SUMMARY OF FINAL RULE – SEPTEMBER 2024

FFY 2025 Inpatient Prospective Payment System

In the August 28 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its final 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). The policy and payment provisions in the final rule are generally effective for FFY 2025 discharges, beginning Oct. 1, 2024.

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

For Additional Information

Questions about this summary should be directed to Megan Howard, vice president of federal policy, at (202) 488-3742. 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.

Contents

FFY 2025 Payment Changes

The table below lists the federal operating and capital rates for FFY 2025 compared to the rates 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 Promoting Interoperability Program, quality penalties/payments, disproportionate share hospitals, etc.).

	Final FFY 2024	Final FFY 2025	Percent Change
Federal Operating Rate	$6,497.77	**$6,606.51** (proposed at $6,666.10)	**+1.67%** (proposed at +2.59%)
Federal Capital Rate	$503.83	**$510.51** (proposed at $516.41)	**+1.33%** (proposed at +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 Medicare Severity Diagnosis Related Groups (MS-DRG) weights or standardized amounts.

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

	Federal Operating/Hospital Specific Rate	Hospital Specific Rate	Federal Capital Rate
Market Basket/Capital Input Price Index update	+3.4%		+2.6%
ACA-Mandated Productivity Adjustment	-0.5 percentage point (PPT)		—
Forecast Error Adjustment	—		+0.5 PPT
Lowest Quartile Wage Index Adjustment	-0.02%	—	-0.06%
Wage Index Cap Policy	-0.05%	—	-0.06%
MS-DRG Weight Cap Policy	-0.01%		-0.01%
All Other Annual Budget Neutrality Adjustments	-1.11%	-0.28%	-1.65%
Net Rate Update	**+1.67%**	**+2.6%**	**+1.33%**

Effects of the Inpatient Quality Reporting and Electronic Health Record 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; combined, these penalties put at risk the entire MB update. A table displaying various update scenarios for FFY 2025 is below:

	Neither Penalty	IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate MB Update (3% MB less 0.4 PPT productivity adjustment)	+2.9%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3%)	—	-0.85 PPT	—	-0.85 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3%)	—	—	-2.55 PPT	-2.55 PPT
Adjusted Net MB Update ***(prior to other adjustments)***	***+2.9%***	***+2.05%***	***+0.35%***	***-0.5%***

Impact Analysis

Impacts will vary based on hospital type and geography. CMS' detailed impact estimates are displayed in Table I of the final rule (page 69,998), which is partially reproduced below.

Hospital Type	All Final Rule Changes
All Hospitals	2.8%
Urban	2.8%
Urban Pacific	0.1%
Rural	2.6%
Rural Pacific	1.5%

The CHA DataSuite analysis estimates that California hospitals will experience a 1.3% decrease in overall Medicare hospital inpatient payments in FFY 2025, compared to FFY 2024.

IPPS FFY 2025 Final Rule Analysis

Estimated Change in Medicare Payments
FFY 2025 Final Rule Compared to FFY 2024 Final Rule

California

Group Impact Summary	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2024 IPPS Payments	$12,683,957,300		$940,282,800		$13,624,240,100	
Estimated FFY 2025 IPPS Payments	$12,514,934,000		$927,731,600		$13,442,665,600	
Total Estimated Change FFY 2024 to FFY 2025	($169,023,200)	-1.3%	($12,551,200)	-1.3%	($181,574,500)	-1.3%

Group Impact Detail	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Provider Type Changes	$0	0.0%	$0	0.0%	$0	0.0%
> Transitional DSH Payment	*$0*	*0.0%*	*N/A*	*N/A*	*$0*	*0.0%*
Change in Hospital Specific Rate Payment Status	$0	0.0%	N/A	N/A	$0	0.0%
Market Basket Update (Includes BN)	$287,336,600	2.3%	$8,052,100	0.9%	$295,388,700	2.2%
ACA-Mandated Market Basket Reduction	($57,501,700)	-0.5%	N/A	N/A	($57,501,700)	-0.4%
Forecast Error Adjustment	N/A	N/A	$4,375,300	0.5%	$4,375,300	0.0%
MS-DRG Weight 10% Reduction Cap BN	($1,535,800)	0.0%	($92,900)	0.0%	($1,628,800)	0.0%
WI/GAF (Wage Data and Reclassification)	($407,654,100)	-3.2%	($28,800,000)	-3.1%	($436,454,100)	-3.2%
> Removal of Previous Rural Floor BN	*$206,720,800*	*1.6%*	*$14,379,700*	*1.5%*	*$221,100,600*	*1.6%*
> Removal of Previous Rural Floor WI	*($955,817,000)*	*-7.5%*	*($69,439,100)*	*-7.4%*	*($1,025,256,000)*	*-7.5%*
> Change due to WI and LS (Prior to Rural Floor)	*($327,501,200)*	*-2.6%*	*($23,193,400)*	*-2.5%*	*($350,694,600)*	*-2.6%*
> Current Rural Floor WI	*$876,531,400*	*6.9%*	*$64,019,300*	*6.8%*	*$940,550,700*	*6.9%*
> Current Rural Floor BN	*($207,588,200)*	*-1.6%*	*($14,566,500)*	*-1.6%*	*($222,154,700)*	*-1.6%*
> Change in LS (Isolated from Previous Breakouts)	*$0*	*0.0%*	*N/A*	*N/A*	*$0*	*0.0%*
WI/GAF (Other Changes)	($12,577,800)	-0.1%	$775,800	0.1%	($11,802,100)	-0.1%
> Expiration of Previous 5% Stop Loss BN	*$4,264,700*	*0.0%*	*$407,600*	*0.0%*	*$4,672,300*	*0.0%*
> Expiration of Previous 5% Stop Loss WI	*$5,361,700*	*0.0%*	*$348,700*	*0.0%*	*$5,710,400*	*0.0%*
> Current 5% Stop Loss WI	*$13,716,700*	*0.1%*	*$925,900*	*0.1%*	*$14,642,600*	*0.1%*
> Current 5% Stop Loss BN	*($33,463,800)*	*-0.3%*	*($1,941,900)*	*-0.2%*	*($35,405,600)*	*-0.3%*
> Removal of Previous Bottom Quartile BN	*$31,291,900*	*0.3%*	*$2,992,400*	*0.3%*	*$34,284,300*	*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	*($33,749,100)*	*-0.3%*	*($1,957,000)*	*-0.2%*	*($35,706,100)*	*-0.3%*
DSH: UCC Payment Changes	($9,543,800)	-0.1%	N/A	N/A	($9,543,800)	-0.1%
> DSH UCC Distribution Factor Change	*$6,248,600*	*0.1%*	*N/A*	*N/A*	*$6,248,600*	*0.1%*
Change in Hospital Specific Rate	($3,100)	0.0%	N/A	N/A	($3,100)	0.0%
MS-DRG Updates	$54,491,600	0.4%	$4,195,500	0.5%	$58,687,100	0.4%
Quality Based Payment Adjustments	($5,900,200)	-0.1%	$15,700	0.0%	($5,884,400)	0.0%
> VBP	*($6,520,800)*	*-0.1%*	*N/A*	*N/A*	*($6,520,800)*	*-0.1%*
> RRP	*$456,300*	*0.0%*	*N/A*	*N/A*	*$456,300*	*0.0%*
> HAC	*$164,400*	*0.0%*	*$15,700*	*0.0%*	*$180,100*	*0.0%*
Net Change due to Low Volume Adjustment	($16,134,900)	-0.1%	($1,072,600)	-0.1%	($17,207,500)	-0.1%

The values shown in the table above do not include the 2% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. Sequestration will reduce FFY 2025 IPPS-specific payments by an estimated $268,853,300.

Outlier Payments

CMS adopts an outlier threshold for FFY 2025 of $46,152 (proposed at $49,237), an increase of 8% and $3,402 from the FFY 2024 amount ($42,750). CMS projects that the outlier threshold for FFY 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 0.957682 to the capital federal rate to fund operating and capital outlier payments, respectively.

Following previous years' approach, CMS will use the latest year of claims data — the FFY 2023 Medicare Provider Analysis and Review File (MedPAR) — and the FFY 2022 Hospital Cost Reporting Information System (HCRIS) data to set the FFY 2025 fix-loss outlier threshold and update MS-DRG weights.

Medicare Disproportionate Share Hospital (DSH) — Uncompensated Care (UCC)

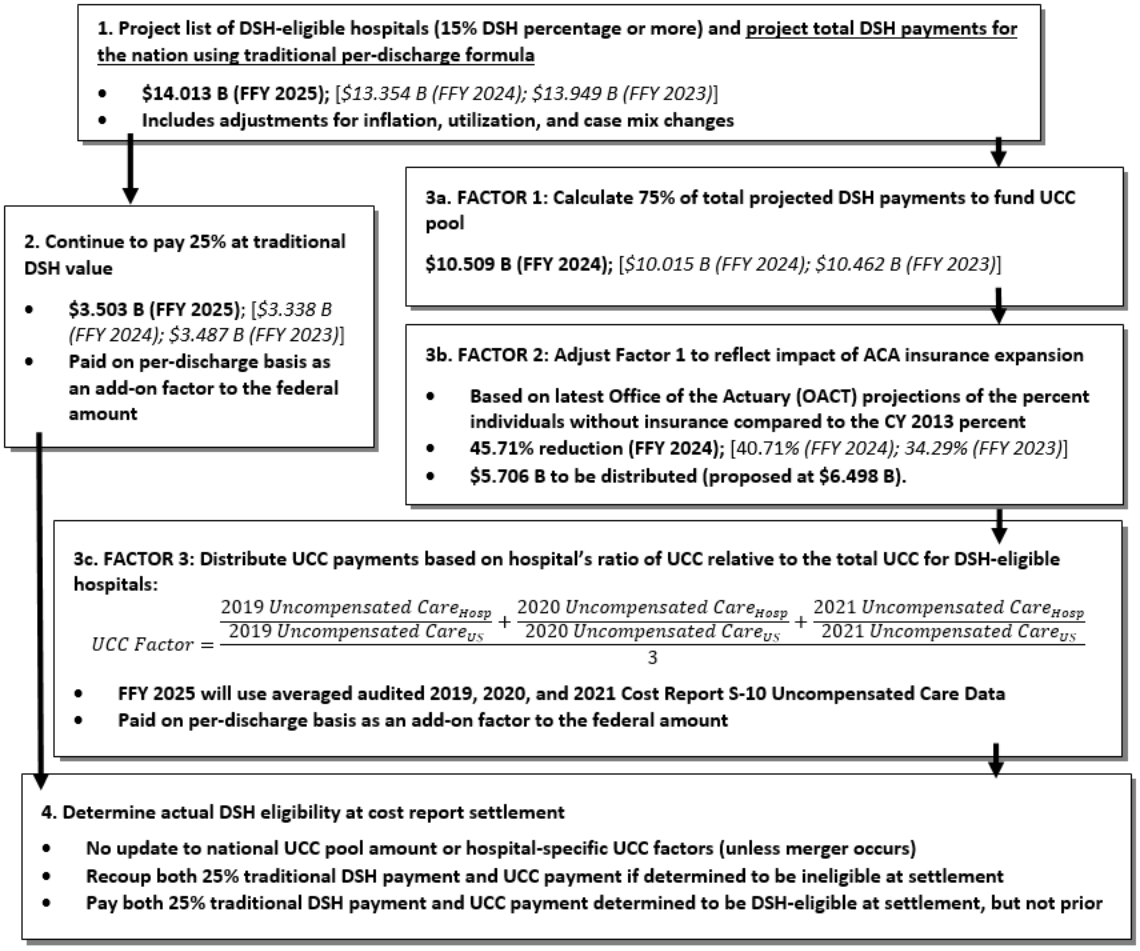
Medicare makes DSH and UCC payments to IPPS hospitals that serve a certain volume of "low income" patients, defined as Medicare-eligible patients who also receive supplemental security income and Medicaid patients who are not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC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

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 program changes from FFY 2024 to FFY 2025:



CMS states that final projected CY 2024 and CY 2025 uninsured rates are lower than those in the proposed rule due to higher expected enrollment in marketplace plans due to "i) the Inflation Reduction Act's extension of the American Rescue Plan Act's enhanced marketplace premium subsidies through 2025 and ii) a Special Enrollment Period open to those who are no longer eligible for Medicaid coverage due to state-based redeterminations." As such, DSH UCC dollars available to hospitals under the ACA's payment formula will decrease by $232 million in FFY 2025 relative to FFY 2024.

The regulatory impact analysis presented in the final 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.

CMS projects 2,399 hospitals would be eligible for DSH payments in FFY 2025. CMS has made available a file that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology.

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) June 2024 Medicare DSH estimates,

which were based on the March 2024 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 June 2024 Medicare estimate of DSH payments for FFY 2025 is $14.013 billion. The Factor 1 amount is 75% of this amount, or $10.510 billion. The final Factor 1 for 2025 is about $495 million more than the final Factor 1 for FFY 2024.

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%; for calendar years (CYs) 2024 and 2025 the rate is 7.3% and 7.7%, respectively. This is lower than the proposed rule estimates of 8.5% and 8.8%, which CMS attributes to an updated calculation of Factor 2 to incorporate more recent data from National Health Expenditure Accounts (NHEA), as well a decrease in expected enrollment in direct purchase insurance. CMS calculates the 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: 7.3%
- Percent of individuals without insurance for CY 2025: 7.7%
- Percent of individuals without insurance for FFY 2025 (0.25 times 0.074) + (0.75 times 0.077): 7.6%

Factor 2 is thus calculated as 1-|((0.076-0.14)/0.14)| = 1 - 0.0457 = 0.5429 (54.29%)

CMS calculated Factor 2 for the FFY 2025 proposed rule to be 0.5429, or 54.29%. The UCC amount for FFY 2025 is expected to be $5.706 billion ($10.510 billion x 0.5428), about $232 million less than the FFY 2024 uncompensated care pool total of about $5.938 billion; the percentage decrease is 3.9%.

FFY 2025 Factor 3

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 UCC payment each eligible hospital will receive.

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

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; the payments are then reconciled following the end of the year.

For FFY 2025 and subsequent fiscal years, CMS will calculate the per-discharge amount for UCC payments using the average of the most recent two years of discharge data, a change from its proposal to use the most recent three years of data. For FFY 2025, CMS will use the average of FFY 2022 and FFY 2023 historical discharge data. For FFY 2026 and beyond, UCC payments will be calculated based on an average of the most recent three years of available historical discharge data, consistent with the proposed rule.

To reduce the risk of overpayments of interim UCC payments and the potential for unstable cash flow 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.

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, listing 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 will utilize FFY 2023 IPPS claims data and FFY 2022 HCRIS data, without modifications, to calculate FFY 2025 rates.

The total number of payable MS-DRGs will be 771 (compared to 764 for FFY 2024). Of those:

- 78.3% will change by less than 5%
- 16.2% will change by at least 5% but less than 10%
- 5.6% will change by more than 10%
- 4% will be affected by the relative weight cap on reductions
- 1.6% are new MS-DRGs

The five MS-DRGs with the greatest year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	MS-DRG Title	Final FFY 2024 Weight	Final FFY 2025 Weight	Percent Change
010	PANCREAS TRANSPLANT	4.8136	7.9726	66.63%
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	3.0320	4.3267	42.70%
770	ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7987	1.0759	37.71%
509	ARTHROSCOPY	1.3661	1.7565	28.58%
599	MALIGNANT BREAST DISORDERS WITHOUT CC/MCC	0.6728	0.8549	27.07%

The full list of the 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.

MS-DRG Changes

CMS adopts changes to a number of MS-DRGs effective for FFY 2025. Specifically, CMS:

- Adds 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)
- Deletes existing MS-DRGs 453, 454, and 455 (Combined Anterior and Posterior Spinal Fusion with Major Complication or Comorbidity [MCC], with Complication or Comorbidity [CC], and without CC/MCC, respectively) and reassigns those procedures to newly adopted groups: MS-DRG 402 (Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical); MS-DRGs 426, 427, and 428 (Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC, with CC, without MCC/CC, respectively); MS-DRGs 429 and 430 (Combined Anterior and Posterior Cervical Spinal Fusion with MCC and without MCC, respectively); and MS-DRGs 447 and 448 (Multiple Level Spinal Fusion Except Cervical with MCC, and without MCC, respectively).
- Reassigns cases that report a principal diagnosis of acute leukemia with an "other" operating room (OR) procedure from MS-DRGs 834, 835, and 836 (Acute Leukemia without Major OR Procedures with MCC, with CC, and without CC/MCC, respectively) to newly adopted MS-DRG 850 (Acute Leukemia with Other OR Procedures). CMS notes that it is also adopting the revision of 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.

CMS modified its proposal to revise the titles of MS-DRGs 459 and 460. Instead, CMS is deleting MS-DRGs 459 and 460 and renumbering them as MS-DRGs 450 and 451 with the titles "Single Level Spinal Fusion Except Cervical" with MCC and without MCC, respectively. These MS-DRGs will also be removed from the post-acute care policy list.

The table on pages 69336-69337 of the final rule details which of these new or revised MS-DRGs are subject to the post-acute care transfer policy for FFY 2025. The table on display page 891 details which of these new or revised MS-DRGs are subject to MS-DRG special payment policy.

Social Determinants of Health (SDOH) Diagnosis Coding

CMS finalizes its proposal to modify the severity level for the following diagnosis codes regarding inadequate housing and homelessness from Non-CC to CC for FFY 2025:

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

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. For FFY 2025, CMS will continue this policy and finalized a budget-neutrality adjustment of 0.999874 (proposed at 0.999617) to the operating rate and 0.9999 (proposed at 0.9996) to the capital rate for all hospitals. The cap only applies if a MS-DRG retains its number from the prior year and will not apply to the relative weight for any new or renumbered MS-DRGs for the year.

CAR-T Cell Therapies

Beginning with FFY 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 FFY 2025, CMS will 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."

Using the FFY 2023 data for determining the final rule FFY 2025 IPPS relative weights, the average costs of cases assigned to MS-DRG 018 that are identified as clinical trial cases ($111,211) were about 33% of the average costs of the cases assigned to MS-DRG 018 that are identified as non-clinical trial cases ($334,119). Accordingly, CMS adopts a payment adjuster of 0.33 to the full payment amount in situations where the hospital does not have a cost for the CAR-T or other immunotherapy product. As in the past, CMS will not apply this payment adjustment to cases where a CAR T-cell therapy product is purchased but the case involves a clinical trial of a different product, as well as where there is expanded use of immunotherapy.

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

Effective for cost reporting periods beginning on or after Oct. 1, 2024, CMS finalizes that the ESRD add-on would be calculated using the annual CY ESRD PPS base rate multiplied by three, for eligible discharges. Under this policy, payments to hospitals will 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 finalizes its proposal to add new MS-DRGs 426, 427, 447, and 448 to the post-acute transfer list. These MS-DRGs will also qualify to receive the special payment methodology. MS-DRGs 459 and 460 are currently subject to the post-acute transfer policy, but CMS removes them from because the finalized revisions to the MS-DRGs make them no longer qualify. All of these MS-DRGs pertain to spinal fusion.

New Technology Payments

The table below lists the 24 technologies CMS finalizes continuing new technology add-on payments for FFY 2025 because the three-year anniversary date of entry into the U.S. market occurs on or after April 1, 2025. The complete table in the final rule (Table II.E.-01) also includes the proposed maximum new technology add-on payments (NTAP) amount for FFY 2025, codes used to identify cases eligible for NTAP, and previous related final rule citations.

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

	Technology	Newness Start Date	NTAP Start Date	Three-Year Anniversary Date of Entry into 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

Continuation of Technologies Approved for FFY 2024 New Technology Add-On Payments Still Considered New for FFY 2025 Because Three-Year Anniversary Date Occurs on or After April 1, 2025				
	Technology	**Newness Start Date**	**NTAP Start Date**	**Three-Year Anniversary Date of Entry into US Market**
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
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	07/19/2026
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 will discontinue NTAP for FFY 2025 because the three-year anniversary date of entry into the U.S. market occurs prior to April 1, 2025. The complete table in the proposed rule also includes the proposed maximum NTAP amount for FFY 2025, codes used to identify cases eligible for NTAP, and previous related final rule citations.

Discontinuation of Technologies Approved for FFY 2024 New Technology Add-On Payments No Longer Considered New for FFY 2025 Because Three-Year Anniversary Date Occurs Prior to April 1, 2025				
	Technology	**Newness Start Date**	**NTAP Start Date**	**Three-Year Anniversary Date of Entry into 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 adopts new technology add-on payments for five technologies under the traditional pathway and 12 under alternative pathways. CMS previously conditionally approved one new technology (taurolidine/heparin) under the alternate pathway for FFY 2024 and will continue payments for this technology for FFY 2025.

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

CMS finalizes its proposal 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 FFY 2025 final rule for the treatment of SCD, effective with discharges on or after Oct. 1, 2024, and concluding at the end of the two- to three-year newness period, to increase the payment percentage from 65% to 75%. This policy will only apply to Casgevy and Lyfgenia when indicated and used specifically for the treatment of SCD. CMS will continue to assess this policy and may propose changes in the future.

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 wage indexes for payments in FFY 2025 is available in Table 2 on the CMS website.

Core-Based Statistical Areas (CBSAs) for the 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 adopts 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 finalizes that FFY 2024 CBSA 31460 (Madera County) would be subsumed by FFY 2025 CBSA 23420 (Fresno).

Worksheet S-3 Wage Data

CMS calculates the final rule FFY 2025 wage index using data from FY 2021 submitted cost reports. CMS does not adopt any changes to the categories of included and excluded costs for FFY 2025 relative to prior years. CMS' calculations of the FFY 2025 wage index are based on wage data of 3,074 hospitals. The data file used to construct the wage index includes FFY 2021 data submitted to CMS as of May 29, 2024.

The wage index data used for the FFY 2025 wage index spans the COVID-19 public health emergency (PHE). The final rule presents data showing a higher proportion of hospitals had an increase in their average hourly wage using the FFY 2020 and FFY 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 calculates an unadjusted national average hourly wage of $55.03.

Occupational Mix Adjustment

CMS will use CY 2022 Occupational Mix Survey to calculate the wage index for FFYs 2025 through 2027. The FFY 2025 occupational mix adjusted wage index based on this survey can be found in Table 2 on CMS' IPPS website. The FFY 2025 national average hourly wage, adjusted for occupational mix, is $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 FFY 2025 wage index for 771 urban hospitals requiring a budget neutrality adjustment factor of 0.977499 (negative 2.25%) applied to hospital wage indexes.

CMS did 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.

Revisions to FFY 2025 Wage Index Based on Geographic Reclassifications

CMS indicates that 1,078 hospitals will be in MGCRB reclassification status for FFY 2025 (with 237 of these hospitals reclassified back to their home area). This figure constitutes 32.5% of IPPS hospitals, and reflects:

- 256 hospitals that were approved for wage index reclassifications starting in FFY 2023 and continuing through FFY 2025
- 256 hospitals that were approved for wage index reclassifications starting in FFY 2024 and continuing through FFY 2025
- 470 hospitals approved for wage index reclassification starting in FFY 2025

Applications for FFY 2026 reclassifications were due to the MGCRB by Sept. 1, 2024. This is also the deadline for canceling a previous wage index reclassification withdrawal or termination for the FFY 2025 cycle. For withdrawal or terminating FFY 2026 reclassifications, CMS finalizes its proposal 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 (i.e., notify CMS by May 24, 2024, that it is declining its Lugar reclassification).

The final 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 out-migration 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 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 finalized its proposal 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 finalizes that 17 of 53 previously urban counties qualify to be Lugar counties. CMS removed 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 applies 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 $65 million to 203 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. No 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 SCHs. This change is discussed in the SCH section below.

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.

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 adjustments when using the lower 62% labor share for hospitals with 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 is implemented in a budget-neutral manner with a final net budget neutrality factor of 0.99953 (proposed at 0.99752) to be applied to the federal operating rate, after backing out the effects of the FFY 2024 adjustment.

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 finalizes its proposal to further extend the policy for FFY 2025 through 2027. Specifically, CMS adopts:

- 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 0.9007 (proposed at 0.8879)
- CMS is applying a budget-neutrality adjustment of 0.99975 (proposed at 1.0001) 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. On July 23, 2024, the U.S. Court of Appeals for the D.C. Circuit affirmed the lower court's ruling, holding that this policy for FFY 2020 was unlawful and that CMS had no statutory authority to issue it. As a result, the court ordered that the rule be vacated and that hospitals affected by the budget neutrality adjustment are entitled to back-payments, including interest. As of the publication of this summary there is still time for the government to seek further review about this decision.

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 Dec. 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*. 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 the ruling. The appeal was argued before the U.S. Court of Appeals for the Ninth Circuit in February and a decision is pending.

In addition to the 2020 litigation, CHA is 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 will 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 1.7789 (national urban hospital CMI excluding teaching hospitals) or the CMI for the hospital's census region (Pacific Census Region, 1.7888)

The median regional CMIs in the final rule reflect the March 2024 update of the FFY 2023 MedPAR file, contains claims received through March 31, 2024. 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 of 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 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 Jan. 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 have been paid based on the IPPS federal rate. With the expiration of the MDH program — absent additional congressional action — these providers will be paid based on the IPPS federal rate beginning with discharges occurring on or after Jan. 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 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 Jan. 1, 2025, the MDH must apply for SCH status at least 30 days before the expiration of the MDH program, or by Dec. 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 finalizes that the indirect medical education (IME) adjustment factor will 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 final rule.

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

The CAA of 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 Jan. 31, 2026. The specifications in CAA of 2023 for awarding additional residents are

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

CMS adopts 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™). CMS considers a number of factors in reviewing applications:

Demonstrated Likelihood. For a hospital to be eligible for additional residents, it must demonstrate a likelihood that it will fill the positions 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 finalizes that a qualifying hospital must also be in at least one of these categories:

- **Located in 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 Dec. 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.** Hospitals located in states that established new medical schools or additional locations and branch campuses on or after Jan. 1, 2000. This category consists of 38 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% 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 one additional resident (or a fraction thereof) 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. Any resident positions awarded to a rural hospital must be used to expand an existing residency that is no longer within its five-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 of 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 four and five, CMS finalizes its proposal 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, a hospital must attest to meeting the CLAS standards to be eligible to receive additional resident positions.

Medicare Payment for Additional Resident Positions. CMS will 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 of 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 of 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. In the FFY 2025 IPPS proposed rule, CMS further clarified its policy on what it means for a medical residency training program to be "new." However, in response to a lack of consensus in public comments, CMS is not finalizing any of its clarifications and is initiating a request for information seeking comment on the appropriate criteria regarding newness of residents. CMS says commenters should review and consider the broad statutory authority provided to the Secretary in this area, CMS' prior rulemaking on this issue, and all of the public comments on this final rule.

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.[1] CMS appears to believe that this "comingling" of residents in new and existing programs allows an existing program to increase the number of residents even though it is not new. CMS requested comments on this issue. No comments were submitted, and no action is being taken.

1 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.

One Hospital Sponsoring Two Programs in the Same Specialty. CMS clarifies that a single hospital may sponsor two programs in the same specialty if each program has separate program directors, separate staff, and separately matched residents.

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 Sacred Heart Hospital located in Eau Claire, Wis.:

Available Resident Cap FTEs

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME Resident Cap	DGME Resident Cap
520013	Sacred Heart Hospital	Eau Claire, Wis.	20740	March 22, 2024	7.62	7.80

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 Oct. 30, 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.

CMS will use 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 2.74% 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 annual update to the TEFRA

limit is 3.4%, based on IGI's 2024 second quarter forecast of the hospital market basket for FFY 2025 with historical data through the first quarter of 2024.

Establishing and Maintaining Access to Essential Medicines

For cost reporting periods beginning on or after Oct. 1, 2024, CMS finalizes its proposal 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 will be provided biweekly or as a lump sum at cost report settlement.

To prevent this policy from either exacerbating existing shortages or contributing to hoarding, CMS finalizes 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 finalizes its proposal to use 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 1065-1066). CMS also adopts 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 finalizes a mandatory five-year episode-based payment model (Jan. 1, 2026–Dec. 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 Finalized Transforming Episode Accountability Model

Acute care hospitals paid under the IPPS are the only entities that may initiate episodes under TEAM. Participation will be mandatory for hospitals in selected CBSAs. Additionally, hospitals that are currently in either the Center for Medicare and Medicaid Innovation (CMMI) Bundled Payment for Care Improvement Advanced (BPCI-A) or Comprehensive Care for Joint Replacement (CJR), and participate through the termination of the model, may elect to participate in TEAM.

TEAM participants (not other providers and suppliers involved in the care provided during an episode) exclusively bear financial accountability for performance under the model[2]. In the case of episodes involving multiple hospitalizations, financial accountability would fall to the TEAM participant that initiated the episode.

2 However, TEAM participants may enter into upside and downside risk-sharing arrangements with providers involved in an episode of care. Additional details below.

TEAM will consist of three tracks defined by varying levels of potential risk and reward:

- Track 1 is available only in performance year (PY) 1 for all TEAM participants and in years 2-3 for qualifying safety-net hospitals and would have only upside financial risk with quality adjustment applied to positive reconciliation amounts.
- Track 2 is available in PYs 2 through 5 to rural, safety-net hospitals, MDHs), SCH, and Essential Access Community Hospitals and would have two-sided financial risk with quality adjustment to reconciliation amounts.
- Track 3 is available in PYs 1 through 5 for all TEAM participants and would have two-sided financial risk with quality adjustment to reconciliation amounts.

In the final rule, CMS provided more time in lower-risk track options for safety-net and rural hospitals given these facilities are typically less able to take on substantial financial risk. The table below summarizes the TEAM tracks.

Summary of Final TEAM Participation Tracks			
Risk Track	**Performance Year (PY)**	**TEAM Participant Eligibility**	**Financial Risk**
Track 1	PY 1	All participants	- Upside only (10% stop-gain limit) - Composite quality score (CQS) adjustment percentage of up to 10% for positive reconciliation amounts
Track 1	PYs 1-3	Safety-net hospitals	- Upside only (10% stop-gain limit) - CQS adjustment percentage of up to 10% for positive reconciliation amounts
Track 2	PYs 2-5	- Safety-net hospitals - Rural hospitals - Medicare dependent hospitals - Sole community hospitals - Essential access community hospitals	- Upside/downside risk (5% stop-gain/stop-loss limit) - CQS adjustment percentage of up to 10% for positive reconciliation amounts and 15% for negative reconciliation amounts
Track 3	PYs 1-5	All participants	- Upside/downside risk (20% stop-gain/stop-loss limits) - CQS adjustment percentage of up to 10% for positive and negative reconciliation amounts

For PY 1, a TEAM participant may elect to participate in either Track 1 or Track 3. TEAM participants that are safety-net hospitals and wish to participate in Track 1 for PYs 2 and 3 must notify CMS of their track selection prior to each performance year. TEAM participants may switch between tracks; however, if a participant fails to timely notify CMS of their election to participate in Track 1 or Track 2, they will be assigned to Track 3 for the performance year they were requesting Track 1 or Track 2 participation.

California CBSAs Selected for Mandatory Participation

Acute care hospitals located in the California CBSAs below are required to participate in TEAM.

Mandatory TEAM Markets: California	
CBSA	**CBSA Name**
12540	Bakersfield-Delano
18860	Crescent City
21700	Eureka-Arcata
25260	Hanford-Corcoran
40140	Riverside-San Bernardino-Ontario
41740	San Diego-Chula Vista-Carlsbad
41860	San Francisco-Oakland-Fremont
41940	San Jose-Sunnyvale-Santa Clara
42020	San Luis Obispo-Paso Robles
42220	Santa Rosa-Petaluma

CMS has provided a list of the specific hospitals that will be required to participate in the model, available on the CMS TEAM website.

Selected Episodes

CMS limits the episodes in TEAM to those included in BPCI Advanced (BPCI-A) and consists of high-expenditure, high-volume care delivered to Medicare beneficiaries. CMS does not include medical episodes in TEAM. The selected episode categories and billing codes are summarized in the table below.

Final Episodes Selected for TEAM	
Episode Category	**Billing Codes (MS-DRG/HCPCS)**
Lower Extremity Joint Replacement (LEJR)	MS-DRG 469, 470, 521, 522 HCPCS 27447, 27130, 27702
Surgical Hip and Femur Fracture Treatment (SHFFT)	MS-DRG 480, 481, 482
Coronary Artery Bypass Graft (CABG)	MS-DRG 231, 232, 233, 234, 235, 236
Spinal Fusion	MS-DRG 402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473 HCPCS 22551, 22554, 22612, 22630, 22633
Major Bowel Procedure	MS-DRG 329, 330, 331

CMS defines 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. Pricing for the lowest-acuity LEJR and spinal fusion episodes will include both procedures performed on an inpatient and outpatient basis, in effect creating site-neutral pricing. This is similar to other CMMI bundled payment models.

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 as Major Diagnostic Categories (MDC)[3]
- New technology add-on payments for drugs, technologies and services identified by value code 77 on IPPS claims

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

Quality Measures and Reporting

CMS finalizes three initial measures for TEAM. Reconciliation payments to participants will be adjusted based on performance on these measures. 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 (PSI-90) (CMIT ID #135)
- Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618). (LEJR Only)

Beginning with PY 2, CMS will remove PSI-90 and replace it with the three following patient safety-focused measures:

- 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)

TEAM participants will 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.

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

Pricing and Payment Methodology

CMS finalizes using three years of baseline data, trended forward to the performance year, to calculate target prices at the level of MS-DRG/Healthcare Common Procedure Coding System (HCPCS) episode type and region. CMS will 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 (third) 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 will 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 MCC, as CMS expects those beneficiaries to have similar clinical characteristics and costs. CMS will cap high-cost outlier episodes at the 99th percentile for each of the MS-DRG/HCPCS episode types and nine regions (which CMS defines as the nine U.S. Census divisions).

CMS will use 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. TEAM participants will be provided the regional prices as episode targets, rather than hospital-specific or a blend of regional/hospital-specific prices.

CMS will apply a prospective trend factor and a variable discount factor 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. In light of comments expressing concerns about this methodology resulting in inaccurate target prices that disadvantage hospital participants, CMS in the final rule adjusted the target price methodology to include a 3% capped retrospective trend factor adjustment applied during reconciliation to construct reconciliation target prices.

CMS initially proposed a 3% discount factor to achieve Medicare's portion of potential savings from the episode. However, due to concerns that this was too high, CMS lowered the discount factor and varied it by episode as illustrated in the table below.

Final Discount Factors Applied to TEAM Episodes	
Episode	**Discount Factor**
LEJR/SHFFT/Spinal Fusion	2%
CABG/Major Bowel Procedure	1.5%

CMS will 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 will calculate 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. 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% of the prospective normalization factor.

CMS also proposed, but did not finalize, a low-volume threshold policy under TEAM for purposes of reconciliation. In the proposed rule, if a TEAM participant did not meet the proposed low-volume threshold of at least 31 total episodes in the baseline period for PY 1, CMS would still reconcile their episodes but the TEAM participant would be subject to the Track 1 stop-loss and stop-gain limits for PY 1. 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. However, based on comments received, CMS did not finalize the low-volume threshold and stated that it will address this issue in subsequent rulemaking.

Risk Adjustment and Normalization. CMS substantially altered its risk adjustment approach and is now finalizing an approach that involves episode category-specific risk adjusters. Common to each episode are beneficiary age, Hierarchical Condition Category (HCC) count, and beneficiary social risk. Hospital bed size, hospital safety-net status, prior post-acute care use, long-term care use, dementia, disability, and a procedure-related variable are used in the risk adjustment for several of the episode categories. In addition, CMS uses 11 to 16 HCCs unique to each episode category. The episode-specific risk adjusters are included in Appendix 2 of this summary.

The risk adjustment methodology uses an HCC count variable. While CMS proposed collecting HCCs from the fee-for-service (FFS) claims for each beneficiary starting 90 days before the anchor hospitalization/ procedure, it did not finalize this proposal. Instead, the agency will address this issue in a future regulation.

The TEAM risk adjustment methodology also includes 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 (above 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).

Process for Reconciliation. CMS will conduct an annual reconciliation calculation that would compare PY 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. As part of the annual reconciliation process, CMS finalizes its approach to adjust the difference between the TEAM participant's performance year spending and their reconciliation price (the reconciliation amount) by its CQS, an approach similar to that used in CJR and BPCI-A.

The baseline period for the Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356) measure, CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135) measure, and the Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618) is CY 2025 baseline (as proposed).

The baseline period for the Hospital Harm – Falls with Injury (CMIT ID #1518) measure, the Hospital Harm – Postoperative Respiratory Failure (CMIT ID #1788) measure, and the Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (CMIT ID #134) measures will use a CQS baseline period of CY 2026.

CMS will 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 and non-participant hospitals, in the CQS baseline period, so that each measure has a scaled quality measure score between 0 and 100 for each episode category. CMS finalizes a modification to its scaled score proposal for inverse quality measures, assigning a scaled score of 0 if the TEAM participant has a raw quality measure score greater than the maximum of the raw quality measure scores in the CQS baseline period and assigning a scaled quality measure score of 100 if the TEAM participant has a raw quality score less than the minimum of the raw scores in the CQS baseline period.

Prior to calculating the CQS, the quality measures will 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 will take the quality measures normalized weights and combine 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 will 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 will adjust the reconciliation amount

for quality performance, and then apply stop-loss and stop-gain limits to calculate the Net Payment Reconciliation Amount (NPRA).[4]

CMS will apply 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.-13 of the final rule, reproduced below.

TABLE X.A.-13 – TEAM 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 PY 1 but would be subject to a stop-gain limit of 10%. Track 2 TEAM participants would be subject to downside and upside risk with symmetric stop-gain and stop-loss limits of 5% for PYs 2-5.

TEAM participants that opt into Track 3 are 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 will calculate total Part A and Part B spending in the 30-day period following the completion of each episode to monitor for cost-shifting outside of the episode window. Starting in PY 1 for Track 3 TEAM participants, and PY 2 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 finalized elsewhere in the rule.

Reconciliation Payments and Repayments. For the PY 1 reconciliation process for Track 1 TEAM participants, CMS will combine a TEAM participant's NPRA and post-episode spending amount. 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.

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

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

A beneficiary can 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 (e.g. Medicare Shared Savings Program). This allows savings generated on an episode in TEAM, and any contribution to savings in the total cost of care model, to be retained by each respective participant. The episode spending in TEAM will 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

For purposes of TEAM, CMS defines safety-net hospitals and rural hospitals and describes flexibilities that are afforded to these providers. In this context, CMS defines "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 that bill Medicare.[5] CMS will identify and share a list of hospitals designated as "safety-net" prior to the start of PY 1.

With respect to identifying rural hospitals, because TEAM participants would be selected from CBSAs, by definition no rural hospitals would be explicitly included in TEAM. CMS defines "rural hospitals" for purposes of TEAM as IPPS hospitals located in rural areas as defined under §412.64 or located in rural census tracts defined under §412.103(a)(1). CMS initially proposed including hospitals that reclassified as a rural hospital under §412.103 or is designated a RRC under §412.96 as rural. However, these two hospital types were excluded from the final rule's definition of rural.

Beneficiary Social Risk Adjustment. CMS incorporates and equally weights 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).

Health Equity Plans and Reporting. 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 all five years of the model. 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 initially proposed that these plans would be mandatory for TEAM participants beginning in PY 2; however, the final rule eliminated this requirement.

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

Similarly, TEAM participants may voluntarily submit demographic data (including data on race, ethnicity, language, disability, sexual orientation, gender identity, sex characteristics, and other demographics) to CMS for all five performance years. CMS proposed this would become mandatory in PY 2 and subsequent years; however, it did not finalize this as a mandatory requirement.

TEAM participants may screen attributed TEAM beneficiaries for at least the following four health-related social needs (HRSN) domains: food insecurity, housing instability, transportation needs, and utilities difficulty. The agency is finalizing its proposed HSRN screening and reporting requirements on a voluntary basis, in a manner that follows the reporting of SDOH-1 and SDOH-2 measures in the Hospital IQR Program.

Financial Arrangements

CMS believes it necessary to provide TEAM participants with the ability to engage in financial arrangements to share reconciliation payment and repayment amounts. With the arrangements finalized, CMS makes the determination that the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR 1001.952(ii)) is available to protect certain remuneration finalized in this section when arrangements with eligible providers and suppliers are in compliance with this rule and 42 CFR 1001.952(ii).

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 accountable care organization (ACO) initiative may be TEAM collaborators:

- Skilled-nursing facility
- Home health agency
- Long-term care hospital
- Inpatient rehabilitation facility
- Physician
- Nonphysician practitioner
- Therapist in a private practice
- Comprehensive Outpatient Rehabilitation Facility
- 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

Commenters suggested adding hospice, rural emergency hospitals, device manufacturers, and other types of non-physician practitioners (e.g., registered dieticians) to the proposed list of TEAM collaborators. CMS indicates that it will consider these suggestions in future rulemaking but did not add them to the list in this final rule.

Sharing Arrangements. CMS finalizes 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 enable sharing of 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. 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 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:
    - 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 finalizes that 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.

Last, 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 requires that 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: quality of care criteria and 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 establishes similar requirements for PGPs, NPPGPs, and TGPs that vary because these entities do not directly furnish billable services.

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.

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.[6]

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. Certain financial arrangements between TEAM collaborators and other individuals or entities called "collaboration agents" are 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, 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 for distribution arrangements largely parallel those 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 non-participation, and the distribution arrangement must require the collaboration agent to comply with all applicable laws and regulations.

Again, as with sharing arrangements, a collaboration agent can only receive a distribution payment if they furnished or billed for an item or service rendered to a beneficiary during an

6 For example, CMS proposed 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 could 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.

episode that occurred during the same performance year for which the TEAM participant accrued the internal cost savings or earned a reconciliation payment amount that comprises the gainsharing payment being distributed. The total amount of all distribution payments in a performance year must not exceed the amount of the gainsharing payment received by the TEAM collaborator from the TEAM participant for that performance year. Documentation requirements are similar to those CMS finalized with respect to sharing arrangements.

TEAM collaborators may not enter into a distribution arrangement with any individual or entity that has a sharing arrangement with the same TEAM participant. Allowing both types of arrangements for the same individual or entity for care of the same beneficiary during the performance year could 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. 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. Items and services above $75 in retail value remain the property of the TEAM participant and must be returned[7] to the TEAM participant at the end of the episode.

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. 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 finalized all documentation requirements as proposed for all beneficiary incentives.

Waivers of Medicare Program Requirements

Homebound and "Incident-To" Rules. CMS does not remove the requirements that a beneficiary be "homebound" in order to receive home health services in the final rule, nor does CMS 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.

7 The rule 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.

Telehealth. CMS waives 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 also finalizes a set of nine HCPCS G-codes to describe the evaluation/management 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 Three-Day Requirement. CMS waives 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.[8] 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 does 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, nor could TEAM participants charge any TEAM collaborator a fee to be included on any list of preferred providers.

TEAM participants must require all ACOs, providers, and suppliers that 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 Medicare FFS patients who would be included under the model.

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

The federal government has the right to audit, inspect, investigate, and evaluate any documents and other evidence regarding implementation of TEAM. 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, 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 will make 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

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

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 will also make 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.

Referral to Primary Care Services

TEAM participants are required to include in hospital discharge planning a referral to a supplier of primary care services for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure. TEAM participants must also comply with beneficiary freedom of choice requirements, as described in the Beneficiary Choice and Notification section of the final rule. and not limit a TEAM beneficiary's ability to choose among Medicare providers or suppliers. If a TEAM participant fails to comply with requiring a referral to a supplier of primary care services during hospital discharge planning, then the TEAM participant would be subject to remedial action.

Decarbonization and Resilience Initiative

CMS finalizes the proposal for a voluntary Decarbonization and Resilience Initiative within TEAM. The voluntary initiative has two elements: technical assistance for all interested TEAM participants and a voluntary reporting option(which CMS expands in final rule to also allow the TEAM participant's corporate affiliates to participate) to capture information related to Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol framework,[9] with the potential to add Scope 3 in future years.

Technical Assistance. CMS will 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 greenhouse gas 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. TEAM participants and their corporate affiliates could elect to report metrics and questions related to emissions to CMS on an annual basis following each

9 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

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 finalizes four areas for reporting:

- Organizational questions
- Building energy metrics
- Anesthetic gas metrics
- Transportation metrics

CMS finalizes specific metrics under each of these four areas. CMS also finalizes a set of questions that TEAM participants opting into the initiative would be required to answer. TEAM participants electing to participate in the Decarbonization and Resilience Initiative will 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. TEAM participants who elect to report all the metrics identified will receive individualized feedback reports and be eligible to receive public recognition for their commitment to decarbonization.

Termination of the TEAM

CMS indicates the agency will 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 – Obstetrical Services Standards for Hospitals, CAHs, and REHs

In the proposed rule, CMS announced its intent 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 subsequently proposed these requirements in the CY 2025 OPPS proposed rule, and CHA refers readers to CHA's proposed rule summary for details on the proposal, as well as CHA's comment letter on the proposed rule.

CoP Requirements for Hospitals and CAHs to Report Respiratory Illness

CMS finalizes its proposal to revise the hospital and CAH infection prevention and control program and antibiotic stewardship program CoPs to extend a modified form of COVID-19 and influenza reporting requirements to include data for respiratory syncytial virus (RSV) and reduce the frequency of reporting — which was required daily during the PHE — for hospitals and CAHs.

The finalized requirements will be required beginning Nov. 1, 2024, a 30-day delay from the proposed rule, which would have required weekly reporting beginning on Oct. 1. In addition, CMS agreed with commenters that certain data elements should be reported weekly as a "snapshot" of a day in a specific week, while others should be reported in aggregate. The finalized data elements are included in the table below:

One-Day-a-Week Snapshot	Weekly Total New Hospital Admissions
• Staffed bed capacity and occupancy including adult and pediatric • Hospitalizations prevalence by respiratory illness and bed type	• Total new hospital admissions for adult and pediatric patients by age range, over a defined weekly period

Data must be reported weekly via a Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) or other CDC-owned or supported system, as determined by the Secretary. Updated guidance for reporting these data elements will be posted on the CDC's website in the coming weeks.

CMS also finalized its proposal that during state, local or national PHEs for acute infectious illnesses as declared by the Secretary of HHS, the agency could add additional reporting requirements or increase the reporting frequency. However, CMS did not adopt its proposal that would have permitted the agency to increase reporting requirements in the event of a "likely" PHE. CMS also did not adopt its proposal to require the reporting of more detailed patient demographic information, including race, ethnicity. and social drivers of health information.

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 Jan. 1-June 30, 2020, from calculations for each of the three quality programs. CMS did not adopt changes to the HRRP or HAC programs. Additional details on each program are 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 did not adopt any changes to the HRRP in this final 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 to 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's FFY 2024 IPPS final rule summary has more details.

In this final rule, CMS adopts changes to the hospital VBP scoring methodology to account for its related policy (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 measures for the program.

Changes to Scoring Methodology for HCAHPS Measure

In alignment with changes finalized to the HCAHPS Survey measure for the IQR program (described in the IQR section of this summary), CMS will adopt the same updates to the VBP program beginning FFY 2030. The measure will be modified in the IQR program beginning with FFY 2027. As a result, CMS adopts 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 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 modifies the scoring of the HCAHPS survey to account for the finalized modifications to the measure, which would include nine dimensions of the survey:

- Score hospitals on the nine dimensions of the survey, which includes newly adopted 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 will still range from 0 to 80 points

- The Consistency Points will still range from 0 to 20 points, calculated on the nine dimensions

Performance and Baseline Periods
Table 3 in the appendix shows the baseline and performance periods for each measure for FFY 2026 through 2030.

Performance Standards
Tables V.L.-08 through V.L.-12 of the final rule have previously established and newly estimated performance standards for the measures in the FY 2027, FY 2028, FY 2029, and FY 2030 program years.

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 adopt 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 adopts 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 adopts 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 newly finalized measure set for FFY 2024 through FFY 2027.

Proposed Measures in the Hospital IQR Measure Set

CMS adopts seven new measures for the IQR program with a focus on patient safety measures and age-friendly care.

Patient Safety Structural Measure
CMS adopts 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 final rule, reproduced below, shows the five attestation domains and corresponding attestation statements. Notably, in response to comments from CHA, CMS

modified Domain 4, Statement B. In the proposed rule, the statement read, "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." In the final attestation statement below, CMS removed the portion related to voluntary reporting to the Network of Patient Safety Databases (NPSD) and to remove references to whether the hospital reports patient safety work product to a Patient Safety Organization (PSO). All other attestation statements remain the same as proposed.

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 boards at hospitals set the tone for commitment to patient safety. They must be accountable for patient safety outcomes and ensure that patient safety is the highest priority for the hospital. While the hospital leadership and the governing board may convene a board committee dedicated to patient safety, the most senior governing board must oversee all safety activities and hold the organizational leadership accountable for outcomes. Patient safety should be central to all strategic, financial, and operational decisions.	(A) Our hospital senior 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 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 three 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. Identifying goals, metrics, and practices to advance progress is	(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

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, therefore equity, with the goal of safety for all individuals, must be embedded in safety planning, goal-setting, policy, and processes.	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 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.	(A) Our hospital conducts a hospital-wide culture of safety survey using a validated instrument annually, or every 2 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. (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 five days a week, with one 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, which 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 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.	(A) Our hospital has a confidential safety reporting system that allows staff to report patient safety events, near misses, precursor events, unsafe conditions, and other concerns, and prompts a feedback loop to those who report. (B) Our hospital voluntarily works with a Patient Safety Organization listed by the Agency for Healthcare Research and Quality (AHRQ) to carry out patient safety activities as described in 42 CFR 3.20, such as, but not limited to, the collection and analysis of patient safety work product, dissemination of information such as best practices, encouraging a culture of safety, or activities related to the operation of a patient safety evaluation system. (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, which 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.

An attestation guide is available on the QualityNet website.

The measure is scored similarly to the existing "Hospital Commitment to Health Equity" measure. A hospital earns 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 will 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 will need to satisfy these criteria for the hospital to affirmatively attest and receive points.

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

Age Friendly Hospital Measure

CMS adopts 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 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 monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm.	(A) Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMS should be considered for discontinuation, and/or dose adjustment as indicated.
Domain 3: Frailty Screening and Intervention	
This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and 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.

The measure consists of five domains and corresponding attestation statements. For each domain, to receive a point for the domain, hospitals will need to affirmatively attest to all the statements within the domain for each hospital reported under their CCN, with a total of five possible points (one per domain). Partial points are not available. However, because the Hospital IQR Program is a pay-for-reporting program, hospitals will receive credit for reporting results regardless of their responses or points. An attestation guide is available on the QualityNet website.

The measure will be reported once annually using a CMS-approved web-based data collection tool available within the HQR System. Reporting of the measure will be required 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 adopts this measure to encourage best practices (set by the CDC) for the use of urinary catheters to reduce the incidence of CAUTIs for patients with cancer. While the measure will not duplicate existing CAUTI reporting requirements, hospitals will need to verify that all locations, including those with oncology patients, are mapped in NHSN in order to report the measure. Guidance on mapping patient care locations in NHSN is available on the CDC's website.

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 will be collected through the CDC's NHSN. For purposes of the Hospital IQR Program requirements, hospitals will report data for the CAUTI-Onc measure quarterly. Hospitals will 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 adopts 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. As with the CAUTI-Onc measure described above, hospitals will 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 will be collected through the CDC's NHSN. For purposes of the Hospital IQR Program requirements, hospitals will 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 adopts 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 adds 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 adopts 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 will 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 will 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 will 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 adds 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 adopts 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 FFY 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, which will be removed as described below.

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 will not be required to report additional data. The measure will 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).

Refinements to Current IQR Program Measures

CMS adopts 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 modifies the HCAHPS Survey measure. As described earlier in this summary, CMS also adopts 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.

The new survey includes three new sub-measures:

- 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 will also remove the “Care Transition” sub-measure. The new “Care Coordination” sub-measure expands on the “Care Transition” sub-measure and is more consistent with other survey questions. This measure will no longer be reported starting January 2026. The existing “Responsiveness of Hospital Staff” sub-measure will also be modified

to replace one of the two survey questions in the current measure with a new question that strengthens the measure.

Seven new questions to address aspects of hospital care identified by patients will 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 caregivers 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 removes the following questions. The first is removed because the hospital call button has been replaced by other mechanisms. The other questions are removed because they do not comply with standard HCAHPS 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 modifies 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 will not be included in public reporting of the survey, nor will they affect scoring under the HVBP

Program. The "Hospital Stay Planned in Advance" question will 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 modifies the measure by expanding the patient cohort to all patients 18 and older.

Measure Removals for the IQR Program

CMS removes 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 removes 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 measure is being replaced by the new Failure-to-Rescue measure described earlier in this summary.

Removal of Four Clinical Episode-Based Payment Measures Beginning with FY 2026 Payment Determination
CMS removes 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 increase eCQM reporting requirements, including specifying more mandatory measures.

eCQM Reporting Requirements

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 will progressively increase the number of mandatory eCQMs that a hospital must report beginning with the CY 2026 reporting period/FFY 2028 payment determination. However, CMS did finalize a more gradual increase than was proposed. so that by the 2028 reporting period (rather than 2027 as proposed), hospitals will report data for a total of 11 eCQMs, eight of which would be specified by CMS. The table below lists the specific reporting requirements for reporting periods through CY 2028.

Reporting Period	Payment Determination	Number of Required eCQMs	eCQM Requirements
CYs 2024 and 2025	FFYs 2026 and 2027	6	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications
CY 2026	FFY 2028	8	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications • Hospital Harm – Severe Hyperglycemia • Hospital Harm – Severe Hypoglycemia
CY 2027	FFY 2029	9	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications • Hospital Harm – Severe Hyperglycemia • Hospital Harm – Severe Hypoglycemia • Hospital Harm – Opioid-related Adverse Events
CY 2028	FFY 2030	11	Three self-selected eCQMs AND: • Safe Use of Opioids – Concurrent Prescribing • Cesarean Birth • Severe Obstetric Complications • Hospital Harm – Severe Hyperglycemia • Hospital Harm – Severe Hypoglycemia • Hospital Harm – Opioid-related Adverse Events • Hospital Harm – Pressure Injury • Hospital Harm – Acute Kidney Injury

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 finalizes that, beginning with CY 2025 eCQM data affecting the FFY 2028 payment determination, eCQM validation scoring will be based on the accuracy of the data. Under this revised process, CMS will assess the extent to which eCQM data abstracted for validation matches the measure data that hospitals submit in their Quality Reporting Document Architecture-I (QRDA-I) files. CMS will calculate a validation score in the same way it does for chart-abstracted measures, and hospitals will need to achieve at least a 75% score to pass eCQM validation. In addition, the validation scores for chart-abstracted measures and eCQMs will be weighted equally. That is, hospitals would need to achieve validation scores of at least 75% 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.

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, beginning with 2023 discharges affecting the FFY 2026 payment determination, CMS will 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 adopts one new measure — the Patient Safety Structural Measure — and modifies the HCAHPS measure consistent with changes adopted for the IQR and hospital VBP programs beginning with the CY 2025 reporting period/FFY 2027 program year. The IQR section of this summary has more details on the newly adopted and modified measures.

CMS finalizes its proposal 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 measure set for the program.

Medicare Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program hospitals that are not identified as meaningful EHR users are subject to a reduction equal to three quarters of the

market basket. A critical access hospital that is not identified as a meaningful user is subject to a payment reduction to 100% of reasonable costs, from the 101% of reasonable costs it might have otherwise earned.

CMS adopts 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 IQR requirements.

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 finalizes its proposal 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 adds an exclusion for hospitals when they do not have a data source containing the minimal discrete data elements that are required for reporting. This exclusion will be applied to both measures, as will exclusion #1 described above. Exclusion #2 described above will be applied to the AU measure and exclusion #3 described above will be applied to the AR measure to align the appropriate exclusion to the data on which each separate measure would rely.

CMS also adopts active engagement for both measures. Eligible hospitals and CAHs are permitted to spend one EHR reporting period at the Option 1: Pre-Production and Validation

level of active engagement. However, for the following EHR reporting period, they must advance to the Option 2: Validated Data Production level when reporting the measure.

CMS does not adopt 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 will continue to be valued at 25 points for reporting of all required measures and the current exclusion redistribution policy will be maintained.

Scoring Methodology for the EHR Reporting Period in 2025

In general, CMS does not adopt changes to the scoring methodology for the CY 2025 EHR reporting period. However, CMS does finalize its proposal to increase the minimum scoring threshold but in a more gradual manner than as proposed. Specifically, CMS will increase the minimum scoring threshold from 60 to 70 points in CY 2025, and to 80 points in CY 2026.

To be considered a meaningful user of EHR technology in the CY 2025 reporting period, 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 70 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	25 points	If an exclusion is claimed for all 6 measures, 25 points

	• Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AU Surveillance • AR Surveillance		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.

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

In alignment with the hospital IQR Program, CMS adopts 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 modifies the Global Malnutrition Composite Score eCQM to add patients ages 18 to 64 to the current cohort of patients 65 years or older. The IQR Program section of this summary includes details of the newly adopted eCQMs

Consistent with the IQR program, CMS will progressively increase the number of mandatory eCQMs that a hospital must report beginning with the CY 2026 reporting period/FFY 2028 payment determination. By the 2028 reporting period, hospitals would report data for a total of 11 eCQMs, eight of which would be specified by CMS. The IQR section of this summary offers a table listing the finalized eCQM reporting requirements.

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 will 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.

Update the Definition of Meaningful EHR User for Health Care Providers That Have Committed Information Blocking

CMS notes that the final rule establishing disincentives for a health care provider determined by the HHS Office of Inspector General (OIG) to have committed information blocking was issued on July 1, 2024. Under that final rule, if the OIG determines a hospital committed information blocking, it refers the hospital to CMS during a calendar year of an EHR reporting period. The hospital is not considered a meaningful EHR user in that reporting period or payment adjustment year. This means the hospital will be subject to the downward payment adjustment two years after the year of the referral (except that CAHs would have the downward payment adjustment

apply to the payment adjustment year in which the OIG referral was made). An eligible hospital subject to this disincentive will be subject to a three-quarters reduction of the annual market basket increase, and a CAH subject to this disincentive will have its payment reduced to 100% of reasonable costs, from the 101% of reasonable costs it might have otherwise earned, for failing to qualify as a meaningful EHR user in an applicable year.

Appendix 1 — 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; HH-HYPO, and HH-HYPER, AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 *GMCS* HH-PI HH-AKI ExRad HH-ORAE HH-FI HH-RF	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications; HH-HYPO, HH-HYPER, and HH-ORAE, AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 *GMCS* ExRad HH-PI,* HH-AKI* 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)				X	X
CLABSI-Onc (CBE #0139)				X	X
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	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)			X	X	X
Efficiency/Payment					
AMI payment per 30-day episode of care (CBE #2431)	X	Remove			
Heart Failure payment per 30-day episode of care (CBE # 2436)	X	Remove			
Pneumonia payment per 30-day episode of care (CBE #2579)	X	Remove			
THA/TKA payment per 30-day episode of care	X	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
Structural Measures					

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2025	**2026**	**2027**	**2028**	**2029**
Maternal Morbidity	X	X	X	X	X
Hospital Commitment to Health Equity (HCHE)		X	X	X	X
Patient Safety			X	X	X
Age Friendly Hospital			X	X	X
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

*HH-PI and HH-AKI will be required for reporting beginning with the FFY 2030 payment determination (had been proposed for FFY 2029)

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

VBP: Baseline and Performance (Perf.) Periods by Measure for the FFYs 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
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										

VBP: Baseline and Performance (Perf.) Periods by Measure for the FFYs 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
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 adopts that for the FY 2027, FY 2028, and FY 2029 program years, it will 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 adopts the substantive updates to the HCAHP Survey beginning with the FFY 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).

Table 4

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 5

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

Appendix 2 – TEAM Episode Specific Risk Adjusters

CABG Episodes: 17 Risk-Adjustment Variables
Age bracket variable
HCC count variable
Prior post-acute care use variable
Beneficiary social risk variable
Hospital bed size variable (based on four categories: 250 beds or fewer, 251 –500 beds, 501 – 850 beds, and 850 beds or more)
Safety-net hospital status variable

HCCs:

1. HCC 18: Diabetes with Chronic Complications
2. HCC 46: Severe Hematological Disorders
3. HCC 58: Major Depressive, Bipolar, and Paranoid Disorders
4. HCC 84: Cardio-Respiratory Failure and Shock
5. HCC 85: Congestive Heart Failure
6. HCC 86: Acute Myocardial Infarction
7. HCC 96: Specified Heart Arrhythmias
8. HCC 103: Hemiplegia/Hemiparesis
9. HCC 111: Chronic Obstructive Pulmonary Disease
10. HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
11. HCC 134: Dialysis Status

SHFFT Episodes: 21 Risk-Adjustment Variables
Age bracket variable
HCC count variable
Beneficiary social risk variable
Hospital bed size variable
Safety-net hospital status variable

HCCs:

1. HCC 18: Diabetes with Chronic Complications
2. HCC 22: Morbid Obesity
3. HCC 82: Respirator Dependence/Tracheostomy Status
4. HCC 83: Respiratory Arrest
5. HCC 84: Cardio-Respiratory Failure and Shock
6. HCC 85: Congestive Heart Failure
7. HCC 86: Acute Myocardial Infarction
8. HCC 96: Specified Heart Arrhythmias
9. HCC 103: Hemiplegia/Hemiparesis
10. HCC 111: Chronic Obstructive Pulmonary Disease
11. HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders
12. HCC 134: Dialysis Status
13. HCC 157: Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone
14. HCC 158: Pressure Ulcer of Skin with Full Thickness Skin Loss
15. HCC 161: Chronic Ulcer of Skin, Except Pressure
16. HCC 170: Hip Fracture/Dislocation

Major Bowel Procedure Episodes: 18 Risk-Adjustment Variables
Age bracket variable
HCC count variable
Beneficiary social risk variable
Long-term institutional care use variable
Hospital bed size variable
Safety-net hospital status variable
HCCs: 1. HCC 11: Colorectal, Bladder, and Other Cancers 2. HCC 18: Diabetes with Chronic Complications 3. HCC 21: Protein-Calorie Malnutrition 4. HCC 33: Intestinal Obstruction/Perforation 5. HCC 82: Respirator Dependence/Tracheostomy Status 6. HCC 85: Congestive Heart Failure 7. HCC 86: Acute Myocardial Infarction 8. HCC 103: Hemiplegia/Hemiparesis 9. HCC 111: Chronic Obstructive Pulmonary Disease 10. HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders 11. HCC 134: Dialysis Status 12. HCC 188: Artificial Openings for Feeding or Elimination

LEJR Episodes: 21 Risk-Adjustment Variables
Age bracket variable
HCC count variable
Procedure-related variable (ankle procedure or reattachment, partial hip procedure, partial knee arthroplasty, total hip arthroplasty or hip resurfacing procedure, and total knee arthroplasty),
Variable for disability as the original reason for Medicare enrollment
Dementia without complications variable
Beneficiary social risk variable
Prior post-acute care use variable
Hospital bed size variable
Safety-net hospital status variable
HCCs: 1. HCC 8: Metastatic Cancer and Acute Leukemia 2. HCC 18: Diabetes with Chronic Complications 3. HCC 22: Morbid Obesity 4. HCC 58: Major Depressive, Bipolar, and Paranoid Disorders 5. HCC 78: Parkinson's and Huntington's Diseases 6. HCC 85: Congestive Heart Failure 7. HCC 86: Acute Myocardial Infarction 8. HCC 103: Hemiplegia/Hemiparesis 9. HCC 111: Chronic Obstructive Pulmonary Disease 10. HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders 11. HCC 134: Dialysis Status 12. HCC 170: Hip Fracture/Dislocation

Spinal Fusion Episodes: 18 Risk-Adjustment Variables
Age bracket variable
HCC count variable
Beneficiary social risk variable
Prior post-acute care use variable
Hospital bed size variable
Safety-net hospital status variable
HCCs: 1. HCC 8: Metastatic Cancer and Acute Leukemia 2. HCC 18: Diabetes with Chronic Complications 3. HCC 22: Morbid Obesity 4. HCC 40: Rheumatoid Arthritis and Inflammatory Connective Tissue Disease 5. HCC 58: Major Depressive, Bipolar, and Paranoid Disorders 6. HCC 85: Congestive Heart Failure 7. HCC 86: Acute Myocardial Infarction 8. HCC 96: Specified Heart Arrhythmias 9. HCC 103: Hemiplegia/Hemiparesis 10. HCC 111: Chronic Obstructive Pulmonary Disease 11. HCC 112: Fibrosis of Lung and Other Chronic Lung Disorders 12. HCC 134: Dialysis Status