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

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Introductory Summary and Background

On August 1, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final 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 based on the patient's diagnoses and the procedures performed during their stay. The facility receives a single payment for each case based on the reimbursement classification determined at discharge. IPPS cases are paid by the Medicare Severity Diagnosis-Related Groups (MS-DRGs).

Certain hospitals and hospital units are excluded from IPPS:

- 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 needed to care for beneficiary cases in that particular DRG, compared to the average resources used to treat cases in all DRGs.

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.

The finalized changes are effective for discharges on or after October 1, 2024, to acute care hospitals under IPPS.

IPPS Final Rule

The FY 2025 final rule is located in its entirety at the following link:
https://public-inspection.federalregister.gov/2024-17021.pdf.

This document in PDF form is 2,987 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

Changes to IPPS Payment Rates

CMS is finalizing a payment increase of approximately 2.9 percent for acute care hospitals under IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) and demonstrate meaningful use of the Electronic Health Record (EHR) program. This reflects the hospital market basket update of 3.4 percent, reduced by a 0.5 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
Market Basket Rate-of-Increase	3.4	3.4	3.4	3.4
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.85	-0.85
Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.55	0.0	-2.55
Productivity Adjustment Under Section 1886(b)(3)(B)(xi) of the Act	-0.5	-0.5	-0.5	-0.5
Applicable Percentage Increase Applied to Standardized Amount	**2.9**	**0.35**	**2.05**	**-0.5**

CMS estimates a $3.2 billion increase in FY 2025 payments. This estimate is based on the proposed FY 2025 applicable percentage increase to IPPS rates in addition to other proposed changes. These changes include operating payments, uncompensated care payments, capital payments, and the September 30, 2024, expiration of the temporary changes in the low-volume hospital and the Medicare Dependent Hospital (MDH) programs.

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.

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 2022 MedPAR claims and FY 2021 cost report data. CMS observed that some shifts in inpatient utilization and costs that occurred in FY 2020 have continued through FY 2022, mainly admissions associated with COVID-19. However, based on current information available, CMS believes there will not be a significant difference in the number of COVID-19 hospitalizations in FY 2025 compared to FY 2022. Therefore, CMS is finalizing their proposal to use FY 2022 data for ratesetting as the most recent and best available data without proposed modifications.

Changes to Specific MS-DRG Classifications

Beginning with FY 2024, CMS revised the deadline to request MS-DRG classifications changes to October 20 each year to allow more time to evaluate MS-DRG change requests. In addition, CMS also explained the new process for submitting requests, questions and feedback using the new electronic intake system, Medicare Electronic Application Request Information System™ (MEARIS™): https://mearis.cms.gov/public/home. CMS stated it would only accept requests submitted through MEARIS™ and no longer through email.

CMS is finalizing changes for the MS-DRG classifications, including 11 additions, 5 deletions, and code restructuring of multiple MS-DRGs for FY 2025. Changes include new MS-DRGs for spinal fusion and leukemia with other procedures.

For FY 2025, CMS is providing the final version of the ICD-10 MS-DRG Grouper Software Version 42, effective October 1, 2024, through March 31, 2025. There are two ICD-10 updates per fiscal year, one in October and one in April for FY 2025. Version 42 includes new diagnosis and procedure codes (Tables 6A and 6B), invalid diagnosis codes (Table 6C), revised diagnosis and procedure code titles (Tables 6E and 6F), the final version of the ICD-10 MS-DRG Definitions Manual Version 42, and the supplement diagnosis code mapping file from version 41 to version 42, among other tables. This information is available through the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page#Tables.

The latest version of the GROUPER Software, the final 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 a designation that determines whether or not the procedure is considered an operating room (O.R.) procedure. This designation is based on the utilization of hospital resources and thus ultimately impacts the MS-DRG assignment.

ICD-10-PCS codes are either designated as a non-O.R. procedure or designated as an O.R procedure. For each procedure that is classified as an O.R. procedure, it is further classified as either extensive or non-extensive. For each procedure that is classified as non-O.R., it is further classified as either affecting the MS-DRG assignment or not affecting 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.

In the FY 2025 IPPS/LTCH PPS proposed rule, CMS did not receive any requests by the October 20, 2023, deadline regarding changing the designation of specific ICD-10-PCS procedure codes from either non-O.R. to O.R. procedures, or from O.R. procedures to non-O.R. procedures. CMS proposes changes based on their internal review and analysis, and has considered the following for each procedure:

- Whether the procedure would typically require the resources of an operating room;
- Whether it is an extensive or non-extensive procedure; and
- To which MS-DRGs the procedure should be assigned.

In this FY 2025 final rule, CMS has identified seven laparoscopic biopsy ICD-10-PCS codes with a current designation of non-O.R. which they are finalizing to redesignate as O.R. procedures.

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. Both ICD-10-CM and ICD-10-PCS codes are effective October 1, 2024, through September 30, 2025.

The ICD-10-PCS code update summary includes 78,948 codes, the greatest number of which are in the Medical and Surgical Section. The total number of codes includes the addition of 371 new codes, 0 title revisions and 61 deleted codes. Of interest is the addition of a new character for a code in section X, which is the New Technology section. This code is established for reporting procedures in which the GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE) is used:

> *X2VE3SA - Restriction of Descending Thoracic Aorta and Abdominal Aorta, using Branched Intraluminal Device, Manufactured Integrated System, Four or More Arteries, Percutaneous Approach, New Technology Group 10*

There are no changes made to the ICD-10-PCS coding guidelines for FY 2025. The codes and their corresponding files can be found at: https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-pcs.

The ICD-10-CM code update summary includes 74,260 codes, 252 codes, 13 title revisions and 36 deletions. The codes and their corresponding files can be found at: https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-cm.

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 new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroups within a base MS-DRG. These subgroups account for the extra resources utilized to care for patients with complications and comorbidities that impact the severity of their condition. The expansion of the criteria included a new non-CC 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 FY 2025, CMS is finalizing their proposal to change the severity level designation for social determinants of health (SDOH) diagnosis codes identifying homelessness from non-complication or comorbidity (NonCC) to complication or comorbidity (CC): *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; and Z59.819 Housing instability, housed, unspecified.* This comes as a result of CMS' recognition of homelessness being an indicator of increased resource utilization in the acute inpatient hospital setting.

The additions and deletions to the diagnosis code MCC and CC severity levels for FY 2025 can be found on Tables 6I-6K at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-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 an implanted device failed or was recalled. Failed devices are often replaced without cost, or the facility is credited for the device. The payment reduction 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 finalizing their proposal 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 is included in this final rule and will 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. CMS is finalizing their proposal to use the methodology to calculate the FY 2025 MS-DRG cost-based relative weights based on claims data in the FY 2023 MedPAR file and data from the FY 2022 Medicare cost reports. The 19 national average CCRs for FY 2025 are listed in the following table:

Group	CCR
Routine Days	0.418
Intensive Days	0.36
Drugs and Cellular Therapies	0.178
Supplies & Equipment	0.297
Implantable Devices	0.259
Inhalation Therapy	0.162
Therapy Services	0.265
Anesthesia	0.071
Labor & Delivery	0.381
Operating Room	0.16
Cardiology	0.088
Cardiac Catheterization	0.104
Laboratory	0.102
Radiology	0.127
MRIs	0.067
CT Scans	0.033
Emergency Room	0.153
Blood and Blood Products	0.246
Other Services	0.336

When the MS-DRG weights are recalibrated for previous years, CMS sets a threshold of 10 cases as the minimum number required to compute a reasonable weight. CMS is using 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. The proposal includes a permanent 10 percent cap on decreases in an MS-DRG relative weight from one fiscal year to the next, and the 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 finalizing their proposal to continue the 10 percent cap.

New Services and Technologies Add-On Payments (NTAP)

Each year CMS reviews applications received before the deadline requesting an add-on payment to the MS-DRG (NTAP) for a new medical service or technology. 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.

These payments are not required to be budget neutral according to the Act. There are three specific criteria which must be met to qualify for the additional payment:

1) NEWNESS – the medical service or technology must be new;
2) COST – 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) SUBSTANTIAL CLINICAL IMPROVEMENT – the service or technology must demonstrate a substantial clinical improvement over existing services or technologies.

Newness Criterion

Under the newness criterion, technology is no longer considered "new" for the purposes of the add-on payment if it is substantially similar to 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 similar to an existing technology, and therefore would not be considered "new" for an add-on payment:

1) whether a product uses the same or a similar mechanism of action to achieve a therapeutic outcome;
2) whether a product is assigned to the same or a different MS–DRG; and
3) whether 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 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 perform 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 compared 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 compared 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.

New NTAPs

Based on information from the applicants at the time of this final rule, CMS estimates total payments for the technologies approved under the alternative pathway will be approximately $171.5 million for FY 2025, payments for new technologies designated as a Qualified Infectious Disease Product (QIDP) are approximately $5.6 million, and the total estimated FY 2025 payments for new technologies that are part of the Breakthrough Device program are approximately $165.9 million.

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
5) Optional DBC Extender Component

According to GORE, the TAMBE Device received premarket approval (PMA) from the FDA on October 1, 2021, and additional PMA from the FDA on January 12, 2024, for a slightly narrower indication for use: 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 device is appropriate for consideration for new technology add-on payment under the alternative pathway criteria.

GORE requested approval from the ICD-10 Coordination and Maintenance Committee for a specific ICD-10-PCS new technology procedure code for the TAMBE device beginning in FY 2025. Approval was granted effective October 1, 2024: *X2VE3SA (Restriction of descending thoracic aorta and abdominal aorta using branched intraluminal device, manufactured integrated system, four or more arteries, percutaneous approach, new technology group 10).*

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 information received by CMS at the time of this final rule, the per patient anticipated hospital cost of the TAMBE Device is $72,675. CMS has approved this new technology add-on payment, with the maximum new payment for a case involving the TAMBE Device at $47,238.75 for FY 2025 (65% of the average cost of the technology).

Technology Name	Pathway	Estimated Cases	FY 2025 NTAP Amount (65% or 75%)	Estimated Total FY 2025 Impact
GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)	Breakthrough Device	518	$47,238.75	$24,469,672.50

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 finalizing their proposal to continue to approve 24 technologies and discontinue 7 technologies as "new" technologies based on the 3-year anniversary date 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	$27,807.00	02VW3DZ in combination with 02VX3EZ

Reporting New Services and Technologies in ICD-10-PCS: Section "X"

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. 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 at: https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-pcs.

Of interest is the addition of a new character for a code in this section. The code established for reporting procedures in which the GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE) is used:

> *X2VE3SA - Restriction of Descending Thoracic Aorta and Abdominal Aorta, using Branched Intraluminal Device, Manufactured Integrated System, Four or More Arteries, Percutaneous Approach, New Technology Group 10*

Hospital Wage Index

The Medicare wage index is one of the factors that determines a hospital's overall payment from CMS, and is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. 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
- All other labor-related services

Based on a multi-step methodology, CMS is finalizing the unadjusted national average hourly wage at $50.33 for FY 2025. This includes adjusting the labor-related share to 67.6 percent for discharges occurring on or after October 1, 2024. 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. CMS anticipates proposing to rebase and revise the IPPS market basket in the FY 2026 IPPS proposed rule to be consistent with their established frequency of rebasing the market basket every 4 years.

CMS is not to making any changes to the labor-related share in 2025, and therefore continuing to use 67.6 percent for the national standardized amounts for all IPPS hospitals (excluding those in Puerto Rico) that have a wage index value greater than 1.0000.

Core-based Statistical Areas (CBSAs)

CMS believes it is important for the IPPS to use the updated labor market area delineations to accurately reflect the current wage index in a given geographic location. Therefore, CMS is finalizing their proposal to implement the revised Office of Management and Budget (OMB) delineations as described in the July 21, 2023, OMB Bulletin No. 23-01, starting with the FY 2025 IPPS wage index. Finalized changes in the core-based statistical areas (CBSAs) for FY 2025 are representative of the updated delineations, including Micropolitan statistical areas, Metropolitan divisions and the change to county-equivalent definitions for Connecticut.

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. Therefore, a hospital's wage index cannot be less than 95 percent of its final wage index for the prior FY. In addition, CMS finalized its proposal to apply this wage index cap policy in a budget neutral manner through a national adjustment to the standardized amount. For FY 2025, CMS finalizes their proposal 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".

CMS is finalizing its proposal to apply a uniform national budget neutrality adjustment to the FY 2025 wage index for the rural floor of 0.977499, which would reduce wage indexes by 2.3 percent. CMS estimates 771 hospitals would see an increase in their FY 2025 wage index due to the application of the rural floor.

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 referred to as 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 final rule, 41 hospitals within the frontier states would receive the frontier floor value of 1.0000 for their FY 2025 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 did not propose 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 offer an opportunity for certain low wage index hospitals to increase employee compensation by increasing the wage index values for these locations (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. Because of this, CMS believes it needs data from additional fiscal years for analysis before making any decision to modify or discontinue the policy. Therefore, for FY 2025, CMS is finalizing its proposal to continue the low wage index hospital policy and budget neutrality adjustment for at least 3 more years. The first full fiscal year of wage data after the COVID-19 PHE is the FY 2024 wage data, which CMS expects to be available for FY 2028 policy making.

Transforming Episode Accountability Model (TEAM)

The FY 2025 IPPS proposed rule contains payment and policy changes for the operating and capital-related costs of acute care hospitals. The proposed Transforming Episode Accountability Model (TEAM) is a 5-year mandatory model starting January 1, 2026, and ending December 31, 2030. Through financial accountability, TEAM is intended to improve patient care for the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacements (LEJR), major bowel procedures, surgical hip/femur fracture treatments (SHFFT), and spinal fusions. Instead of paying providers and suppliers individually for each item or service, TEAM proposes to hold hospitals and suppliers accountable for all items and services provided during the entire episode of care. This will reduce fragmented, unnecessary or duplicative care and incentivize providers to better coordinate, resulting in improved patient care.

With limited exceptions, all acute care hospitals paid under IPPS and located within the Core-Based Statistical Areas (CBSAs) that CMS selects for model implementation are required to participate in TEAM. CMS estimates that TEAM will save Medicare $481 million across the 5 testing years. Because this is a multi-faceted model, CMS is finalizing some TEAM policies as proposed (including model performance period and start date, TEAM participant requirements, monitoring model activities, noncompliance repercussions and model termination); and others with modification (such as refining the definition of TEAM participant to account for hospitals eligible to volunteer for the model). There are also certain proposed TEAM policies that CMS is not finalizing and will instead go through future rulemaking to implement new policies before the model start date.

Changes to the Hospital Readmissions Reduction Program (HRRP)

Under the Hospital Readmissions Reduction Program (HRRP), 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. The program uses six claims-based measures to track unplanned inpatient admissions within 30 days following discharge: 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.

CMS used the data collected from these measures and notes a reduction in inpatient readmission rates for the conditions and procedures included in the program. However, studies have found an increase in other types of post-discharge events, such as patients visiting the emergency department (ED) or receiving observation services as an outpatient after being discharged from an inpatient stay. CMS is concerned that the hospital quality reporting and value-based purchasing programs are not providing adequate incentive for hospitals to

improve quality of care by accounting for additional types of post-discharge events in addition to inpatient readmissions.

For FY 2025, CMS did not propose any changes. However, CMS requested 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.

Among the public comments provided, some commenters included recommendations to track ED visits and observation services through the HRRP, which would provide better analysis of post-discharge care; while others recommended only tracking post-discharge observation services but not ED visits. Some commenters expressed concerns the readmission measures may not account for factors out of the patient's or hospital's control, such as patient's condition severity, social determinants of health, and admissions unrelated to the initial admission. And still other commenters urged CMS to "ensure that measures capturing readmissions would not unfairly penalize hospitals that disproportionately serve populations with health-related social needs."

CMS stated they would take all feedback in consideration as part of future rulemaking and referred readers to their updated Z code payment policy for homelessness and housing instability for FY 2025 (see section "Changes to Code Severity (MCCs, CCs or non-CCs)".

Changes to the Hospital Value-Based Purchasing (VBP) Program

The Hospital Value-Based Purchasing (VBP) Program was created to provide value-based incentive payments to hospitals based on their performance on measures established in a performance period for a fiscal year. CMS estimates no net financial impact to the Hospital VBP Program for FY 2025. By law, the amount available for value-based incentive payments under the program for each year must equal the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount available for value-based incentive payments for FY 2025 discharges is approximately $1.7 billion.

CMS is finalizing their proposals for FY 2025:

- Modify 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 in the Hospital VBP Program 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 scoring on the HCAHPS Survey beginning with the FY 2030 program year to incorporate the updated HCAHPS Survey measure into nine survey dimensions.
- Provide previously and newly established performance standards for FY 2027 through FY 2030 program years for the Hospital VBP Program.

CMS is not making any changes to previously adopted quality measures for the Hospital VBP program. Readers should refer to the FY 2023 IPPS/LTCH PPS final rule (87 FR 49110 through 49111) for summaries of previously adopted measures for FY 2025.

Hospital-Acquired Condition (HAC) Reduction Program

Section 1186 of the Act established 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 ranks hospitals based on six measures.

CMS is not making any proposals or updates for the HAC Reduction Program for FY 2025. Readers should refer to the FY 2014 IPPS/LTCH PPS final rule (78 FR 50707 through 50709) for a general overview and detailed discussion of the statutory basis of the HAC Reduction Program. Readers should refer to 42 CFR 412.170 through 412.172 for codified HAC Reduction Program requirements. The previously finalized measures for the HAC Reduction Program are shown in the following table:

TABLE V.M.-01: HAC REDUCTION PROGRAM MEASURES FOR FY 2025 AND SUBSEQUENT YEARS

Short Name	Measure Name	Consensus Based Entity (CBE) #
CMS PSI 90*	CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531
CAUTI**	CDC NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure	0138
CDI**	CDC NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure	1717
CLABSI**	CDC 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**	CDC NHSN Facility-wide Inpatient Hospital-onset Methicillin resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure	1716

*Technical specifications for the CMS PSI 90 measure can be found on the QualityNet website available at: https://qualitynet.cms.gov/inpatient/measures/psi/resources

**Technical specifications for the CDC National Healthcare Safety Network (NHSN) HAI measures can be found at the CDC's NHSN website at http://www.cdc.gov/nhsn/acute-care-hospital/index.html and on the QualityNet website available at: https://qualitynet.cms.gov/inpatient/measures/hai/resources

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 is finalizing their proposal of a 3.4 percent operating market basket rate-of-increase for FY 2025, which will be applied to the FY 2024 target amounts to calculate the FY 2025 target amounts.