

CMS also proposes to have two separate validation scores – one for chart-abstracted measures and one for eCQMs – rather than the existing combined validation score. Hospitals would need to receive passing scores for both chart-abstracted measures and eCQMs to pass validation. A hospital that fails to meet validation requirements may not receive the full annual payment update. Under the proposal, to be eligible for the full update (if all other Hospital IQR Program requirements are met) a hospital would have to attain at least a 75% validation score for each of the separate scores.

Hospitals can request reconsideration of a CMS determination that the hospital did not meet validation requirements. As part of that process, hospitals must resubmit copies of all medical records originally submitted to the Clinical Data Abstraction Center, but this is no longer necessary given the transition to electronic submission of copies of medical records for the validation. Therefore, CMS proposes – beginning with 2023 discharges affecting the FFY 2026 payment determination – to no longer require the resubmission of previously submitted medical records as part of a hospital's request for reconsideration of validation.

PPS-Exempt Cancer Hospital Quality Reporting Program

In the FFY 2013 IPPS final rule, CMS established a Quality Reporting Program beginning in FFY 2014 for PPS-exempt cancer hospitals (PCHs). The PCH Quality Reporting (PCHQR) Program follows many of the policies established for the hospital IQR Program, including the principles for selecting measures and the procedures for hospital participation. No policy was adopted to address the consequences for a PCH that fails to meet the quality reporting requirements; CMS has indicated its intention to discuss the issue in future rulemaking.

For the PCHQR program, CMS proposes to adopt one new measure – the Patient Safety Structural Measure – and modify the HCAHPS measure consistent with changes proposed for the IQR and hospital VBP programs beginning with the CY 2025 reporting period/FFY 2027

program year. CHA refers readers to the IQR section of this summary for more details on the newly proposed and modified measures.

CMS also proposes to move up the start date for public reporting of the previously finalized Hospital Commitment to Health Equity measure from July 2026 to January 2026, based on the 2024 reporting period. Table 4 of the Appendix of this summary lists the proposed and adopted measure set for the program.

Medicare Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program — previously the EHR incentive program — hospitals that are not identified as meaningful EHR users are subject to a reduction equal to three quarters of the market basket.

CMS proposes several changes to the program, including changes to one of its public health reporting measures, increasing the program's minimum scoring threshold, and increasing eCQM reporting in alignment with the proposed IQR requirements. CMS also includes several requests for information (RFI) about future program policies.

Proposed Change to Antimicrobial Use and Resistance (AUR) Surveillance Measure Beginning with EHR Reporting Period in 2025

CMS previously adopted a measure under the Public Health and Clinical Data Exchange objective that requires hospitals to report antimicrobial use (AU) data and antimicrobial resistance (AR) data to the CDC NHSN as one measure, AUR Surveillance.

CMS proposes 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."

Currently, if a hospital meets the exclusion criteria for reporting either AU data or AR data then it is excluded from the entire measure. There are three exclusions for which a hospital could be eligible:

- 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.

CMS proposes to add an exclusion for hospitals when they do not have a data source containing the minimal discrete data elements that are required for reporting. If the proposal for two separate measures is finalized, this exclusion would be applied to both measures, as would exclusion #1 described above. Exclusion #2 described above would be applied to the AU measure and exclusion #3 described above would be applied to the AR measure to align the appropriate exclusion to the data on which each separate measure would rely.

CMS also proposes 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 does not propose changes to the scoring of the Public Health and Clinical Data Exchange objective to account for the increase in measures from five to six. The objective would continue to be valued at 25 points for reporting of all required measures and the current exclusion redistribution policy would be maintained.

Scoring Methodology for the EHR Reporting Period in 2025

In general, CMS does not propose changes to the scoring methodology for the CY 2025 EHR reporting period. However, CMS does propose to increase the minimum scoring threshold from 60 to 80 points. CMS notes that based on 2022 performance results, 98.5% of hospitals (97% of CAHs and 99% of eligible hospitals) that reported to the program successfully met the current minimum threshold of 60 points, and 81.5% of hospitals (78% of CAHs and 83% of eligible hospitals) would have exceeded the proposed threshold of 80 points.

To be considered a meaningful user of EHR technology, an eligible hospital or CAH will be required to:

- 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
- Achieve a total score of at least 80 points, based on the methodology in the table below

Failure to meet any of the first three requirements results in an automatic score of zero.

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.

Proposed eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

In alignment with the hospital IQR Program, CMS proposes the to adopt the following new eCQMs available for the Promoting Interoperability Program eCQM measure set from which hospitals may self-select, beginning with the CY 2026 EHR reporting period: Hospital Harm – Falls with Injury eCQM and Hospital Harm – Postoperative Respiratory Failure eCQM. CMS also proposes to modify the Global Malnutrition Composite Score eCQM to add patients ages 18 to 64 to the current cohort of patients 65 years or older. CHA refers readers to the IQR Program section of this summary for a full discussion of the proposed eCQMs.

Consistent with the IQR program, CMS proposes to progressively increase the number of mandatory eCQMs that a hospital must report beginning with the CY 2026 reporting period/FFY 2028 payment determination, so that by the 2027 reporting period, hospitals would report data for a total of 11 eCQMs, eight of which would be specified by CMS. Specifically, CMS proposes the following:

- If the proposals to adopt the Hospital Harm – Falls with Injury eCQM and the Hospital Harm – Postoperative Respiratory Failure eCQM are finalized, those measures would be available for hospitals to select as one of their three self-selected eCQMs for the 2026 reporting period and subsequent years.

- Beginning with the 2026 reporting period, CMS would mandate reporting of the Hospital Harm –Severe Hypoglycemia eCQM, Hospital Harm – Severe Hyperglycemia eCQM, and the Hospital Harm – Opioid-Related Adverse Events eCQMs. This would result in three self-selected eCQMs and six required eCQMs selected by CMS that would need to be reported, for a total of nine eCQMs that would be reported.
- Beginning with the 2027 reporting period, CMS would mandate reporting of two additional eCQMs (the Hospital Harm – Pressure Injury eCQM and the Hospital Harm – Acute Kidney Injury eCQM). This would result in three self-selected eCQMs and eight required eCQMs selected by CMS needing to be reported, for a total of 11 eCQMs that would be reported.

Potential Future Update to the SAFER Guides Measure

CMS adopted the SAFER Guides measure under the Protect Patient Health Information Objective beginning with the EHR reporting period in 2022. CMS notes that efforts to update the SAFER Guides are underway, the agency anticipates that updated versions may become available as soon as 2025, and that it would consider proposing a change to the measure for the EHR reporting period beginning in 2026 to permit use of an updated version of the SAFER Guides at that time.

Future Goals of Promoting Interoperability Program

Fast Healthcare Interoperability Resources (FHIR) Application Programming Interfaces (APIs) for Patient Access

CMS describes how the agency is working in partnership with ONC on a number of initiatives, including the use of APIs that use the Health Level Seven International (HL7) FHIR. CMS highlights provisions finalized by ONC in the HTI-1 final rule, including revisions to the standardized API for patient and populations services certification criterion, the adoption of the HL7 FHIR US Core Implementation Guide (IG) Standard for Trial Use version 6.1.0, and the creation of the Insights Condition and Maintenance of Certification requirements (Insights Condition) within the ONC HIT Certification Program. CMS believes these updated standards, implementation specifications, certification criteria, and conditions of certification will improve interoperability, transparency, and the exchange of health information.

Improving Cybersecurity Practices

CMS reviews resources regarding appropriate cybersecurity practices, including the National Institute of Standards and Technology (NIST) updated guidance and the recently released HHS voluntary healthcare specific Cybersecurity Performance Goals (CPGs). CMS indicates the agency's intent to consider how it could use the Promoting Interoperability program to promote cybersecurity best practices for hospitals in the future.

Improving Prior Authorization Processes

CMS references the CMS Interoperability and Prior Authorization final rule (CMS-0057-F), in which the agency finalized the Electronic Prior Authorization measure under the HIE objective for the Merit-based Incentive Payment System (MIPS) promoting interoperability performance category and for the Medicare PIP. For the Medicare PIP the measure is included beginning in the EHR reporting period in 2027.

RFI Regarding Public Health Reporting and Data Exchange

CMS is working with the CDC and ONC on ways that the Promoting Interoperability Program could advance the public health infrastructure through health IT and data exchange standards. The agency describes that current public health-related certification criteria and standards support single patient, evidence-based submission of data from health care providers to public health agencies (PHAs) but may not adequately support complex data exchange use cases, such as bulk exchange data for patients who received a specific vaccine. CMS believes that increased use of FHIR-based APIs could enable PHAs to use health IT to securely query data directly when needed. ONC is evaluating standards development around the use of FHIR for public health data exchange that could be incorporated into certification criteria. CMS describes the benefits of establishing minimum functional capabilities and exchange standards to send and receive public health data as part of health IT certification criteria, including helping PHAs to align with health care provider data sources.

Appendix — Quality Reporting Program Tables

Table 1

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure	2025	2026	2027	2028	2029
Chart-Abstracted Process of Care Measures					
Severe sepsis and septic shock: management bundle (CBE #500)	X	X	X	X	X
PC-01 Elective delivery < 39 weeks gestation (CBE#0469)	X	*Remove*			
Electronic Clinical Quality Measures					
ED-2 Time from admit decision to ED departure for admitted patients (CBE #0497) PC-05 Exclusive breast milk feeding (CBE #0480) STK-02 Antithrombotic therapy for ischemic stroke (CBE #0435) STK-03 Anticoagulation therapy for Afib/flutter (CBE #0436) STK-05 Antithrombotic therapy by end of hospital day 2 (CBE #0438) STK-06 Discharged on statin (CBE #0439) VTE-1 VTE prophylaxis (CBE #0371) VTE-2 ICU VTE prophylaxis (CBE #0372) Safe Use of Opioids – Concurrent Prescribing (CBE #3316c) HH-01 Hospital Harm-Severe Hypoglycemia (CBE #3503e) HH-02 Hospital Harm-Severe Hyperglycemia (CBE #3533e) Hospital Harm Opioid Related Adverse Events HH-ORAE ePC-02 Cesarean Birth ePC-07/SMM Sever Obstetric Complications *Global Malnutrition Composite Score GMCS (CBE #3592e)* HH-PI Hospital Harm-Pressure Injury (CBE 3498e) HH-AKI Hospital Harm-Acute Kidney Injury (CBE 3713e) Excessive Radiation Does or Inadequate Image Quality for Diagnostic CT in Adults (ExRad) *HH-FI Hospital Harm-Falls with Injury (CBE#4120e)* *HH-RF Hospital Harm-Postoperative Respiratory Failure (CBE#4130e)*	Report: Safe Use of Opioids AND 3 of the following eCQMs: ED-2 PC-05 STK-02 STK-03 STK-05 STK-06 VTE-1 VTE-2 HH-01 HH-02 ePC-02 ePC-07	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications; AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS HH-PI HH-AKI ExRad	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications *[AND, AS PROPOSED, HH-HYPO, HH-HYPER, and HH-ORAE]* AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 *GMCS* HH-PI HH-AKI ExRad *HH-FI HH-RF*	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications *[AND, AS PROPOSED, HH-HYPO, HH-HYPER, and HH-ORAE*, *HH-PI, HH-AKI]* AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 *GMCS* ExRad *HH-FI HH-RF*
Healthcare-Associated Infection Measures					
Healthcare Personnel Influenza Vaccination (NQF #0431)	X	X	X	X	X

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2025	**2026**	**2027**	**2028**	**2029**
Healthcare Personnel COVID-19 Vaccination	X	X	X	X	X
CAUTI-Onc (CBE #0138)				*Proposed*	*Proposed*
CLABSI-Onc (CBE #0139)				*Proposed*	*Proposed*
Mortality					
Stroke 30-day mortality rate	X	X	X	X	X
Readmission/Coordination of Care					
Hospital-wide all-cause unplanned readmission (CBE #1789)	X	Removed			
Excess days in acute care after hospitalization for AMI (CBE #2881)	X	X	X	X	X
Excess days in acute care after hospitalization for HF (CBE #2880)	X	X	X	X	X
Excess days in acute care after hospitalization for PN (CBE #2882)	X	X	X	X	X
Claims and Electronic Data Measures (Hybrid)					
Hybrid HWR (all-cause readmission) (CBE #2879)	Voluntary	X	X	X	X
Hybrid HWM (all-cause mortality)	Voluntary	X	X	X	X
Patient Safety					
PSI-04 Death among surgical inpatients with serious, treatable complications (CBE #0351)	X	X	*Proposed Remove*		
THA/TKA complications	X	X	X	X	X (Remove 2030, remains in VBP)
FTR 30-day Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (CBE #4125)			*Proposed*	*Proposed*	*Proposed*
Efficiency/Payment					
AMI payment per 30-day episode of care (CBE #2431)	X	Proposed Remove			
Heart Failure payment per 30-day episode of care (CBE # 2436)	X	Proposed Remove			
Pneumonia payment per 30-day episode of care (CBE #2579)	X	Proposed Remove			
THA/TKA payment per 30-day episode of care	X	Proposed Remove			
MSPB-Hospital	X	X	X	Remove FFY 2028 (Remains in VBP)	
Patient Experience of Care					
HCAHPS survey (CBE #0166)	X	X	Proposed Modifications	X	
Patient-Reported Outcome-Based Performance Measure (PRO-PM)					
Hospital-Level THA/TKA PRO-PM			Voluntary	X	X

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2025	**2026**	**2027**	**2028**	**2029**
Structural Measures					
Maternal Morbidity	X	X	X	X	
Hospital Commitment to Health Equity (HCHE)		X	X	X	
Patient Safety			*Proposed*	*Proposed*	*Proposed*
Age Friendly Hospital			*Proposed*	*Proposed*	*Proposed*
Process Measures					
SDOH-1 Screening for Social Drivers of Health	Voluntary	X	X	X	X
SDOH-2 Screen Positive Rate for Social Drivers of Health	Voluntary	X	X	X	X

Note: *Italics* indicates proposals included in this proposed rule

Table 2

Summary Table VBP-1: Measures and Domains by Payment Year				
Measure	**CBE #**	**2024-2025**	**2026-2029**	**2030+**
Clinical Outcomes Domain				
Acute Myocardial Infarction (AMI) 30-day mortality rate	0230	X	X	X
Heart Failure (HF) 30-day mortality rate	0229	X	X	X
Pneumonia (PN) 30-day mortality rate	0468	X	X	X
Complication rate for elective primary total hip arthroplasty/total knee arthroplasty	1550	X	X	X**
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate	1893	X	X	X
CABG 30-day mortality rate	2558	X	X	X
Safety Domain				
Central Line Associated Blood Stream Infection (CLABSI)	0139	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	0138	X	X	X
Colon and Abdominal Hysterectomy Surgical Site Infections (SSI)	0753	X	X	X
Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Bacteremia	1716	X	X	X
Clostridium Difficile Infection (CDI)	1717	X	X	X
Severe Sepsis and Septic Shock: Management Bundle (Sep-1)	0500		X	X
Person and Community Engagement Domain				
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)***	0166	X	X Proposed Modifications FY 2027	X
Efficiency and Cost Reduction Domain				
Medicare Spending per Beneficiary*	2158	X	X*	X

* Substantive updates to the MSPB measure beginning with FFY 2028 program year
**Substantive updated to the THA/TKA Complications measure beginning with the FFY 2030 program year
***Substantive modifications to HCAHPS measure proposed beginning in FFY 2027; changes to VBP scoring methodology for FFYs 2027-2029, and additional changes for FFY 2030

Table 3

HAC Reduction Program Measures for FFY 2024 and Subsequent Years		
	NQF #	**FFY 2024+**
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531	X
CDC NSHN Measures		
Central Line-associated Blood Stream Infection (CLABSI)	0139	X
Catheter-associated Urinary Tract Infection (CAUTI)	0138	X
Colon and Abdominal Hysterectomy Surgical Site Infections	0753	X
Methicillin-resistant staphylococcus aureus (MRSA)	1716	X
Clostridium difficile (CDI)	1717	X

Table 4

PCHQR Program Measures and Public Display Requirements	
Measure	**Public Reporting**
Safety and Healthcare Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	2019 and subsequent years
NHSN CDI (NQF #1717)	2019 and subsequent years
NHSN MRSA bacteremia (NQF #1716)	2019 and subsequent years
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	2019 and subsequent years
NHSN COVID-19 vaccination coverage among health care personnel	October 2022 and subsequent years
NHSN CLABSI (NQF #0139)	October 2022 and subsequent years
NHSN CAUTI (NQF #0138)	October 2022 and subsequent years
Patient Safety Structural Measure	*Proposed Fall 2026*
Clinical Process/Oncology Care	
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (NQF #0210)	July 2024 or as soon as feasible thereafter
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	July 2024 or as soon as feasible thereafter
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	July 2024 or as soon as feasible thereafter
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	July 2024 or as soon as feasible thereafter
Patient Experience of Care	
HCAHPS (NQF #0166) *(Modifications proposed FFY 2027)*	2016 and subsequent years
Documentation of Goals of Care Discussions Among Cancer Patients	July 2026 or as soon as feasible thereafter
Claims-Based Outcomes	
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	October 2023 or as soon as feasible thereafter
Surgical Treatment Complications for Localized Prostate Cancer	July 2024 or as soon as feasible thereafter
Health Equity Measures	
Facility Commitment to Health Equity	*Proposed January 2026 or as soon as feasible thereafter*
Screening for Social Drivers of Health	July 2027 or as soon as feasible thereafter
Screen Positive Rate for Social Drivers of Health	July 2027 or as soon as feasible thereafter