Fiscal Year (FY) 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule (CMS-1808-P)

W.L. GORE and Associates

INTRODUCTORY SUMMARY AND BACKGROUND

On April 10, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) for fiscal year (FY) 2025.

With a few exceptions as defined by law, CMS reimburses acute care hospitals under IPPS. Under this payment system, CMS sets prospective base payment rates for inpatient admissions on the diagnoses and procedures performed. The facility receives a single payment for each case based on the reimbursement classification determined at discharge. IPPS cases are paid by Medicare Severity Diagnosis-Related Groups (MS-DRGs).

Certain hospitals and hospital units are excluded from IPPS, but are included in the IPPS policy changes:

- Inpatient rehabilitation facility (IRF) hospitals and units
- Long-term care hospitals (LTCHs)
- Psychiatric hospitals and units
- Children's hospitals
- Cancer hospitals
- Extended neoplastic disease care hospitals
- Hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa)
- Religious nonmedical health care institutions (RNHCIs)
- Critical Access Hospitals (CAHs)

The formula used to calculate the base payment rate for a specific case multiplies an individual hospital's payment rate per case by the weight of the MS-DRG to which the case is assigned. Each MS-DRG weight represents the average resources required to care for beneficiary cases in that particular DRG, relative to the average resources used to treat cases in all DRGs.

To specify further, the base payment rate comprises a standardized amount divided into labor-related and non-labor-related shares. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. The base rate is multiplied by the DRG relative weight.

Section 1886(d)(4)(C) of the Act requires the Secretary to adjust the MS-DRG classifications and relative weights at least annually to account for changes in use of resources. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. This is known as the "market basket" for the hospital.

If finalized, the proposed changes would apply to acute care hospitals under IPPS for discharges occurring on or after October 1, 2024.

IPPS PROPOSED RULE

The FY 2025 proposed rule is located in its entirety at the following link: https://public-inspection.federalregister.gov/2024-07567.pdf.

This document in PDF form is 1,902 pages in length. The information format is intended to summarize the proposed changes so readers are encouraged to view the document for further details.

Proposed Changes to IPPS Payment Rates

The proposed increase in payment rates for acute care hospitals under IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) and demonstrate meaningful use of Electronic Health Record (EHR) program by approximately 2.6 percent. This reflects the projected hospital market basket update of 3.0 percent, reduced by a 0.4 percent productivity adjustment. The following table reflects the proposed FY 2025 applicable percentage increases for IPPS:

FY 2025	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	3.0	3.0	3.0	3.0
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.75	-0.75
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.25	0.0	-2.25
Proposed Productivity Adjustment Under Section 1886(b)(3)(B)(xi) of the Act	-0.4	-0.4	-0.4	-0.4
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.6**	**0.35**	**1.85**	**-0.4**

CMS projects the operating payment rate increase with the other proposed changes to IPPS payment polices will be approximately $3.2 billion, primarily led by proposed changes in FY 2025 operating payments and capital

payments, in addition to expiration of the temporary changes in the low-volume hospital program and the Medicare Dependent Hospital (MDH) program on January 1, 2025.

Individual hospitals may be subject to other payment adjustments including:

- Penalties for excess admissions under the Hospital Readmissions Reduction Program (HRRP);
- Penalties for worst performing under the Hospital Acquired Condition (HAC) reduction program;
- Adjustments under the Hospital Value-Based Purchasing (VBP) program;
- Add-on payments under the disproportionate share hospital (DSH) adjustment;
- Add-on payments under the Indirect Medical Education (IME) adjustment;
- Add-on payments for approved new technologies/medical services; and
- Add-on payments for outlier cases.
- Supplemental payment for Indian Health Service and Tribal hospitals and Puerto Rico hospitals.

When calculating the payment rates for FY 2025, CMS proposes to return to their historical practice of using the most recent data available, including FY 2023 MedPAR claims and FY 2022 cost report data. Therefore, CMS is proposing to use FY 2023 data for ratesetting with modifications as the most recent and best available data without proposed modifications.

Proposed Changes to Specific MS-DRG Classifications

Beginning in FY 2024, CMS changed the deadline to request MS-DRG classifications changes from November 1 of each year to October 20 to allow more time to evaluate MS-DRG change requests and propose updates, and thus added 5 additional weeks for the data analysis and review process. In addition, CMS implemented a new electronic application intake system Medicare Electronic Application Request Information System™ (MEARIS™): https://mearis.cms.gov/public/home. MS-DRG classification change requests for FY 2025 had to be submitted by October 20, 2023, through the MEARIS™ system.

CMS is proposing 12 new MS-DRGs and deletion of 9 existing MS-DRGs in multiple Major Diagnostic Categories (MDCs) for FY 2025, and is requesting feedback and suggestions based on the proposed MS-DRGs.

CMS is providing a test version of the ICD-10 MS-DRG Grouper Software Version 42, which includes new diagnosis and procedure codes (Tables 6A and 6B); invalid diagnosis codes (Table 6C); the draft version of the ICD-10 MS-DRG Definitions Manual Version 42; and the supplement diagnosis code mapping file from version 41 to version 42. This information is available through the CMS website: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-proposed-rule-home-page#Tables.

The test version of the GROUPER Software, the draft version of the Definitions Manual Version 42 and supplemental mapping files can be found at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/ms-drg-classifications-and-software.

O.R. vs Non-O.R. Procedures

Currently, each ICD-10-PCS procedure code has designations that determine whether and if so, in what way the presence of that procedure on a claim impacts the MS-DRG assignment:

- Each ICD-10-PCS procedure code is either designated as an O.R. procedure for purposes of MS DRG assignment (“O.R. procedures”) or is not designated as an O.R. procedure for purposes of MS-DRG assignment (“Non-O.R. procedures”).

- For each procedure designated as an O.R. procedure, that procedure is further classified as extensive or non-extensive.
- For each procedure designated as a non-O.R. procedure, that non-O.R. procedure is further classified as either affecting the MS-DRG assignment or not the MS-DRG assignment.
- For new procedure codes that have been finalized and are proposed to be classified as O.R. procedures or non-O.R. procedures affecting the MS-DRG, MS-DRG assignment is then selected and subject to public comment.

CMS did not receive any requests regarding changing the designation of specific ICD-10-PCS procedure codes from non-O.R. to O.R. procedures, or to change the designation from O.R. procedures to non-O.R. procedures by the October 20, 2023, deadline. In this FY 2025 proposed rule, CMS is proposing redesignation of certain "diagnostic" laparoscopic codes from non-O.R. to O.R. procedures.

Proposed Changes to the ICD-10-CM and ICD-10-PCS Coding Systems

CMS has identified new, revised and deleted diagnosis and procedure codes for FY 2025. These code titles are adopted as a part of the ICD-10 Coordination and Maintenance Committee meeting process. Therefore, they are not subject to comment in the proposed or final rules. At the time of this proposed rule for FY 2025, the proposed codes include 252 new ICD-10-CM codes and 41 new ICD-10-PCS codes. These codes can be found on Tables 6A-6E at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-proposed-rule-home-page#Tables.

Proposed Changes to Code Severity (MCCs, CCs or non-CCs)

In the FY 2021 IPPS final rule, CMS finalized their proposal to expand the existing criteria to create a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within a base MS-DRG. This expansion of the criteria included a NonCC subgroup for a three-way severity level split, recognizing this application may result in modifications to certain MS-DRGs which are currently split into three severity levels. This process involves the analysis of claims data and the application of nine guiding principles, as well as the plan to present findings and proposals in future rulemaking. The nine guiding principles include:

- Represents end of life/near death or has reached an advanced stage associated with systemic physiologic decompensation and debility.
- Denotes organ system instability or failure.
- Involves a chronic illness with systemic physiologic decompensation and debility.
- Serves as a marker for advanced disease states across multiple different comorbid conditions.
- Reflects systemic impact.
- Post-operative/post-procedure condition/complication impacting recovery.
- Typically requires higher level of care (that is, intensive monitoring, greater number of caregivers, additional testing, intensive care unit care, extended length of stay).
- Impedes patient cooperation or management of care or both.

For 2025, CMS is proposing to change the several level designation for social determinants of health (SDOH) diagnosis codes describing inadequate housing and housing instability from non-complication or comorbidity (NonCC) to complication or comorbidity (CC). This comes as a result of CMS' recognition of inadequate housing and housing instability being an indicator of increased resource utilization in the acute inpatient hospital setting.

CMS is also proposing to continue to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way severity level split for FY 2025 to provide time for CMS to review and consider public comments

received in response to the FY 2024 rulemaking. CMS is also encouraging interested parties to review the impacts and other information available in connection with the FY 2024 IPPS proposed rule.

The proposed additions and deletions to the diagnosis code MCC and CC severity levels for FY 2025 can be found on Tables 6I.1-6J.2 at:

https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-proposed-rule-home-page#Tables.

Replaced Devices Offered without Cost or with a Credit

In FY 2008, CMS implemented a policy to reduce a hospital's IPPS payment for certain MS-DRGs in which the implantation of a device that failed or was recalled determined the base MS-DRG assignment. This is based on a credit for a replaced device equal to 50 percent or more of the cost of the device. For FY 2025, CMS is proposing to include the existing MS-DRGs currently under the policy as listed in the table below:

MDC	MS-DRG	MS-DRG Title
05	216	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with MCC
05	217	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization with CC
05	218	Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization without CC/MCC
05	219	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with MCC
05	220	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization with CC
05	221	Cardiac Valve and Other Major Cardiothoracic Procedure without Cardiac Catheterization without CC/MCC
05	268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC
05	269	Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC
05	270	Other Major Cardiovascular Procedures with MCC
05	271	Other Major Cardiovascular Procedures with CC
05	272	Other Major Cardiovascular Procedures without CC/MCC

The final list of MS-DRGs subject to the IPPS policy for replaced devices offered without cost or with a credit will be included in the FY 2025 IPPS final rule and will also be issued to providers in the form of a Change Request (CR).

MS-DRG Relative Weights

CMS calculates MS-DRG relative weights based on 19 national cost to charge ratios (CCRs), claims data from the MedPAR (Medicare Provider Analysis and Review) file and Medicare cost reports. After adjustments are made to determine Medicare-specific charges, the total specific Medicare costs (for all hospitals) are divided by the sum of the total Medicare-specific charges to produce national average, charge-weighted CCRs. CMS calculated the proposed FY 2025 relative weights based on 19 CCRs just like FY 2024. The methodology CMS is proposing to use to calculate the FY 2025 MS-DRG cost-based relative weights is based on claims data in the FY 2023 MedPAR file and data from the FY 2022 Medicare cost reports. The proposed 19 national average CCRs for FY 2025 are listed in the following table:

Group	CCR
Routine Days	0.417
Intensive Days	0.364
Drugs	0.182
Supplies & Equipment	0.302
Implantable Devices	0.270
Inhalation Therapy	0.163
Therapy Services	0.269
Anesthesia	0.075
Labor & Delivery	0.385
Operating Room	0.162
Cardiology	0.089
Cardiac Catheterization	0.106
Laboratory	0.103
Radiology	0.129
MRIs	0.068
CT scans	0.033
Emergency Room	0.155
Blood and Blood Products	0.253
Other Services	0.341

When the MS-DRG weights were recalibrated for previous years, CMS sets a threshold of 10 cases as the minimum number required to compute a reasonable weight. CMS is proposing to use the same case threshold in recalibrating the proposed MS-DRG relative weights for FY 2025.

In light of the concerns regarding the fluctuations in relative weights from year to year and financial impacts of those fluctuations, CMS finalized their proposal in FY 2023 to recalibrate the MS-DRG relative weights, including a 10 percent cap on decreases in an MS-DRG relative weight from one fiscal year to the next; and application of a budget neutrality adjustment to the standardized amount for all hospitals to ensure this cap does not result in an increase or decrease of estimated cumulative payments. For FY 2025, CMS is proposing to continue the 10 percent cap.

Add-on Payments for New Services and Technologies (NTAP)

Each year CMS reviews applications received per the deadline for a new medical service or technology requesting an add-on payment to the MS-DRG (NTAP). There are specific criteria which must be met to qualify for the additional payment:

1) the medical service or technology must be new;
2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and
3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies.
4) Certain transformative new devices and antimicrobial products may qualify under an alternative impatient new technology add-on payment pathway, as mandatory in the regulations.

Newness Criterion

Under the newness criterion, technology is no longer considered "new" for the purposes of the add-on payment if it is substantially like one or more existing technologies, even if it has recently received FDA approval or clearance. In addition, if it has been on the market for more than 2 to 3 years, it is no longer considered "new".

In FY 2010, CMS established criteria to evaluate if a new technology is "substantially similar" to an existing technology. If all the following criteria is met, the technology is considered substantially like an existing technology, and therefore would not be considered "new" for an add-on payment:

1) If a product uses the same or a similar mechanism of action to achieve a therapeutic outcome;
2) If a product is assigned to the same or a different MS–DRG; and
3) If the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population.

Cost Criterion

Under the cost criterion, CMS will evaluate whether the charges of the cases involving a new medical service or technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges); or 75 percent of one standard deviation beyond the geometric mean standardized charge for all cases in the MS-DRG to which the new medical service or technology is assigned (or the case-weighted average of all relevant MS-DRGs if the new medical service or technology occurs in many different MS-DRGs). CMS does provide access to the data files utilized for this analysis.

Applicants are expected to submit a significant sample of data to demonstrate the technology meets the high-cost threshold. The sample size is expected to be significant to allow for CMS to be able to do an initial validation and analysis of the data.

Substantial Clinical Improvement Criterion

The third and final criterion is the technology must represent an advancement that significantly improves the diagnosis or treatment relative to already existing technologies. Some of the criteria which may support the clinical improvement include:

- The new medical service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments;
- The new medical service or technology offers the ability to diagnose a medical condition in a patient population where that medical condition is currently undetectable, or offers the ability to diagnose

a medical condition earlier in a patient population than allowed by currently available methods, and there must also be evidence that use of the new medical service or technology to make a diagnosis affects the management of the patient;

- The use of the new medical service or technology significantly improves clinical outcomes relative to services or technologies previously available as demonstrated by one or more of the following:
    - A reduction in at least one clinically significant adverse event, including a reduction in mortality or a clinically significant complication;
    - A decreased rate of at least one subsequent diagnostic or therapeutic intervention;
    - A decreased number of future hospitalizations or physician visits;
    - A more rapid beneficial resolution of the disease process treatment including, but not limited to, a reduced length of stay or recovery time;
    - An improvement in one or more activities of daily living; an improved quality of life; or a demonstrated greater medication adherence or compliance; or
    - The totality of the circumstances otherwise demonstrates that the new medical service or technology substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.
- Evidence from published or unpublished sources with the United States or elsewhere may be sufficient to establish the improvement.
- The medical condition diagnosed or treated by the new medical service or technology may have a low prevalence among Medicare beneficiaries.
- The new medical service or technology may represent an advance that substantially improves, relative to services or technologies previously available, the diagnosis or treatment of a subpopulation of patients with the medical condition diagnosed or treated by the new medical service or technology.

Proposed NTAP

Applicants for add-on payments for new medical services or technologies must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new medical service or technology represents a substantial clinical improvement (unless the application is under one of the alternative pathways, such as the Breakthrough Devices Program) along with a significant sample of data to demonstrate that the medical service or technology meets the high cost threshold. CMS will review the application based on the information provided by the applicant under the pathway specified by the applicant at the time of application submission.

W.L. Gore and Associates, Inc., submitted an application for new technology add-on payments for the GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device) for FY 2025. According to the applicant, the TAMBE Device is a modular device consisting of multiple components, each of which is pre-mounted on a catheter delivery system for treatment of thoracoabdominal aortic aneurysms (TAAA) and high-risk surgical patients with pararenal abdominal aortic aneurysms (PAAA):

1) Aortic component (AC);
2) Branch components;
3) Distal bifurcated component (DBC);
4) Contralateral Leg component; and
5) Optional DBC extender component.

According to GORE, the TAMBE Device received premarket approval (PMA) from the FDA the TAMBE Device received premarket approval (PMA) from the FDA on January 12, 2024, for a slightly narrower indication for use, specifically, TAAA and high-surgical risk patients with PAAA who have appropriate anatomy.

According to CMS, since the applicant received premarket approval, which is included in the indications of the Breakthrough Device designation, it appears that the PMA indication is appropriate for consideration for new technology add-on payment under the alternative pathway criteria. In addition, the TAMBE Device is not yet available for sale due to the required lead time to train physicians on the TAMBE Device; therefore, the first commercial device will only be implanted May 1, 2024, or later.

From a coding perspective, GORE stated there are no ICD-10-PCS codes to identify the TAMBE Device. However, GORE submitted a request for approval for a specific ICD-10-PCS new technology procedure code for the TAMBE Device beginning in FY 2025 through the ICD-10 Coordination and Maintenance Committee. GORE did provide associated ICD-10-CM codes in their application:

I71.40 Abdominal aortic aneurysm, without rupture, unspecified
I71.41 Pararenal abdominal aortic aneurysm, without rupture
I71.42 Juxtarenal abdominal aortic aneurysm, without rupture
I71.60 Thoracoabdominal aortic aneurysm, without rupture, unspecified
I71.61 Supraceliac aneurysm of the thoracoabdominal aorta, without rupture
I71.62 Paravisceral aneurysm of the thoracoabdominal aorta, without rupture

Based on the preliminary information received by CMS at the time of this proposed rule, the per patient anticipated hospital cost of the TAMBE Device is $72,675. CMS stated this cost information may be updated in the final rule based on revised or additional information. If CMS approves this new technology add-on payment in the final rule, the maximum new payment for a case involving the TAMBE Device would be $47,238.75 for FY 2025 (65% of the average cost of the technology). Public comments are requested on whether this technology meets cost criterion and CMS' proposal to approve add-on payments for the TAMBE Device for FY 2025.

Continuation of NTAPs

Based on CMS policy, a medical service or technology may continue to be considered "new" for the purposes of NTAPs. Based on the newness criterion, CMS is proposing to continue to approve 24 technologies as "new" technologies and thus, continue the NTAP because the three-year anniversary for each of these technologies will occur on or after April 1, 2025.

Of interest is the GORE® TAG® Thoracic Branch Endoprosthesis (TBE) device that was approved for FY 2023 NTAP. The table below shows the technology and the information pertaining to its NTAP status:

Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Proposed Maximum NTAP for FY 2023	Coding Used to Identify Cases Eligible for NTAP
GORE® TAG® Thoracic Branch Endoprosthesis	05/13/2022	10/1/2022	05/13/2025	87 FR 48966 through 48969 88 FR 58800	$27,807.00	02VW3DZ in combination with 02VX3EZ

CMS is requesting public comments on the proposal to continue NTAPs for FY 2025 for the listed technologies, include the GORE® TAG® TBE.

Reporting New Services and Technologies in ICD-10-PCS

In the FY 2016 IPPS final rule, ICD-10-PCS included a new section containing the "X" codes, which began being reported for discharges on and after October 1, 2015. CMS established the use of section "X" New Technology codes within ICD-10-PCS classification to more specifically identify new technologies or procedures that have not been captured through ICD-10-CM codes; or to more accurately describe information on a specific procedure or technology not found in the other sections of ICD-10-PCS. Proposals to create, delete or revise Section "X" codes for new services and technologies will be under the ICD-10 Coordination and Maintenance Committee. Coding guidelines for these "X" codes can be found on the CMS website: https://www.cms.gov/files/document/2023-official-icd-10-pcs-coding-guidelines.pdf.

Proposed Hospital Wage Index

The Medicare wage index is one of the factors that determines a hospital's overall payment from CMS. Its sole purpose is to maintain a consistent payment structure across IPPS hospitals and recognize the difference in labor market costs across the country. Beginning in FY 2022, CMS moved the base year cost structure for IPPS from 2014 to 2018 and revised the data sources used in the price index in the IPPS market basket to reflect a 2018 base year using major cost categories:

- Wages and salaries;
- Employee benefits;
- Labor-related professional fees;
- Administrative and facilities support services;
- Installation, maintenance, and repair services; and
- All other labor-related services.

Based on a multi-step methodology, CMS is proposing the unadjusted national average hourly wage is $54.80 for FY 2025. This includes adjustment of the labor-related share for discharges occurring on or after October 1, 2024, of 67.6 percent. CMS is proposing not to make any further changes to the labor-related share, and therefore continuing to use 67.6 percent for the national standardized amounts for all IPPS hospitals (including those in Puerto Rico) that have a wage index value greater than 1.0000. The labor-related share is used to determine the part of the national IPPS base payment rate to which the area wage index is applied.

Core-based Statistical Areas (CBSAs)

For FY 2025, CMS is proposing to use the core-based statistical areas (CBSAs) established by the Office of Management and Budget (OMB) as described in the July 21, 2023, OMB Bulletin No. 23-01. CMS believes implementation of the new OMB will result in wage index values that are more representative of the actual current costs of labor in a given area. However, they also recognize some hospitals would see decreases in wage index values, while others would see higher wage index values.

Permanent Cap of Wage Index Decreases

For FY 2023, CMS finalized their proposal to apply a 5 percent cap on any decrease to a hospital's wage index from the prior FY's wage index, regardless of the decline origin. Meaning, a hospital's wage index would not be less than 95 percent of its final wage index for the prior FY. In addition, CMS finalized to apply this wage index cap policy in a budget neutral manner through a national adjustment to the standardized amount. For FY 2025, CMS proposes to continue applying this wage index cap and associated budget neutrality adjustment, noting the budget neutrality adjustment would be updated as appropriate based on the final rule data.

Rural Floor

According to the Balanced Budget Act of 1997, the area wage index of a hospital located in an urban area of a state may not be less than the area wage index of a hospital located in a rural area in that state. This is called the rural floor. Implementing the rural floor must be done in conjunction with a related budget neutrality adjustment. For FY 2023 and subsequent years, the finalized policy includes the wage data of hospitals that have been reclassified from urban to rural under the Act to calculate "the wage index for rural areas in the State in which the county is located", as it is referred to in the Act. CMS is proposing to apply a uniform national budget neutrality adjustment to the FY 2025 wage index for the rural floor of 0.985868. CMS estimates 494 hospitals would receive the rural floor in FY 2025.

Frontier Floor Policy

By law, hospitals in frontier states (Montana, North Dakota, South Dakota and Wyoming) cannot be assigned a wage index of less than 1.0000. This is called the frontier floor policy, and it has been in place since FY 2011. This ensures the lower population states are not "penalized" for reimbursement due to the low number of people per square mile when compared to other states. In this proposed rule, 43 hospitals within the frontier states would receive the frontier floor value of 1.0000 for their FY 2024 wage index. CMS noted while Nevada met the definition of a frontier state, all hospitals within that state currently receive a wage index value greater than 1.000. For FY 2025, CMS is proposing no further changes to the frontier floor policy.

Low Wage Index Hospital Policy

In the FY 2020 IPPS final rule, CMS adopted a policy to help offset the wage index differences between high wage and low wage hospitals. This policy was thought to provide an opportunity for certain low wage index hospitals to increase employee compensation by increasing the wage index values for certain hospitals with low wage index values (known as the low wage index hospital policy). This policy was adopted in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. CMS indicated this policy would be effective for at least 4 years, beginning in FY 2020, to allow sufficient time for employee compensation increases implemented by these hospitals to be reflected in the wage index calculation. Although CMS is using FY 2021 cost report data to for the FY 2025 wage index, at the time of this proposed rule, CMS does not have enough relevant data to evaluate any potential impacts of this policy during the COVID-19 public health emergency (PHE). Because of this, CMS believes it needs data from additional fiscal years after the PHE for analysis before making any decision to modify or discontinue the policy. Therefore, for FY 2025, CMS is proposing to continue the low wage index hospital policy and budget neutrality adjustment for at least 3 more years.

Proposed Changes to the Hospital Readmissions Reduction Program

Under the Hospital Readmissions Reduction Program, Medicare payments under IPPS for discharges may be reduced for certain excess readmissions. Beginning in FY 2017 and for subsequent years, the reduction is based on a hospital's risk adjusted readmission rates for a 3-year period for the following: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), elective primary total hip arthroplasty/total knee arthroplasty (THA/TKA), and coronary artery bypass graft (CABG) surgery. For FY 2025, CMS is not proposing any changes, and refers readers to the FY 2023 finalized changes to this program.

However, CMS is requesting public comment on how these programs could further encourage hospitals to improve discharge processes, specifically input to adopt measures which better represent the range of outcomes of interest to patients, including unplanned returns to the ED and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.

Proposed Changes for the Hospital Value-Based Purchasing (VBP) Program

The Hospital VBP Program was created to provide value-based incentive payments in a fiscal year to hospitals based on their performance on measures established in a performance period for such fiscal year. For FY 2025, CMS is proposing the following:

- Modify the scoring of the Person and Community Engagement Domain for the FY 2027 through FY 2029 program years to only score six unchanged dimensions of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey;
- Adopt the updated HCAHPS survey beginning with the FY 2030 program year after the updated survey would have been publicly reported under the Hospital Inpatient Quality Reporting (IQR) Program for 1 year;
- Modify the scoring on the HCAHPS Survey beginning with the FY 2030 program year to incorporate the updated HCAHPS Survey measure into nine survey dimensions; and
- Provide previously and newly established performance standards for the FY 2027 through FY 2030 program years.

CMS is not proposing any changes to previously adopted quality measures for the Hospital VBP in the FY 2023 IPPS final rule. The following table summarizes the previously adopted Hospital VBP Program measure set for FY 2025:

TABLE V.L.-01: SUMMARY OF PREVIOUSLY ADOPTED MEASURES FOR THE FY 2025 PROGRAM YEAR

Measure Short Name	Domain/Measure Name	CBE #
Person and Community Engagement Domain		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	0166 (0228)
Safety Domain		
CAUTI	National Healthcare Safety Network (NHSN) Catheter Associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CLABSI	National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure	0139
Colon and Abdominal Hysterectomy SSI	American College of Surgeons Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure	0753
MRSA Bacteremia	National Healthcare Safety Network (NHSN) Facility wide Inpatient Hospital onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716
CDI	National Healthcare Safety Network (NHSN) Facility wide Inpatient Hospital onset *Clostridioides difficile* Infection (CDI) Outcome Measure	1717
Clinical Outcomes Domain		
MORT-30-AMI	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN (updated cohort)	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-COPD	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-CABG	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	2558
COMP-HIP-KNEE	Hospital Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550
Efficiency and Cost Reduction Domain		
MSPB	Medicare Spending Per Beneficiary (MSPB) Hospital	2158

Hospital-Acquired Condition (HAC) Reduction Program

Section 1186 of the Act establishes an incentive to reduce the number of hospital-acquired conditions (HACs) by a 1 percent payment reduction to applicable hospitals, effective October 1, 2014. This adjustment applies to hospitals which rank in the worst performing 25 percent of all applicable hospitals (compared to the national average) of acquired conditions during the specified period and all hospital discharges for the specified year. The HAC reduction program is based on six measures and scoring methodology in which hospitals are ranked:

- One claims-based composite measure of patient safety:
  - Patient Safety and Adverse Events Composite (CMS PSI 90)
- Five chart-abstracted measures of healthcare-associated infections (HAIs) submitted to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN):
  - Central Line-Associated Bloodstream Infection (CLABSI)
  - Catheter-Associated Urinary Tract Infection (CAUTI)
  - Surgical Site Infection (SSI) for abdominal hysterectomy and colon procedures
  - Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia
  - Clostridium difficile Infection (CDI)

For FY 2025, CMS is not proposing additions or deletions of any measures, including retention policies from the Hospital-Acquired Condition (HAC) Reduction Program.

Transforming Episode Accountability Model (TEAM)

For FY 2025, CMS is proposing the creation and testing of the Transforming Episode Accountability Model (TEAM), which is a new mandatory alternative payment model. The intent of TEAM is to improve beneficiary care through financial accountability for episode of care categories which include one of the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion. Through this process, TEAM would test whether financial accountability for these entire episodes of care would reduce Medicare costs, while maintaining or boosting the quality of care for Medicare beneficiaries.

Under traditional Medicare, separate payments are made to providers and suppliers for items and services provided to a beneficiary over the entire episode of care. Because of this, providers may not be motivated to participate in quality improvement and care coordination activities. By holding hospitals accountable for all items and services during an episode of care, they would be motivated to coordinate patient care and improve the care transition process, all while preventing duplicate or unnecessary services.

With limited exceptions, all acute care hospitals located within the Core-Based Statistical Areas (CBSAs) that CMS selects for model implementation must participate in TEAMS. These facilities would continue to bill Medicare FFS but would receive target prices for episodes of care prior to each performance year. These target prices would be based on 3 years of baseline data, trended forward to the relevant performance year and calculated at the of the MS-DRG/HCPCS episode type and locality. Facility performance in the model would then be assessed by a comparison of the of actual FFS spending to the target price. Based on a quality performance adjustment of whether actual spending was below or above the target price, the facility would either receive a payment from CMS; or owe CMS a repayment amount.

CMS believes TEAM would benefit Medicare beneficiaries through "improving the coordination of items and services paid for through Medicare fee-for-service (FFS) payments; encouraging provider investment in health care infrastructure and redesigned care processes; and incentivizing higher value care across the inpatient and post-acute care settings for the episode". Under authority of section 1115A of the Act, TEAM would have a 5-

year model performance period, beginning January 1, 2026, and ending December 31, 2030. CMS estimates TEAM will save the Medicare program $705 million in the five-year performance period.

Hospitals Excluded from IPPS

Hospitals excluded from the prospective payment system (PPS) receive payment for inpatient hospital services on the basis of reasonable costs, subject to a rate of increase ceiling. A discharge limit is set for each hospital based on its own cost experience in its base year and updated annually by a rate-of-increase percentage. CMS has proposed the FY 2025 operating market basket rate-of-increase percentage of 3.0, which will be applied to the FY 2024 target amounts to calculate the FY 2025 target amounts. If more recent data becomes available for the FY 2024 IPPS final rule, CMS would use it to calculate the final IPPS operating market basket update for FY 2025.

Submitting Comments

Comments to CMS regarding the IPPS proposed rule must refer to file code **CMS-1808-P** and must be received **no later than 5 p.m. EDT on June 10, 2024**. Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.