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Significant Changes Affecting Hospitals in CMS's FY 2025 IPPS Final Rule

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CMS published its FY 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) final rule on August 1, 2024. Under this final rule, CMS is implementing several changes to its Hospital Inpatient Quality Reporting Program (IQR program), Value-Based Purchasing Program, and the Medicare Promoting Interoperability Program. These changes will be effective October 1, 2024.

Hospital Inpatient Quality Reporting (IQR) Program

Under the final rule, CMS is making several changes to the metrics it includes in its voluntary, pay-for-reporting program for acute care hospitals, as set forth under section 1886(b)(3)(B)(viii) of the Social Security Act. Specifically, CMS is: (1) adding seven measures; (2) amending two existing measures; (3) removing five existing measures; and (4) modifying the data reporting and submissions requirements for electronic clinical quality measures (eQCMs). As further noted below, each of these revisions is to reflect changes in CMS's data collection needs as it reviews studies on hospital performance and evaluates the efficacy of current data collection processes. Ultimately, these changes indicate the types of data that an acute care hospital must track and submit to CMS to receive higher reimbursement rates. If an acute care hospital does not meet the requirements of the IQR program, the hospital's market basket update will subsequently be reduced by 25 percent. The market basket update is used by CMS to update payments to reflect input price inflation that medical service providers experience.

For data reporting and submissions requirements, CMS is implementing a "progressive increase in the number of mandatory eCQMs a hospital would be required to report" beginning with the CY 2026 reporting period/FY 2028 payment determination. CMS will also: (1) implement eCQM validation scoring based on the accuracy of eCQM data beginning with the validation of CY 2025 eCQM data affecting the FY 2028 payment determination; and (2) make medical records submission optional for reconsideration requests beginning with CY 2023 discharges/FY 2026 payment determination.

The seven additional metrics that CMS is adding to the program are as follows.

- *Patient Safety Structural measure*: This measure assesses, through hospital attestation, whether hospitals have a "structure and culture that prioritizes safety" evaluating: (1) leadership commitment to eliminating preventable harm; (2) strategic planning and organizational policy; (3) culture of safety and learning health system; (4) accountability and transparency; and (5) patient and family engagement;

- *Age-Friendly Structural measure*: This measure is intended to address the aging population in the United States, specifically the "complex medical, behavioral, and psychosocial needs" of this population. It is a single streamlined version of two prior geriatric care measures publicized by CMS. With the assistance of several organizations, CMS has centered this measure on the "4 Ms" identified as "What Matters, Medication, Mentation, and Mobility." This measure will specifically align across five domains that each must be attested to by a hospital: (1) eliciting patient healthcare goals; (2) responsible medication management; (3) frailty screening and intervention; (4) social vulnerability;

and (5) age-friendly care leadership;

- *Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations (beginning with the CY 2026 reporting period/FY 2028 payment determination)*: This measure carries on efforts made in prior measures to address CAUTI by specifically requiring reporting for inpatients in cancer wards. Prior changes to reporting of CAUTIs had created a lack of reporting in this specific area;

- *Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations (beginning with the CY 2026 reporting period/FY 2028 reporting period)*: This measure carries on efforts made in prior measures to address CLABSI by specifically requiring reporting for inpatients in cancer wards. Prior changes to reporting of CLABSI had created a lack of reporting in this specific area;

- *Hospital Harm - Falls with Injury eCQM (beginning with the CY 2026 reporting period/FY 2028 payment determination)*: This measure is risk-adjusted based on factors such as age. It is intended to capture data on "acute care inpatient falls with major or moderate injury";

- *Hospital Harm - Postoperative Respiratory Failure eCQM (beginning with the CY 2026 reporting period/FY 2028 payment determination)*: This measure is risk-adjusted based on factors such as age. It is intended to capture data on the "rate of postoperative respiratory failure" specifically for "a much larger patient population" as CMS seeks to understand what care is necessary to avoid postoperative respiratory failure; and

- *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)*: This risk-standardized measure expands on prior efforts by CMS to record a "hospitals' ability to rescue patients who experience clinically significant complications after inpatient operations, so that these complications do not result in death."

The two measures to be amended are: (1) Global Malnutrition Composite Score (GMCS); and (2) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey. CMS is expanding the GMCS score from hospitalized adults 65 or older to hospitalized adults 18 or older. CMS will incorporate a modified version of the HCAHPS Survey into the measure that reflects scoring changes. As discussed further below, this patient survey is being updated with variable effective dates for the different CMS programs.

The five measures to be removed are: (1) Death Among Surgical Inpatients with Serious

Treatable Complications (CMS PSI 04) measure (to be replaced by the Failure-to-Rescue measure that is being added); (2) Hospital-level, Risk-Standardized Payment

Associated with a 30-day Episode-of-Care for Acute Myocardial Infarction (AMI) measure; (3) Hospital-level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Heart Failure (HF) measure; (4) Hospital-level, Risk-Standardized Payment Associated with a 30-day Episode-of-Care for Pneumonia (PN) measure; and (5) 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. CMS is removing these measures because it believes each of these measures is more broadly covered by other existing measures or measures to be added under the final rule.

Hospital Value-Based Purchasing (VBP) Program

Under the final rule, CMS is also modifying two of the measures for the Hospital VBP Program. Under this program, value-based incentive payments are made in a fiscal year to hospitals based on their performance on the program's measures. The changes largely address integration needs with the Hospital IQR Program changes and implementation concerns as additional changes are considered for the HCAHPS Survey. In this final rule, CMS is specifically: (1) updating program requirements to reflect the updated HCAHPS Survey measure that would be publicly reported under the Hospital IQR Program as discussed above; and (2) modifying scoring under the Hospital VBP Program so that the Person and Community Engagement Domain of the HCAHPS Survey only evaluates its six unchanged domains for the FY 2027 through FY 2029 program years, as opposed to the nine domains that are to be implemented as of the FY 2030 program year.

Medicare Promoting Interoperability (PI) Program

The final rule also sets forth several changes to be implemented under the Medicare Promoting Interoperability Program which align with changes discussed above and reflect current performance under the program. Specifically, CMS is taking the following actions.

- CMS is separating the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures, an Antimicrobial Use (AU) Surveillance measure and an Antimicrobial Resistance (AR) Surveillance measure so as to:
  - Create a "new exclusion for eligible hospitals or critical access hospitals (CAHs) that do not have a data source containing the minimal discrete data elements that are required for AU or AR Surveillance reporting";
  - Update existing exclusions to reflect either this division; and
  - Ensure the AU and AR Surveillance measures are treated as new measures with respect to active engagement beginning with the EHR reporting period in CY 2025.

- CMS is adopting two new eCQMs (as additionally discussed under the Hospital IQR Program changes) that hospitals can select as one of their three self-selected eCQMs beginning with the CY 2026 reporting period: the Hospital Harm – Falls with Injury eCQM and the Hospital Harm – Postoperative Respiratory Failure eCQM.

- CMS is, beginning with the CY 2026 reporting period, modifying the Global Malnutrition Composite Score eCQM (as discussed above).

- CMS is modifying eCQM data reporting and submission requirements by implementing a progressive increase in the number of mandatory eCQMs eligible hospitals and CAHs would be required to report on beginning with the CY 2026 reporting period (as discussed above).

- CMS is increasing the performance-based scoring threshold for eligible hospitals and CAHs reporting under the Medicare Promoting Interoperability Program from 60 points to 70 points beginning with the EHR reporting period in CY 2025 in order to reflect the positive performance results in the CY 2022 Medicare Promoting Interoperability Program. CMS will then increase the threshold to 90 points beginning with the EHR reporting period in CY 2026. CMS hopes to "incentivize more eligible hospitals and CAHs to align their health information systems with evolving industry standards and would encourage increased data exchange."

Under the PI program, eligible hospitals and critical access hospitals must achieve a certain number of points to avoid a downward payment adjustment. These changes demonstrate the objectives that the PI program is now focused on and that eligible hospitals and critical access hospitals must address. Additionally, as demonstrated by the final change listed above, the PI program is incrementally requiring greater compliance

with its objectives by increasing the threshold points required to avoid a downward payment adjustment. Those programs that have only been meeting the prior threshold of 60 points will need to introduce changes into their programs to ensure continued compliance with the PI program.

Hospital and CAH Respiratory Infection Data Reporting

Under the Final Rule, CMS is also renewing and revising hospital and critical access hospital Conditions of Participation data reporting requirements for data related to respiratory infections. These data reporting requirements are effective November 1st, 2024, and will require hospitals and critical access hospitals to electronically report information about COVID-19, influenza, and respiratory syncytial virus. The Secretary of Health and Human Services will set the exact reporting schedule. The Final Rule also allows the Secretary to require additional reporting categories in the event that a PHE is declared for an acute respiratory illness. These data reporting requirements are a continuation of some COVID-19 public health emergency requirements that have now expired. CMS hopes that they will serve to ensure that hospitals and critical access hospitals maintain appropriate insight into infection control needs.

For more information about the Final Rule or further analysis regarding these issues, please contact Alissa D. Fleming, Katherine Denney, or any other member of Baker Donelson's Reimbursement Group.