HEALTHCARE REGULATORY ROUND-UP #78

TEAM and Other Key Provisions of the 2025 IPPS Final Rule

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Introductions

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Today's Top 10

1. Payment rates and wage index policy
2. Buffer stocks of essential medicines
3. New technology add-on payments
4. Severity designation of Z-codes for housing inadequacy/instability
5. Value-based purchasing programs
6. Inpatient Quality Reporting Program
7. Promoting Interoperability
8. Respiratory disease reporting requirements
9. FY 2025 IRF, IPF, and SNF final rules
10. Transforming Episode Accountability Model (TEAM)

1. Payment Rates and Wage Index Policy

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Payment Update - Is It REALLY a 2.9% Increase?

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**

89 Fed. Reg. 69,343 (Aug. 28, 2024)

American Hospital Association
https://www.aha.org › news › headline › 2024-08-01-cm...

CMS hospital IPPS final rule to increase payments by 2.9% ...

Aug 1, 2024 — CMS **hospital** IPPS final rule to increase payments by **2.9**% for FY **2025** · Adopt new core-based statistical areas for the purposes of determining ...

Becker's Hospital Review
https://www.beckershospitalreview.com › finance › cms...

CMS sets 2.9% inpatient pay bump for hospitals in 2025

Aug 2, 2024 — CMS on Aug. 1 released its **Inpatient** Prospective Payment System fi which will increase **inpatient hospital** payments by **2.9**% in fiscal year 2025.

Healthcare Dive
https://www.healthcaredive.com › news › medicare-inp...

Medicare finalizes higher 2.9% inpatient payment rate for ..

Aug 2, 2024 — The Biden administration has finalized a **2.9**% payment hike for **inpati hospitals** in Medicare next year, an increase over the 2.6% that ...

FierceHealthcare
https://www.fiercehealthcare.com › regulatory › cms-fi...

CMS finalizes 2.9% pay bump for inpatient hospitals in ...

Aug 1, 2024 — The Centers for Medicare & Medicaid Services said in a press release rates will likely increase payments to **inpatient hospitals** by $2.9 billion.

Actual Payment Update

- Increase of ~1.67% over FY 2024
  - Start with market basket update of 3.4%, less 0.5 percentage points productivity adjustment
  - And then budget neutrality (BN) adjustments –
    - Revised CBSA BN transition/5% cap policy = -0.05%
    - Lowest quartile BN = -0.02%
    - MS-DRG/Wage Index BN = -0.27%
    - MS-DRG Weight Cap BN = -0.01%
    - Reclassification BN = -0.88%
    - Rural Demonstration BN = +0.03%
- Used FY 2023 claims and FY 2022 cost report data for rate setting

Other Rate Revisions

- Capital rate increased to $510.51
  - Currently $503.83; proposed at $516.61
- Outlier threshold increased to $46,152
  - Currently $42,750; proposed $49,237
  - Decrease in outlier payments relative to FY 2024

MS-DRG Relative Weights and Classifications

- Use single year data to set weights
  - FY 2023 MedPAR claims
- Update list of reimbursable MS-DRGs
  - 12 new DRGs, deleted 3
- Modify list of MS-DRGs subject to post-acute care transfer policy
  - Add MS-DRGs 426-428 (multiple level combined anterior and posterior spinal fusion except cervical)
  - Add MS-DRGs 447 and 448 (multiple level spinal fusion except cervical)

Core-Based Statistical Area (CBSA) Changes

- Adopted updated OMB labor market areas
  - Rural markets becoming urban, urban becoming rural
- CMS: current 5% cap on year-to-year decreases adequately mitigates any negative financial impacts of changes

Low Wage Index Redistribution Policy

- Maintain low wage index hospital policy (hospitals with wage index < 25th percentile) for FY 2025
  - Increases wage index to half the difference between otherwise applicable hospital-specific wage index value and 25th percentile for all hospitals
  - Policy applied in budget-neutral manner by adjusting standardized amounts (winners and losers)
- Potential impact of court decision to vacate CMS low wage index redistribution policy
  - In July, appeals court held CMS lacked statutory authority to make redistributions
  - Previous court decision remanded the rule (2022) and told CMS to recalculate the wage indexes
  - How will CMS respond?
    - Appeal to Supreme Court?
    - Application to hospitals outside the appeal?
    - Potential for repayment/recoupment?

Medicare DSH and UCC

- Uses three most recent years of audited data from Worksheet S-10 (FYs 2019-2021)
- Decrease in DSH/UCC payments of ~$235 million
  - Proposed rule projected increase of ~$568 million
- Uses current Medicare DSH formula
  - 25% of “empirically justified” payments (based on original statutory formula)
  - 75% separate funding pool updated to reflect percent of uninsured
    - Distributed based on proportion of total uncompensated care provided
    - Uses 3-year average of most recent fiscal years for which audited cost report data available

Graduate Medical Education

- Increase GME funding by $74 million
  - Per section 4122 of Consolidated Appropriations Act, 2023
  - Allows for 200 additional residency slots from 2026-2036
  - Focus on health professional shortage areas (HPSAs) and psychiatry/psychiatry subspecialty residents (at least 100 slots)

2. Buffer Stocks of Essential Medicines

Image Source: Shutterstock

New Payments To Cover Buffer Stock Maintenance

- Intended to address resiliency of medical supply chains
- Separate IPPS payment to small, independent hospitals to cover cost of maintaining voluntary six-month buffer stock of 86 essential medicines
  - Small = 100 or fewer beds
  - Independent = not part of chain organization
- Payment covers additional resource costs related to maintenance (ventilation, managing expiration dates, etc.), not cost of drugs themselves
- Applies to cost reporting periods beginning on/after 10/1/24 (lump sum at cost report settlement or biweekly payments reconciled with cost report)

3. New Technology Add-On Payments

Image Source: Shutterstock

New Technology Add-On Payments (NTAP)

- Increase NTAP percentage from 65% to 75% of estimated costs of new technology for gene therapy for treatment of sickle cell disease
  - FY 2025 through end of ‘new’ period (2-3 years)
- Continue coverage for 24 technologies still considered ‘new’
  - Discontinued coverage for 7 no longer considered ‘new’
  - Approved 5 new technologies for FY 2025
- Change from April 1 to October 1 cut-off to determine 2-3-year newness period
  - Applies to new NTAP applicants and when extending NTAP for extra year for technologies initially approved in FY 2025 or later

4. Z-codes for Housing Inadequacy & Instability

Image Source: Shutterstock

Severity Level Designation – Non-CC to CC

- In 2024, changed severity level designation from (Non-CC) to (CC) for claims with Z-codes for homelessness
  - Based on claims data analysis of impact on resource use (i.e., more costly to care for these patients than previously believed)
  - Example – simple pneumonia
    - MS-DRG 195 (non-CC) = 0.6256
    - MS-DRG (CC) = 0.8222
- For 2025, add Z-codes for housing inadequacy/instability

ICD-10-CM Code[a]	Description[b]
Z59.10	Inadequate housing, unspecified
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing utilities
Z59.19	Other inadequate housing
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified

5. Value-Based Purchasing

Image Source: Shutterstock

Maintain Status Quo

1. Hospital Readmission Reduction Program (HRRP)
   - No changes
2. Hospital Value-Based Purchasing (HVP)
   - Future changes to HCAHPS survey measures and scoring
3. Hospital-Acquired Conditions (HAC) Penalty
   - No changes

6. Inpatient Quality Reporting Program

Image Source: Shutterstock

New Measures

- eCQMs
  - Falls With Injury eCQM (CY 2026)
  - Post-operative Respiratory Failure eCQM (CY 2026)
- Claims-based measure
  - 30-day Risk-standardized Death Rate Among Surgical Inpatients With Complications (failure-to-rescue) measure (7/1/2023 – 6/30/2025 reporting period) (replaces Death Among Surgical Inpatients with Serious Treatable Complications measure)
- Structural measures
  - Patient Safety structural measure (CY 2025)
  - Age-friendly Hospital structural measure (CY 2025)
- Healthcare associated infection (HAI) measures
  - Catheter-associated UTI Standardized Infection Ratio Stratified for Oncology Locations measure (CY 2026)
  - Central Line-associated Bloodstream Infection Standardized Infection Ratio Stratified for Oncology Locations measure (CY 2026)

Measure Updates

- Future increases in eCQM reporting
  - Currently report 6 measures; increase to 8 in 2026, 9 in 2027, 11 in 2028 (3 self-selected each year)
- Modified measures
  - Global Malnutrition Composite Score eCQM – include patients ages 18 to 64 (2026)
  - HCAHPS Survey – changes to survey measures for patients admitted on or after 01/01/2025.
- Payment measures to be deleted beginning with FY 2026 payment determination
  - Hospital-level, Risk-Standardized Payment for 30-Day Episode of Care for AMI
  - Hospital-level, Risk-Standardized Payment for 30-Day Episode of Care for Heart Failure
  - Hospital-level, Risk-Standardized Payment for 30-Day Episode of Care for Pneumonia
  - Hospital-level, Risk-Standardized Payment for 30-Day Episode of Care for Elective Primary THA/TKA

7. Promoting Interoperability

Image Source: Shutterstock

Program Updates

- Separate current Antimicrobial Use and Resistance Surveillance measure into 2 measures beginning in CY 2025
  - Antimicrobial Use Surveillance
  - Antimicrobial Resistance Surveillance
- Increase performance-based scoring threshold from 60 to 70 points for CY 2025 and from 70 to 80 points for CY 2026
- Changes to eCQM reporting to align with IQR Program

8. Respiratory Infection Reporting Requirements

Image Source: Shutterstock

Hospital and CAH Conditions of Participation

- Revise Infection Prevention and Control and Antibiotic Stewardship CoP to require weekly electronic reporting to CDC on respiratory infections (COVID-19, influenza, RSV) (with additional requirements during PHE)
  - Confirmed infection among hospitalized patients
  - Bed census and capacity
  - Limited patient demographics
- **Effective November 1, 2024**

9. FY 2025 IRF, IPF, and SNF Final Rules

Image Source: Shutterstock

Payment Rates

- New CBSA designations apply to IRF, IPF, and SNF programs
  - IRF (14.9%) and IPF (17%) rural add-on phased out over 3 years for facilities losing rural designation
- Payment updates
  - IRF - 3.0% rate increase (proposed 2.8%)
  - IPF - 2.8% rate increase (proposed 2.6%)
    - Includes revisions to IPF PPS patient-level adjustment factors (principal diagnosis, selected comorbidities, age, variable per diem rate) using updated regression model (previously used 2005 model)
  - SNF – 4.2% rate increase (proposed 4.1%)

10. Go, TEAM!

Image Source: Shutterstock

Transforming Episode Accountability Model

- Mandatory 5-year episodic payment model beginning 01/01/2026 under which hospital financially accountable for total cost of defined episode of care for traditional Medicare beneficiaries
  - Hospital = Selected PPS hospitals + voluntary participants
  - Episode of care = anchor event (specified inpatient stay/outpatient procedure) + ***30 days*** post-discharge/post-procedure
  - Total cost = all non-exempt Part A & B payments (prorated if service staddles episode)
  - Accountable = owe money if total cost > target price, receive additional payment if total cost < target price

Selected Episodes

1. Coronary artery bypass graft (CABG) (MS-DRGs 231-236)
2. Lower extremity joint replacement (LEJR) (MS-DRGs 469-470, 521-522 and HCPCS codes 27447, 27130, 27702)
3. Major bowel procedures (MS-DRGs 329-331)
4. Surgical hip/femur fracture treatment (SHFFT) (MS-DRGs 480-482)
5. Spinal fusion (MS-DRGs 402, 426-430, 447-448, 450, 471-473 and HCPCS codes 22551, 22554, 22612, 22630, 22633)

PPS Hospitals in Selected CBSAs

- Selected 188 of 803 eligible CBSAs
  - Weighted towards CBSAs with safety net hospitals and hospitals with limited bundled payment experience
  - At least 2 CBSAs with no eligible hospitals
- Includes 700+ hospitals representing 200,000+ episodes/year
- CMS anticipates nearly $0.5 billion in savings over 5 years

Table X.A.-07, 2025 IPPS Final Rule

Voluntary Participants

- Eligible hospitals
  - Comprehensive Care for Joint Replacement (CJR) participants as of 12/31/2024
  - 324 hospitals in 34 MSAs
  - Bundled Payment for Care Improvement-Advanced (BPCI-A) participating hospitals as of 12/31/2025
    - Physician practice groups, conveners not eligible
- Submit written participation election letter during voluntary election period (January 2025)

Level of Risk Based on Hospital Classification

- Safety net hospitals (exceed 75th percentile for either dual eligibles or Part D low-income subsidy recipients)
  - Upside only for PY 1-3 (10% stop-gain limit)
  - Upside/downside for PY 4-5 (5% stop-loss/stop-gain limits)
  - May elect higher degree of risk at beginning of performance year
- Rural hospitals (located in rural area or rural census tract, not hospitals reclassified as rural), Medicare dependent hospitals (MDH), sole community hospitals (SCH)
  - Upside only for PY 1 (10% stop-gain limit)
  - Upside/downside for PY 2-5 (5% stop-loss/stop-gain limits)
  - May elect higher degree of risk at beginning of performance year
- All other hospitals
  - Upside only for PY 1 (10% stop-gain limit)
  - Upside/downside PY 2-5 (20% stop-gain and stop-loss limits)

Preliminary Target Prices

- Prior to the start of each performance year, calculate price-standardized average hospital spending by DRG/HCPCS for 9 census regions
  - Use 3 years of historical data (e.g., 2026 based on 2022-24 data)
    - Year 1 = 17%; Year 2 = 33%; Year 3 = 50%
  - Exclude outlier episodes (≥ 99th percentile) and costs within episodes for specified unrelated items/services (e.g., certain inpatient admissions)
  - Apply prospective trend to performance year to account for changes in healthcare spending between baseline period and performance year
  - Apply applicable discount factor (CMS' guaranteed savings)
    - 1.5% for major bowel and CABG
    - 2.0% for LEJR, SHFFT, and spinal fusion

Risk Adjustment Factors

Prior to start of each performance year, perform linear regression analysis to produce exponentiated coefficients (anticipated impact of each factor on episode costs)

- Hospital-specific risk adjustment factors
  - Number of beds
  - Safety net hospital
- Beneficiary-specific risk adjustment factors
  - Age bracket
  - Number of HCCs during look-back period (length to be determined)
  - Social need
  - Episode category-specific beneficiary level risk adjustment factors (specified HCCs present as of first day of episode)

Annual Reconciliation Process

- Determine if low volume hospital policy applies
  - If hospital has less than to-be-determined number of episodes, no reconciliation performed
- For each qualifying episode, calculate performance year spend
  - Same methodology used to calculate preliminary target prices
- For each qualifying episode, calculate reconciliation target price
  - Adjust preliminary target price by applying risk adjustment factors
  - Apply normalization factor to account for changes in beneficiary health status/demographics
  - Apply retrospective trend factor to estimate realized changes in spending patterns during performance year (not to exceed +/- 3% of prospective trend factor)
- Calculate reconciliation amount by subtracting total reconciliation target price from total performance year spend
- Calculate Quality Composite Score (QCS) adjustment percentage and adjust reconciliation amount accordingly, subject to applicable percentage cap
- Apply stop loss/stop gain limits to determine final payment/re-payment amount

TEAM Quality Measures

- Performance Year 1
  - Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and EHR Data
  - CMS Patient Safety and Adverse Events Composite
  - Hospital-Level Total Hip and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (LEJR episodes only)
- Performance Year 2
  - Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and EHR Data
  - Hospital Harm – Falls with Injury
  - Hospital Harm – Postoperative Respiratory Failure
  - 30-day Risk Standardized Death Rate Among Surgical Inpatients with Complications
  - Hospital-Level Total Hip and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (LEJR episodes only)

Collaborator Sharing Arrangements

- Two types of permitted payments
  - Gainsharing payment – annual payment by participant to collaborator made exclusively from reconciliation payments and/or internal cost savings
    - Internal cost savings = measurable, actual, and verifiable savings realized by participant from care redesign
  - Alignment payment – payment by collaborator to participant to share in participant's repayment amount
- Requirements
  - Collaborator selected by participant based on criteria detailed in written P&P
  - Written agreement between participant and collaborator signed prior to episode initiation
  - Payment conditioned on meeting specified quality standards + provision of billable services to TEAM beneficiaries; cannot be based directly/indirectly on volume/value of referrals

Beneficiary Protections

- Provide written beneficiary notification regarding hospital's participation in TEAM prior to discharge from anchor admission/procedure
- Require collaborators to provide written beneficiary notification regarding sharing arrangement no later than first delivery of services (or as soon as practical)
- Do not restrict beneficiary freedom of choice for post-acute services
  - Provide complete list of post-acute care providers, identifying those with which hospital has sharing arrangement
  - May recommend preferred providers
- As part of discharge planning, provide notice of potential financial liability for any non-covered post-acute care services beneficiary may be considering

Primary Care Referrals

- As part of discharge planning process for each TEAM beneficiary, hospital must make referral to primary care provider prior to discharge from anchor admission/procedure
- Comply with beneficiary freedom of choice
- Failure to provide such referrals may result in remedial action against hospital
  - E.g., corrective action plan, discontinuation of data sharing, recoupment of payments

Data Sharing

- To receive beneficiary-identifiable claims data, hospital must submit annual request in manner required by CMS and sign formal data sharing agreement
  - Claims data for baseline period then made available at least one month prior to start of PY and monthly during PY
- CMS will provide regional aggregate data for 3-year baseline period at least one month prior to start of performance year and monthly during PY

Payment Waivers

- Telehealth furnished during episode not subject to geographic and originating site restrictions
- Waiver of SNF 3-day rule for TEAM beneficiary admission to CMS-identified qualified SNF

Lessons from BPCI-A

- In Model Year 4 (2021), BPCI-A reduced episode spending by 3.5%
- Level of participation
  - 1 in 5 eligible hospitals participated
  - 1 in 4 eligible clinicians triggered a BPCI-A episode
  - 1 in 5 hospitalizations/outpatient procedures were under BPCI-A

https://www.cms.gov/priorities/innovation/data-and-reports/2024/bpci-adv-ar5

Exhibit 22: The Four Domains of Care Transformation

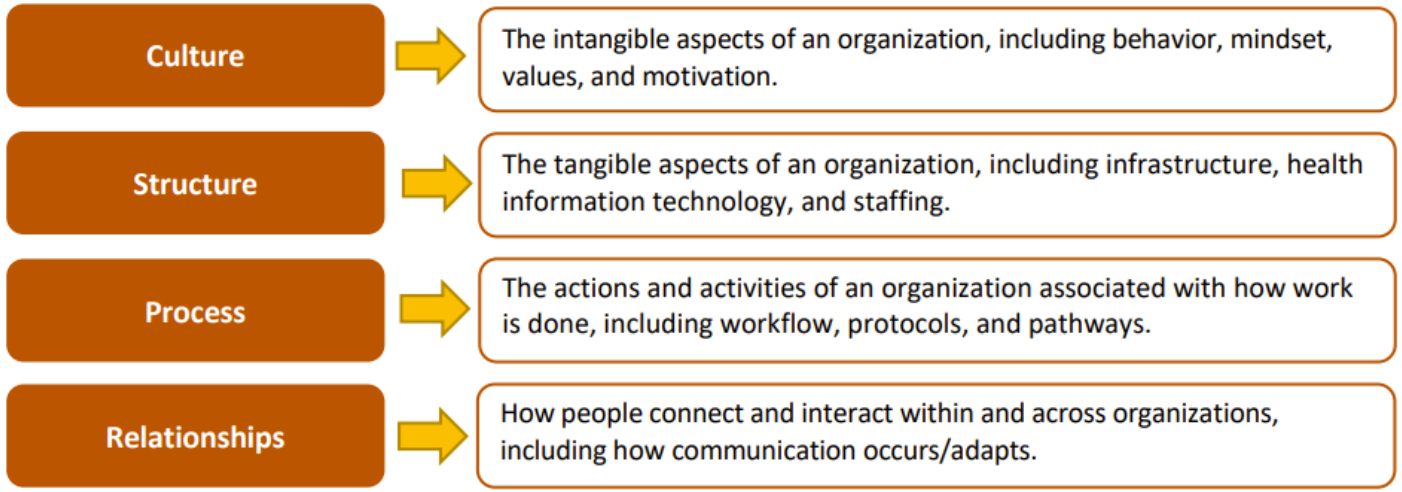
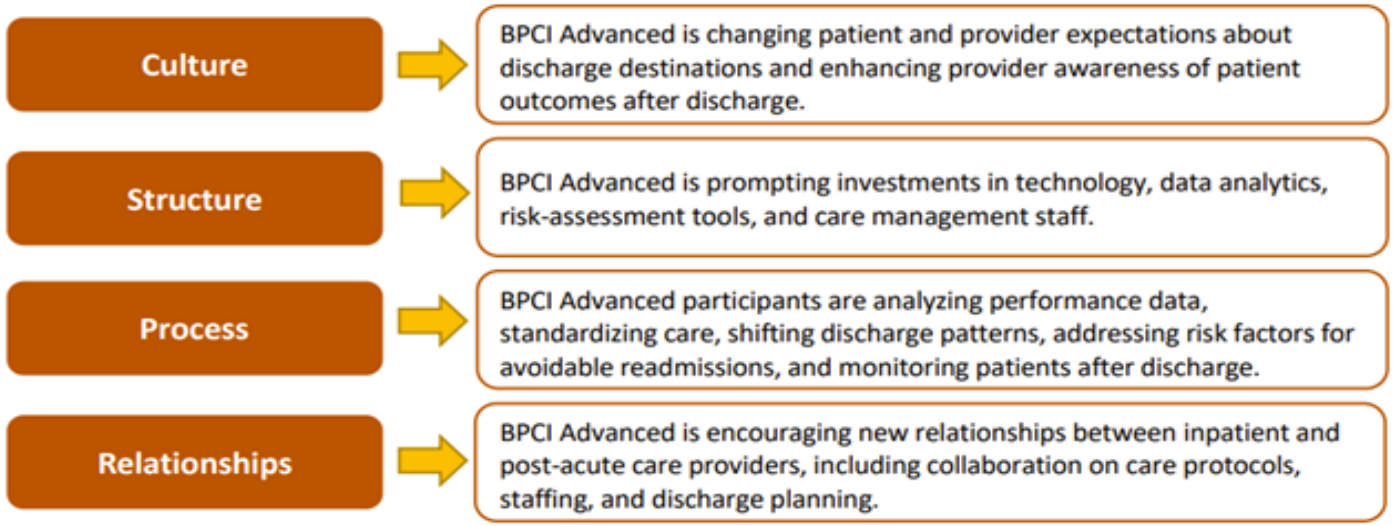


Exhibit 24: The Impact of BPCI Advanced on Four Domains of Care Transformation



Care Re-Design: Pre-Hospitalization

- Educate patients/caregivers during preoperative appointments on what to expect during procedure/recovery
- Screen patients for medical risks or social needs that may affect surgical outcomes or make recovery at home more challenging
- Refer patients to preoperative rehabilitation or surgical classes
- Refer patients to PCP to optimize health prior to elective surgery (e.g., weight loss)
- Schedule follow-up appointments with PCPs/specialists

Care Re-Design: Hospitalization

- Use risk-assessment tools to identify medical and social risks that may affect health outcomes or recovery
- Establish standard clinical pathways to reduce care variations
- Enhance interdisciplinary rounding, including specialists and therapists, to improve care coordination and discharge planning
- Use clinical decision-making tools to support discharge destination decisions and discharge planning
- Increase education to patients/caregivers on diagnoses, treatments, and recovery expectation

Care Re-Design: Post-Hospitalization

- Form preferred SNF and HHA networks based on quality metrics
- Hold weekly calls with SNFs to discuss patient progress and obstacles to discharge
- Deliver standard clinical pathways for providers to follow, specifying expectations about length of stay and timing and frequency of services
- Place of hospitalists, pharmacists in post-acute facilities
- Engage care managers to call patients during post-discharge period to address questions/concerns
- Connect beneficiaries to PCPs or specialists after discharge

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