American College of Radiology™

Fiscal Year 2025 Inpatient Prospective Payment System Proposed Rule
Detailed Summary

On Wednesday, April 10th, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2025 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System Proposed Rule. The proposed rule provides updates for Medicare fee-for-service payment rates and policies for inpatient hospitals and long-term care hospitals for FY 2025. CMS pays acute care for inpatient stays under the IPPS. Under this payment system, CMS sets base payment rates for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge through Medicare Severity Diagnosis-Related Groups (MS-DRGs). Comments are due to CMS by June 10, 2024.

Proposed Payment for FY 2025
CMS proposes a base FY 2024 update of +2.6%. This is based on a market basket update of 3.0% and the multifactor productivity (MPF) adjustment, which CMS estimates to be a 0.4 percentage point reduction. CMS proposed an update of 0.35 percent for hospitals that submit quality data and are not considered "meaningful EHR users," proposed update of 1.85 percent for hospitals that fail to submit quality data but are considered "meaningful EHR users". For hospitals that fail to submit quality data and are not considered "meaningful EHR users" have a proposed update of -0.4%. For FY 2025, CMS expects the proposed changes in operating and capital IPPS payment rates will generally increase hospital payments by $3.2 billion.

Data Used in Rate Setting
CMS proposes to use the FY 2023 Medicare Provider Analysis and Review (MedPAR) claims file as well as the Medicare cost report data files from the December 2023 update of the FY 2022 Healthcare Cost Report Information System (HCRIS) dataset for purposes of FY 2025 ratesetting. This is consistent with CMS's historical practice of using the HCRIS dataset that is 3 years prior to the IPPS fiscal year.

Market-Based MS-DRG Relative Weight: Proposed Policy Changes
CMS calculated the proposed FY 2025 relative weights based on 19 cost-to-charge (CCR) ratios. The proposed methodology uses claims data in the FY 2023 MedPAR file and data from the FY 2022 Medicare cost reports. The charges for each of the 19 cost groups for each claim were standardized to remove the effects of differences in area wage levels, indirect medical education (IME) and disproportionate share hospital (DSH) payments, and for hospitals located in Alaska and Hawaii, the applicable cost-of-living adjustment.

Proposed FY 2025 Applications for New Technology Add-On Payments

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To improve flexibility for applicants for NTAP, CMS is proposing to use the start of the fiscal year, October 1, instead of April 1, to determine whether a technology is within its 2- to 3-year newness period. This change would be effective starting in FY 2026 for new applicants for NTAP and when extending NTAP for an additional year for technologies initially approved for NTAP in FY 2025 or subsequent years. Beginning with applications for NTAP for FY 2026, CMS is proposing to no longer consider an FDA marketing authorization hold status to be an inactive status for the purpose of the NTAP application eligibility.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals
CMS is proposing to revise the labor market areas used for the wage index based on the most recent core-based statistical area delineations issued by the Office of Management and Budget (OMB) based on 2020 Census data.

Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2025
Medicare makes DSH payments to IPPS hospitals that serve a high percentage of certain low-income patients. In this proposed rule, CMS is proposing to update their estimates of the three factors used to determine uncompensated care payments for FY2025. Consistent with the regulation at § 412.106(g)(1)(iii)(C)(11), which was adopted in the FY 2023 IPPS/LTCH PPS final rule, for FY 2025, CMS will use the 3 most recent years of audited data on uncompensated care costs from Worksheet S–10 of the FY 2019, FY 2020, and FY 2021 cost reports to calculate Factor 3 in the uncompensated care payment methodology for all eligible hospitals. Beginning with FY 2023, CMS established a supplemental payment for Indian Health Service (IHS) and Tribal hospitals and hospitals located in Puerto Rico.

CMS is also proposing, for FY 2025 and subsequent fiscal years, to calculate the per-discharge amount for interim uncompensated care payments using the average of the most recent 3 years of discharge data. Accordingly, for FY 2025, CMS proposes to use an average of discharge data from FY 2021, FY 2022, and FY 2023. CMS believes this will likely result in a better estimate of the number of discharges during FY 2025 and subsequent years for purposes of the interim uncompensated care payment calculation. CMS projects Medicare uncompensated care payments to disproportionate share hospitals (DSH) will increase in FY 2025 by approximately $560 million.

Medicare Promoting Interoperability Program
The Medicare Promoting Interoperability Program encourages eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record (EHR) technology (CEHRT).

CMS is proposing to separate one existing measure into two distinct measures, proposing to adopt two new eCQMs, proposing to modify one current eCQM, proposing to increase the

performance-based scoring threshold, notifying eligible hospitals and CAHs of one Request for Information.

CMS is also proposing to increase the total number of mandatory eCQMs reported by hospitals over two years.

Distribution of GME residency slots under section 4122 of the Consolidated Appropriations Act (CAA), 2023

Section 4122 of the CAA, 2023, requires the distribution of an additional 200 Medicare-funded residency positions to train physicians. The provision dedicates at least one-half of the total number of positions to psychiatry or psychiatry subspecialty residencies. The law requires CMS to notify hospitals receiving residency positions under section 4122 by January 31, 2026. CMS is proposing to implement policies that will govern the application and award process in line with the statutory requirements. Additionally, CMS is proposing, to the extent slots are available, to focus on health professional shortage areas to help bolster the healthcare workforce in rural and underserved areas. CMS estimates that this additional funding will total approximately $74 million from FY 2026 through FY 2036.

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The PCHQR Program was established by Section 3005 of the Affordable Care Act, which added subsections (a)(1)(W) and (k) to section 1866 of the Social Security Act. The eleven designated eligible hospitals are excluded from payment under the Inpatient Prospective Payment System. CMS collects and publishes data from PCHs on applicable quality measures. In this proposed rule, CMS is proposing to adopt the Patient Safety Structural measure beginning with the CY 2025 reporting period/FY 2027 program year. CMS is also proposing to modify the HCAHPS Survey measure and to move up the start date from July 2026 to January 2026 for publicly displaying hospital performance on the Hospital Commitment to Health Equity measure, or as soon as feasible thereafter.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program is a value-based purchasing program that reduces payments to hospitals with excess readmissions. CMS is not proposing any changes to the Hospital Readmissions Reduction Program in the FY 2025 IPPS/LTCH PPS proposed rule.

Hospital Inpatient Quality Reporting (IQR) Program

New Measures

In the FY 2025 IPPS/LTCH PPS proposed rule, CMS proposes adopting seven new quality measures into the Hospital Inpatient Quality Reporting (IQR) program. While most of the proposed measures focus on reducing hospital harm by collecting data on infection rates and postoperative outcomes, the Patient Safety and Age Friendly structural measures proposed to begin with calendar year 2025 reporting and fiscal year 2027 payment determination intends to

measure hospitals' and facilities' patient-centered safety culture. The measures comprise five domains, each containing quality statements that users must affirm are implemented in their hospital or facility. These structural measures are scored based on a site's attestation that the statements within each domain are met. Because IQR is a pay-for-reporting program, hospitals would be awarded credit for reporting their measure results regardless of their responses to the attestation questions.

Reporting and Submission Requirements for eCQMs
In this rule, CMS proposes increasing the mandatorily reported electronic clinical quality measures (eCQMs) over two years, starting with calendar years 2026 and 2027. Over these two years, hospitals will be required to report five additional eCQMs, compared to the three they are currently required to report. While the three measures CMS proposes for adoption into the IQR program beginning with the 2026 reporting period address hospital harm associated with hypoglycemia and opioid-related events, the measures proposed for IQR inclusion starting with the 2027 reporting period focus on hospital harm regarding acute kidney injury and pressure injury. However, when a hospital or facility does not have patients meeting the measure denominator criteria for any of the proposed eCQMs, the hospital would submit a zero-denominator declaration for the measure, allowing a hospital to meet the reporting requirements for a particular eCQM. If these eCQM proposals are finalized, hospitals and facilities will become responsible for reporting up to nine eCQMs. CMS would designate six measures for mandatory reporting and three for self-selection from a list of available eCQMs.

Finalized in the FY 2024 IPPS/LTCH PPS Final Rule, the *Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults* eCQM will become available at the start of the 2025 reporting year. This measure is directly attributable to radiology departments and facilities included in the IQR program; CMS includes it as an option for one of the three measures hospitals and facilities must choose to submit. ACR continues communicating with CMS and our allied organizations to prepare participating hospitals and facilities for the measure's implementation.

Request for Information to Advance Patient Safety and Outcomes Across the Hospital Quality Programs
CMS is requesting comments on ways to build on current measures in several quality reporting programs that account for unplanned patient hospital visits to encourage hospitals to improve discharge processes. While CMS's hospital quality reporting and value-based purchasing programs currently encourage hospitals to address concerns about unexpected returns through several existing measures, CMS recognizes that these measures do not comprehensively capture unplanned patient returns to inpatient or outpatient care after discharge. CMS is interested in input on adopting measures that better represent the range of outcomes of interest to patients, including unplanned returns to the emergency departments and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.