Kansas Hospital Association

Summary of the Fiscal Year 2025 Inpatient Prospective Payment System Final Rule

The Centers for Medicare and Medicaid Services released the FY 2025 Inpatient Prospective Payment System (IPPS) Final Rule on August 1, 2024. KHA has prepared the summary of major provisions below. Our comments to CMS on the proposed rule can be found here.

Summary of Major Provisions:

- IPPS Payment Increase of 2.9%

- Disproportionate Share Hospital (DSH) uncompensated care payments will decline by approximately $200 million due to a lower national uninsured rate.

- Wage Index:
  - CMS extended the low wage index policy for three more years (which, unless appealed, is vacated due to the D.C. Court of Appeals decision in Bridgeport Hospital v. Becerra)
  - County redesignations:
    - Cherokee County becomes urban under the Joplin, MO-KS CBSA
    - Kingman County is will no longer designated urban
    - Franklin County is redesignated as urban as a "Lugar" county (Kansas City, MO-KS)

- Extension of MDH designation and LVH adjustment
  - CMS is implementing the extension of the MDH program and LVH adjustment through December 31, 2024 as mandated by Congress.
  - Unless Congress extends these into 2025, the Medicare-Dependent, Small Rural Hospital (MDH) Program and Low Volume Hospital adjustment will end.
  - CMS notes that if the program expires, MDH hospitals will be able to apply for Sole Community Hospital designation in advance of the expiration of the MDH program.
    - **MDH hospitals must apply for SCH status by December 2, 2024** to gain SCH status by January 1, 2025

- Separate IPPS payment for establishing and maintaining access to essential medicines
  - CMS will provide a separate IPPS payment to independent hospitals with 100 beds or less to establish and maintain a 6-month buffer stock of one or more of 86 essential medicines
    - Costs can include those associated with "utilities like cold chain storage and heating, ventilation, and air conditioning, warehouse space, refrigeration, management of stock including stock rotation, managing expiration dates, and managing recalls, administrative costs related to contracting and recordkeeping, and dedicated staff for maintaining the buffer stock(s)."
    - These costs do not include the cost of the medicines themselves, which would continue to be paid in the current manner.

- The use of IPPS shares in this payment adjustment would be consistent with the use of these shares for the payment adjustment for domestic NIOSH approved surgical N95 respirators, which is based on the IPPS and OPPS shares of the difference in cost between domestic and non-domestic NIOSH approved surgical N95 respirators for the cost reporting period in which costs are claimed (87 FR 72037).
- Hospitals will report these costs to CMS on forthcoming supplemental cost reporting worksheets associated with this proposed policy
- Estimated payment from Medicare is $600 per each eligible hospital

- Quality:
  - Hospital Value-Based Purchasing (VBP) Program
    - CMS adopted certain measures for the Clinical Outcomes domain (MORT–30– AMI, MORT–30–HF, MORT–30–PN (updated cohort), MORT–30– COPD, MORT–30–CABG, and COMP–HIP– KNEE) and the Efficiency and Cost Reduction domain (MSPB Hospital) for future program years.
    - CMS established performance standards for the FY 2030 program year for the Clinical Outcomes domain and the Efficiency and Cost Reduction Domain.
    - Modifying scoring of the HCAHPS survey measure in the Hospital VBP Program for the FY 2027 to FY 2029 program years to only score on the six unchanged dimensions of the survey
    - Modifying scoring on the HCAHPS Survey measure beginning with the FY 2030 program year to account for the updated measure

  - Inpatient Quality Reporting (IQR) Program
    - Adopted seven new measures:
      - Patient Safety Structural measure beginning with the CY 2025 reporting period/FY 2027 payment determination;
        - Assesses whether hospitals have a structure and culture that prioritizes safety as demonstrated by the following 5 domains:
          - Leadership commitment to eliminating preventable harm;
          - Strategic planning and organizational policy;
          - Culture of safety and learning health system;
          - Accountability and transparency; and
          - Patient and family engagement
        - Hospitals will attest to whether they engage in specific evidence-based best practices within each of these domains to achieve a score from zero to five out of five points
      - Age Friendly Hospital measure beginning with the CY 2025 reporting period/FY 2027 payment determination;

- Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations beginning with the CY 2026 reporting period/FY 2028 payment determination;
- Central Line Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations beginning with the CY 2026 reporting period/FY 2028 payment determination;
- Hospital Harm - Falls with Injury eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination;
- Hospital Harm - Postoperative Respiratory Failure eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination;
- Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) measure beginning with the July 1, 2023 – June 30, 2025 reporting period/FY 2027 payment determination.

▪ Refined two current measures:
- Global Malnutrition Composite Score (GMCS) eCQM, beginning with the CY 2026 reporting period/FY 2028 payment determination;
- HCAHPS Survey beginning with the CY 2025 reporting period/FY 2027 payment determination

▪ Removed five existing measures:
- Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI 04) measure beginning with the July 1, 2023 – June 30, 2025 reporting period/FY 27 payment determination;
- Hospital- level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Acute Myocardial Infarction (AMI) measure beginning with the July 1, 2021 – June 30, 2024 reporting period/ FY 2026 payment determination;
- Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Heart Failure (HF) measure beginning with the July 1, 2021 – June 30, 2024 reporting period/FY 2026 payment determination;
- Hospital level, Risk-Standardized Payment Associated with a 30-Day Episode-of-Care for Pneumonia (PN) measure beginning with July 1, 2021 – June 30, 2024 reporting period/FY 2026 payment determination,
- 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) measure beginning with the April 1, 2021 – March 31, 2024 reporting period/FY 2026 payment determination

o Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS):
▪ The HCAHPS survey is updated with a new total of 32 questions (up from 29 questions).
▪ Changes would be implemented in the Hospital IQR and PCHQR Programs beginning with patients discharged on January 1, 2025.
▪ The updated survey includes three new sub-measures and seven new questions:

- Care Coordination (three new questions):
  - During this hospital stay, how often were doctors, nurses and other hospital staff informed and up-to-date about your care?
  - During this hospital stay, how often did doctors, nurses and other hospital staff work well together to care for you?
  - Did doctors, nurses or other hospital staff work with you and your family or caregiver in making plans for your care after you left the hospital?
- Restfulness of Hospital Environment (three new questions):
  - During this hospital stay, how often were you able to get the rest you needed?
  - During this hospital stay, how often was the area around your room quiet at night?
  - During this hospital stay, did doctors, nurses and other hospital staff help you to rest and recover?
- Information About Symptoms (one new question):
  - 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?

▪ The existing "Care Transition" sub-measure is removed
▪ "Responsiveness of Hospital Staff" sub-measure is modified to remove the current question and add one new survey question:
  - During this hospital stay, when you asked for help right away, how often did you get help as soon as you needed?
▪ Removed four questions:
  1. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
  2. 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.
  3. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
  4. When I left the hospital, I clearly understood the purpose for taking each of my medications.

- eCQMs
  - Eligible hospitals and CAHs will be required to report a total of eight eCQMs for the CY 2026 reporting period, a total of nine eCQMs for the CY 2027 reporting period, and a total of eleven eCQMs beginning with the CY 2028 reporting period.
  - Adopt two new eCQMs that hospitals can select as one of their three self-selected eCQMs beginning with the CY 2026 reporting period:
    - Hospital Harm – Falls with Injury eCQM

- Hospital Harm – Postoperative Respiratory Failure eCQM

- Medicare Promoting Interoperability Program
  - Separate the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures beginning with the EHR reporting period in CY 2025:
    - Antimicrobial Use (AU) Surveillance measure
    - Antimicrobial Resistance (AR) Surveillance measure
  - Add a new exclusion for eligible hospitals and CAHs that do not have a data source containing the minimal discrete data elements that are required for AU or AR Surveillance reporting
  - Increase the performance-based scoring threshold for eligible hospitals and CAHs reporting under the Medicare Promoting Interoperability Program from 60 points to 70 points for the EHR reporting period in CY 2025 and from 70 points to 80 points beginning with the EHR reporting period in CY 2026

- Proposed Distribution of Additional Residency Positions Under the Provisions of Section 4122 of Subtitle C of the Consolidated Appropriations Act, 2023 (CAA, 2023)
  - CMS finalized its distribution policy for the 200 residency positions Congress allocated in the Consolidated Appropriations Act of 2023 (CAA, 2023). At least 100 of these positions will be for psychiatry residency training programs.
    - For FY 2026, the Secretary shall initiate an application round to distribute the positions
      - Application deadline will be March 31, 2025
  - The Secretary is required to distribute not less than 10% of resident positions available for distribution to each of four categories of hospitals:
    - Hospitals that are located in a rural area or treated as being located in a rural area
    - Hospitals operating over their Medicare residency cap
    - Hospitals located in states with new medical schools or additional locations (Kansas included)
    - Hospitals that serve areas designated as Health Professional Shortage Areas (HPSAs)
  - CMS must consider the "demonstrated likelihood" of filling the additional slots.
    - Defined as a hospital demonstrating that 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
  - Each qualifying hospital that submits a timely application would receive at least 1 (or a fraction of 1) of the positions made available before any hospital receives more than 1 of such positions. Hospitals are capped to receiving no more than 10 additional FTEs.
  - Any remaining residency slots will be assigned via HPSA score
    - CMS recognized KHA's comments of concerns and recommendations for updating the HPSA formula to better reflect the needs of areas with small populations. The current metrics to calculate a HPSA score are not reflective of rurality or unique access problems associated with rural areas including that rural areas see higher utilization of services by

older adult populations. CMS disagreed and stated that "education and outreach regarding the opportunities available … rather than abandoning the HPSA prioritization method … is the appropriate course of action at this point."

- Proposed Modifications to the Criteria for New Residency Programs and Requests for Information
    - CMS recognized comments expressing concern from the vast majority of stakeholders, including KHA, and did not finalize a proposal for determining "newness" of a residency program. CMS has initiated another RFI on this topic.

- Transforming Episode Accountability Model (TEAM)
    - A 5-year mandatory model beginning on January 1, 2026
    - Tests a new episode-based payment model for acute care hospitals (paid under IPPS) based on lessons learned from the BPCI and CJR models.
    - Goal:
        - Improve beneficiary care and reduce costs through financial accountability for episode categories that begin with one of the following procedures: coronary artery bypass graft surgery (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion.
        - TEAM will test whether financial accountability for these episode categories reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.
        - If TEAM is successful, CMS hopes this model would establish the framework for managing episodes as a standard practice in Traditional Medicare.
    - Risk:
        - All hospitals will have the option of Track 1, a 1-year glide path for all TEAM participants (all upside risk with the quality adjustment applied to positive reconciliation amounts)
            - Subject to a 10 percent stop-gain limit and a Composite Quality Score (CQS) adjustment percentage of up to 10 percent
            - During Track 1, TEAM participants will be rewarded for their work to improve quality and cost outcomes for their episodes, but not be held financially accountable if spending exceeds the reconciliation target price.
            - Safety-net hospitals can extend this glide path for the first 3 years.
        - Track 2: years 2-5, safety net, rural, MDH, SCHs and essential access community hospitals can select financial risk of upside and downside of 5% and a CQS adjustment percentage of up to 10% for positive reconciliation amounts and up to 15% for negative reconciliation amounts.
        - Track 3: available to all TEAM participants for all 5 years and has two-sided financial risk in the form of reconciliation payments or repayment amounts, subject to 20 percent stop-gain and stop-loss limits and a CQS adjustment percentage of up to 10 percent.

TABLE X.A.-02: SUMMARY OF FINAL TEAM PARTICIPATION TRACKS

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

- Safety Net Hospital Definition:
  - Exceeds the 75th percentile of the proportion of Medicare beneficiaries considered dually eligible for Medicare and Medicaid across all PPS acute care hospitals in the baseline period.
  - Exceeds the 75th percentile of the proportion of Medicare beneficiaries partially or fully eligible to receive Part D low-income subsidies across all PPS acute care hospitals in the baseline period.
- Episode Length:
  - Will include non-excluded Medicare Parts A and B items and services and would begin with an anchor hospitalization or anchor procedure and will end 30 days after hospital discharge
- Episodes begin with an acute care hospital stay or HOPD procedure visit.
  - It is not appropriate to hold a PAC provider or hospital other than the TEAM participant fully financially accountable for an episode.
- Structure:
  - TEAM participants continue to bill Medicare under the traditional FFS system for services furnished to Medicare FFS beneficiaries. However, the TEAM participant may also receive a reconciliation payment amount from CMS depending on their Composite Quality Score (CQS) and if their performance year spending is less than their reconciliation target price. As TEAM is a two-sided risk model, meaning the model requires TEAM participants to be accountable for performance year spending that is above or below their reconciliation target price, TEAM participants may also owe CMS a repayment amount depending on their CQS and if their performance year spending is more than their reconciliation target price.
  - Performance in the model will be assessed by comparing TEAM participants' actual Medicare FFS spending during a performance year to their reconciliation target price as well as by performance on three quality measures.

- CMS did not finalize a low-volume threshold but originally proposed a threshold of 31 cases across the three baseline years.
  - CMS will propose a new threshold in future rulemaking before the model goes live in 2026.
- Areas Selected in Kansas:
  - CBSA 11680 Arkansas City-Winfield (1 sample)
    - No PPS hospital – transitioned to an REH
  - CBSA 24460 Great Bend, KS (1 sample)
    - The University of Kansas Health System Great Bend
  - CBSA 25700 Hays, KS (2 sample)
    - HaysMed
  - CBSA 26740 Hutchinson, KS (3 sample)
    - Hutchinson Regional Medical Center
    - Summit Surgical Hospital
  - CBSA 29940 Lawrence, KS (1 sample)
    - LMH Health

- CoP Requirements for Hospitals and CAHs to Report Acute Respiratory Illnesses
  - CMS is revising and making permanent the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend a modified form of the current COVID-19 and influenza reporting requirements that would include data for RSV
  - Beginning on November 1, weekly reporting by hospitals and CAHs will include:
    - Confirmed infections of respiratory illnesses, including COVID-19, influenza, and RSV, among hospitalized patients;
    - Hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric]); and
    - Limited patient demographic information, including age
  - Outside of a declared PHE for an acute infectious illness, hospitals and CAHs will have to report these data on a weekly basis through the NHSN or other CDC-owned or supported system as determined by the Secretary.

- Changes to the Severity Level Designation for Z Codes Describing Inadequate Housing and Housing Instability
  - CMS changed the Z Codes of inadequate housing and housing instability from non-complication or comorbidity (non-CC) to complication or comorbidity (CC) for FY 2025.