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Special Bulletin

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CMS Releases Hospital Inpatient PPS Final Rule for Fiscal Year 2025

The Centers for Medicare & Medicaid Services (CMS) Aug. 1 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS final rule for fiscal year (FY) 2025. This Special Bulletin reviews highlights of provisions related to the inpatient PPS as well as the Center for Medicare and Medicaid Innovation (CMMI) Transforming Episode Accountability Model (TEAM) alternative payment model, which will begin Jan. 1, 2026. LTCH PPS provisions are covered in a separate Special Bulletin.

The rule finalizes a net 2.9% increase for inpatient PPS payments in FY 2025. This update reflects a hospital market basket increase of 3.4% as well as a productivity cut of 0.5%. CMS expects overall payments to increase by $2.9 billion, which it says includes a $200 million decrease in disproportionate share hospital (DSH) payments (due to a decrease in the uninsured rate), a $300 million increase in new medical technology payments, and a $400 million decrease in rural health payments if the Medicare-dependent hospital and enhanced low-volume adjustment programs are not extended by legislation.

KEY HIGHLIGHTS

CMS' final policies will:

- Increase inpatient PPS payment rates by a net 2.9% in FY 2025.
- Establish a new mandatory CMMI model, the TEAM, that will provide bundled payment for five surgical procedures.
- Create a separate inpatient PPS payment for small, independent hospitals to establish and maintain access to essential medicines.
- Distribute new graduate medical education slots under section 4122 of the Consolidated Appropriations Act of 2023.
- Modify the questions and sub-measures in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.
- Increase the Promoting Interoperability Program's performance threshold score and update the program's Antimicrobial Use and Resistance Surveillance measure.
- Modify and make permanent the condition of participation (CoP) requiring hospitals and critical access hospitals (CAHs) to report certain data to the Centers for Disease Control and Prevention (CDC) on acute respiratory illnesses.

AHA TAKE

CMS' payment updates for hospitals will exacerbate the already unsustainable negative or break-even margins many hospitals are already operating under as they care for their patients. The AHA is deeply concerned about the impact these inadequate payments will have on patient access to care, especially in rural and underserved communities.

In addition, while the AHA has long supported widespread adoption of meaningful value-based and alternative payment models to deliver high quality care at lower costs, the rule's mandatory bundled payment model for five different surgical episodes will not advance these objectives. Not only is the model extremely similar to other bundled payment approaches that have failed to meet the statutory criteria for expansion as they have not reduced program costs or generated net savings, it puts at particular risk many hospitals that are not of an adequate size or in a position to support the investments necessary to succeed. **See AHA's full statement that was shared with the media.**

Highlights of the rule follow.

INPATIENT PPS PAYMENT UPDATE

The final rule will increase inpatient PPS rates by a net of 2.9% in FY 2025, compared to FY 2024, after accounting for inflation and other adjustments required by law. Specifically, CMS finalized an initial market-basket update of 3.4%, less 0.5 percentage points for productivity, as required by the Affordable Care Act (ACA). Table 1 below details the impact of these final policies.

Table 1: Impacts of FY 2025 CMS Final Policies

Policy	Average Impact on Payments
Market-basket update	+ 3.4%
Productivity cut mandated by the ACA	- 0.5%
Total	**+ 2.9%**

Additionally, hospitals not submitting quality data will be subject to a one-quarter reduction of the initial market basket and, thus, will receive an update of 2.05%. Hospitals that were not meaningful users of electronic health records in FY 2020 will be subject to a three-quarter reduction of the initial market basket and, thus, will receive an update of 0.35%. Hospitals that fail to meet both of these requirements will be subject to a payment decrease of 0.5%.

CMMI TRANSFORMING EPISODE ACCOUNTABILITY MODEL

CMS finalized the establishment of a new mandatory alternative payment model, the TEAM.

Participation: Inpatient PPS hospitals in 188 selected core-based statistical areas (CBSAs) will be required to participate in all five surgical episode categories proposed for the model. There also will be a one-time opportunity for hospitals currently participating in Bundled Payments for Care Improvement Advanced (BPCIA) or Comprehensive Care for Joint Replacement (CJR) to opt-in to participate in TEAM. Participant hospitals will be the episode initiators and bear financial risk. Maryland hospitals will be excluded due to their participation in the Maryland Total Cost of Care model.

Episode of Care: CMS will test TEAM for five years, beginning Jan. 1, 2026, and ending Dec. 31, 2030. The model will include five surgical episode categories:

- Coronary artery bypass graft (CABG), to include any coronary revascularization procedure that is paid through the inpatient PPS under Medicare Severity Diagnosis Related Groups (MS–DRGs) 231-236. This would include both elective CABG and CABG procedures performed during initial acute myocardial infarction treatment.
- Lower extremity joint replacement (LEJR), to include a hip, knee or ankle replacement that is paid through the inpatient PPS under MS–DRGs 469, 470, 521 or 522, or through the outpatient prospective payment system (PPS) under Healthcare Common Procedure Coding System (HCPCS) codes 27447, 27130 or 27702.
- Major bowel procedures to include any small or large bowel procedure paid through the inpatient PPS under MS–DRGs 329-331.
- Surgical hip/femur fracture treatment (SHFFT), to include a hip fixation procedure, with or without fracture reduction, but excluding joint replacement, that is paid through the inpatient PPS under MS–DRGs 480-482.
- Spinal fusion to include procedures paid through the inpatient PPS under MS–DRGs 402, 426-430, 447-448, 450-451, 471-473, or through the outpatient PPS under HCPCS codes 22551, 22554, 22612, 22630 or 22633.

An episode will begin with a beneficiary's acute care hospital stay or a hospital outpatient department procedure visit. The episode will end 30 days after the date of discharge from the hospital. It will include the surgical procedure and inpatient stay, as well as all related care covered under Medicare Parts A and B within 30 days of discharge. Unrelated services will be excluded from the episode.

Payment Methodology: TEAM will have a one-year glide path to assume two-sided risk for most participants. CMS finalized a longer glidepath to downside risk for safety net hospitals – three years instead of one year. It also lowered the stop-gain/stop-loss for track 2 (described below). Overall:

- Track 1 will be available in performance year (PY) 1 for all participants. It will include upside-only risk and quality adjustments. There will be a 10% stop-gain and a limit on the composite quality score (CQS) adjustment percentage of 10%.
- Safety-net hospitals will be able to stay in track 1 for PY 1 though 3.

- Track 2 will be available in PY 2 through 5 for a limited set of participants including safety net hospitals, rural hospitals, Medicare-dependent hospitals, sole community hospitals and essential access community hospitals. It will include two-sided risk with quality adjustments. There will be a 5% stop-gain and stop-loss limit (compared to the 10% which was proposed), a limit on the CQS adjustment percentage of 10% for positive reconciliation amounts and 15% for negative reconciliation amounts.
- Track 3 will be available in PY 1 through 5 for all participants. It will include two-sided risk with quality adjustments. There will be a 20% stop-gain and stop-loss limit, and a limit on the CQS adjustment percentage of 10%.

Providers will receive preliminary "target prices." Hospitals will continue to bill Medicare fee-for-service as usual for services. After the completion of a performance year, services furnished to beneficiaries in that year's episodes will be grouped into episodes and aggregated. CMS will compare the participating hospital's total episode payments to their "target price." If total episode payments are below the target price, Medicare will pay the hospital the difference (subject to a quality adjustment). If spending is in excess of the target price, the hospital will pay Medicare the difference.

CMS proposed a 3% discount factor to the benchmark price to serve as Medicare's portion of reduced expenditures from the episode. However, in the final rule, it established separate, lower, discount factors based on the episode category:

- CABG- 1.5% discount factor
- LEJR- 2% discount factor
- Major Bowel- 1.5% discount factor
- SHFFT- 2% discount factor
- Spinal Fusion- 2% discount factor

The agency did not finalize low-volume policies or policies for the look-back period for the risk adjustment. It indicated that subsequent rulemaking will be provided for these policies.

Gainsharing: CMS finalized its proposals regarding gainsharing. Specifically, participating hospitals will be allowed to share payments received from Medicare as a result of reduced episode spending as well as hospital internal cost savings with collaborating providers and suppliers. Participants also can share financial accountability for increased episode spending with collaborating providers and suppliers. CMS clarified that the Anti-Kickback Statute (AKS) Safe Harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives is available to protect remuneration exchanged pursuant to certain financial arrangements and patient incentives that may be permitted under the final rule. However, CMS did not provide any fraud and abuse waivers in the final rule.

Waivers: CMS finalized waivers pertaining to telehealth waivers, including waiving the geographic and originating site requirements. It also finalized the creation of nine new

G-codes for TEAM telehealth evaluation and management (E/M) codes administered to patients in their homes.

In addition, CMS finalized a waiver to the skilled nursing facility (SNF) three-day rule, but only if the SNF is rated an overall of three stars or better in the Five-Star Quality Rating System. It did not waive the home health "homebound" requirement or "incident to" rule.

Beneficiary Choice and Incentives: Beneficiaries will not be able to opt-out of TEAM. However, CMS notes that the model does not limit the ability of beneficiaries to choose among Medicare providers, or the range of services available to the beneficiary. The model will allow participant hospitals to recommend preferred providers, but only within the constraints of current law.

In addition, CMS finalized proposals to allow certain in-kind patient engagement incentives under TEAM, which may include, for example, items of technology, subject to certain conditions. For example, there must be a reasonable connection between the items or services and the beneficiary's medical care, and it must be a preventive care item or advance a clinical goal for the beneficiary. For technology, CMS finalized several safeguards to prevent abuse.

Decarbonization and Resilience Initiative: CMS finalized elements of the voluntary Decarbonization and Resilience Initiative for TEAM. The voluntary initiative will have two elements: technical assistance for all interested TEAM participants and a proposed voluntary reporting option to capture information related to Scope 1 and Scope 2 emissions as defined by the Greenhouse Gas Protocol framework, with the potential to add Scope 3 in future years.

Linking Performance to Quality: CMS finalized its proposal to use the following measures in determining the TEAM CQS:

- For all TEAM episodes: Hybrid Hospital-Wide All-Cause Readmission Measure with Claims and Electronic Health Record Data (CMIT ID #356).
- For all TEAM episodes: CMS Patient Safety and Adverse Events Composite (CMS PSI 90) (CMIT ID #135).
- For LEJR episodes: Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA).

CMS finalized its proposal that reporting will be accomplished through existing Hospital inpatient quality reporting (IQR) program processes.

DISPROPORTIONATE SHARE HOSPITAL PAYMENT CHANGES

Under the DSH program, hospitals receive 25% of the Medicare DSH funds they would have received under the former statutory formula (described as "empirically justified" DSH payments). The remaining 75% flows into a separate funding pool

for DSH hospitals. This pool is updated as the percentage of uninsured individuals changes and is distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

For FY 2025, CMS estimates empirically justified DSH payments to be $3.5 billion. It estimates the 75% pool to be approximately $10.51 billion. After adjusting this pool for the percent of individuals without insurance, CMS states that it will total approximately $5.7 billion. This will result in a decrease in DSH and uncompensated care payments of $200 million as compared to FY 2024.

In order to distribute the 75% pool, the agency will continue to use cost report data on uncompensated care. Specifically, it will use a three-year average of the three most recent fiscal years for which audited cost report data are available.

AREA WAGE INDEX

CMS finalized several proposals in the rule around the area wage index, which adjusts payments to reflect differences in labor costs across geographic areas. First, the agency finalized changes to hospital labor market areas, which are based on the Office of Management and Budget (OMB) CBSAs. OMB issues major revisions every 10 years based on the results of the decennial census; as such, it released Bulletin No. 23-01 based on the current decennial census.

Second, CMS will continue its low-wage index hospital policy as established in the FY 2020 final rule. Under this policy, for hospitals with a wage index value below the 25th percentile, the agency increases a hospital's wage index by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value for all hospitals. As it has done previously, the agency will reduce the FY 2025 standardized amount for all hospitals to make this policy budget neutral.

MEDICARE GRADUATE MEDICAL EDUCATION

The Consolidated Appropriations Act 2023 added 200 additional Medicare-funded residency positions starting in FY 2026. At least 100 of the positions must be for psychiatry or psychiatry subspecialty residency training programs. Similar to the distribution of 1,000 new residency slots as a result of the Consolidated Appropriations Act of 2021, the Health and Human Services Secretary is required to distribute at least 10% of the aggregate number of total residency positions available to each of four categories of hospitals: 1) rural areas; 2) hospitals operating above their residency cap; 3) hospitals in states with new medical schools; and 4) hospitals serving health professional shortage areas. CMS will distribute these new slots effective July 1, 2026.

MS-DRG CLASSIFICATION CHANGES ANALYSIS

CMS finalized the creation of 12 new MS-DRGs and the deletion of five MS-DRGs. This includes additional changes since the proposed rule was published – two new MS-DRGs were added and three new MS-DRG were deleted. Most of the MS-DRG classification changes are within MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue).

Complication/Comorbidity (CC) and Major Complication/Comorbidity (MCC) Analysis: In the FY 2021 inpatient PPS final rule, CMS discussed its plan to continue a comprehensive CC/MCC analysis, using a combination of mathematical analysis of claims data and the application of nine guiding principles. For FY 2025, CMS finalized the adoption of these nine guiding principles.

CMS finalized severity level changes related to seven social determinants of health ICD-10-CM diagnosis codes (SDOH Z codes) that describe inadequate housing and housing instability. Specifically, it changed these codes from non-CC to CC for FY 2025. CMS continues to have interest in receiving feedback on how to otherwise foster the documentation and reporting of diagnosis codes describing social and economic circumstances to better reflect health care encounters and improve the reliability and validity of the coded data in support of efforts to advance health equity. CMS will continue to monitor and propose changes to other codes, including SDOH Z code reporting, and reporting based on SDOH screening completed as a result of quality measures in the hospital IQR program.

HOSPITAL QUALITY REPORTING AND VALUE PROGRAMS

Inpatient Quality Reporting: CMS will add seven new measures to the IQR programs:

- Patient safety structural measure, which will require hospitals to report whether they are implementing 25 CMS-specified patient safety-related practices (CY 2025 reporting/FY 2027 payment).
- Age-friendly hospital structural measure, which will require hospitals to report whether they are implementing 10 CMS-specified practices related to the care of older adults. (CY 2025 reporting/FY 2027 payment).
- Failure-to-rescue, a Medicare claims-based measure reflecting 30-day death rates among surgical patients with complications (FY 2027).
- Two hospital harm electronic clinical quality measures (eCQMs) that are calculated using EHRs — falls with injury and post-operative respiratory failure (CY 2026 reporting/FY 2028 payment).
- Two health care associated infection (HAI) measures assessing the rates of central-line associated bloodstream infections and catheter-associated urinary tract infections (CAUTIs) for inpatient oncology units (CY 2026 reporting/FY 2028 payment).

CMS will remove five measures from the IQR programs due to their redundancy with existing or proposed IQR measures. For FY 2026, CMS will remove four condition-specific hospital risk-standardized payment measures due to their overlap with the Medicare Spending per Beneficiary measure. For FY 2027, CMS will remove Patient Safety Indicator-04 because of its similarity to the failure to rescue measure.

Lastly, CMS will require the reporting of the hospital harm-related eCQMs it adopted in prior rulemaking. This will result in a stepwise increase to the number of eCQMs that hospitals must report. By the CY 2028 reporting/FY 2030 payment years, hospitals will be required to report 11 eCQMs, three of which will continue to be self-selcted from the menu of available eCQMs. CMS continues to align the IQR's eCQM reporting requirements with those in the Promoting Interoperability Program.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): CMS finalized changes to several of the questions included in the HCAHPS patient experience survey for patients discharged on or after Jan. 1, 2025. As a result, CMS will modify the composite sub-measures used to calculate overall HCAHPS performance in both the IQR and the Hospital Value-Based Purchasing (HVBP) program. Specifically, for the CY 2025 reporting/FY 2027 payment years, CMS will add three new sub-measures — care coordination, restfulness of the hospital environment and information about symptoms — each of which reflect new or modified survey questions. The care coordination sub-measure supersedes the current care transition sub-measure, which CMS intends to remove from public reporting in January 2026. CMS also finalized revisions to the survey questions included in the responsiveness of hospital staff sub-measure.

For the HVBP program, CMS will adopt the updated HCAHPS sub-measures beginning with the FY 2030 program to ensure it can calculate updated baseline and performance period scores. In addition, for FYs 2027-2029, CMS will exclude the care transition and responsiveness of hospital staff sub-measures from scoring to ensure hospitals are scored on only those aspects of the HCAHPS that would remain unchanged from the current survey.

Promoting Interoperability Program: As urged by AHA, CMS finalized its proposed modifications to the Antimicrobial Use and Resistance (AUR) surveillance measure. Specifically, CMS will:

- Split the AUR measure into two separate measures -- AU Surveillance and one for AR Surveillance, starting from the EHR reporting period in CY 2025.
- Add a new exclusion for eligible hospitals or CAHs that do not have electronic access to the data elements needed for AU or AR Surveillance reporting.
- Change the existing exclusions for the AUR Surveillance measure to apply to the AU Surveillance and AR Surveillance measures, respectively.
- Consider the AU Surveillance and AR Surveillance measures as two new measures for active engagement starting from the EHR reporting period in CY 2025.

CMS also finalized its proposal to increase the performance-based scoring threshold for eligible hospitals and CAHs reporting to the Medicare Promoting Interoperability Program from 60 points to 80 points beginning with the EHR reporting period in CY 2025. In response to feedback from AHA and other stakeholders on the potential adverse impacts on eligible hospitals and CAHs associated with this policy, the final rule adopted a more gradual increase to the threshold score: rather than go from 60 to 80 points in CY 2025, the minimum threshold will now increase incrementally from 60 to 70 in CY 2025, and 70 to 80 in CY 2026.

COP FOR ACUTE RESPIRATORY ILLNESS DATA REPORTING

In 2020, CMS adopted a CoP requiring hospitals and CAHs to submit certain data related to COVID-19 and other acute respiratory illnesses (i.e., influenza) to the Department of Health and Human Services for the duration of the COVID-19 public health emergency (PHE). In 2022, CMS updated the CoP to require reporting from the conclusion of the PHE through April 30, 2024. However, in this rule, CMS states that it continues to need to monitor the impact of acute respiratory illnesses across the country to inform federal surveillance efforts. The agency also asserts that the reporting of such data is related to and could inform hospital-level infection control and prevention efforts.

As a result, CMS will modify and make permanent its CoP requiring hospitals and CAHs to report certain data on acute respiratory illnesses, including during times outside of a PHE. Beginning on Nov. 1, CMS will require hospitals and CAHs to report data once per week on confirmed infections of COVID-19, influenza and respiratory syntactical virus among hospitalized patients, hospital capacity and limited patient demographic information, including age. Consistent with previous requirements, hospitals will submit their data to the CDC's National Healthcare Safety Network. CMS also finalized its proposal to potentially increase the number of data elements and frequency of reporting during declared state, local or federal PHEs.

In response to feedback from AHA and other stakeholders, CMS did not finalize its proposals to allow for expanded reporting during "likely" PHEs or to require collection of more detailed patient-level demographic information.

SEPARATE INPATIENT PPS PAYMENT FOR ESTABLISHING AND MAINTAINING ACCESS TO ESSENTIAL MEDICINES

As part of the Administration's effort to strengthen the resilience of medical supply chains, CMS sought comments in the CY 2024 outpatient PPS and proposed FY 2025 inpatient PPS rules on ways to support practices that can curtail pharmaceutical shortages of essential medicine and promote resiliency to safeguard and improve the care hospitals are able to provide. As such, CMS is finalizing its policy to establish a separate payment under the inpatient PPS for small (100 beds or fewer) independent hospitals for the estimated additional resource costs of voluntarily establishing and

maintaining access to a six-month buffer stock. This separate payment will not be budget neutral.

FURTHER QUESTIONS

The final rule will be published in the Aug. 28 Federal Register and provisions will generally take effect Oct 1. Watch for a more detailed analysis of the final rule in the coming weeks.

If you have further questions, contact Shannon Wu, AHA's director of inpatient payment policy, at 202-626-2963 or swu@aha.org for inpatient PPS payment issues; Akin Demehin, AHA's senior director of quality and patient safety, at 202-626-2365 or ademehin@aha.org for inpatient PPS quality issues; or Jennifer Holloman, AHA's senior associate director of physician payment policy, at 202-626-2320 or jholloman@aha.org for CMMI payment model issues.