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WASHINGTON perspectives

An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

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CMS Issues Final FY 2025 IPPS and LTCH Rule

The Centers for Medicare and Medicaid Services (CMS) have issued a final rule to update the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for fiscal year (FY) 2025.

A copy of the 2,987-page document is currently on public display at the ***Federal Register*** office and is scheduled for publication on August 28. A display version of the rule is currently available at: https://public-inspection.federalregister.gov/2024-17021.pdf.

The IPPS tables for the FY 2025 final rule are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled "FY 2025 IPPS Final Rule Home Page" or "Acute Inpatient—Files for Download."

The LTCH tables are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1808-F.

Comments

At nearly 3,000 pages this is an extremely long rule. It may be CMS' longest rule to date, and CMS has not provided any form of a table of contents. In fact, this rule is 900 pages greater than the proposed version.

The rule's first 43 pages provides a basic executive summary of the changes being made; and a summary of major provisions. Rather than attempting to distill the information, please refer to the summary of costs and benefits table below. The table is not all inclusive, but does provide helpful information.

As is customary for us, we are adding page numbers based on the display version.

Many payment issues can be found in the rule's Addendum (beginning on page 2,660).

This analysis does not follow the rule's organization.

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Summary of Costs and Benefits (Page 24)

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Continuation of the Low Wage Index Hospital Policy	CMS is finalizing its proposal to continue the low wage index hospital policy and the related budget neutrality adjustment for at least 3 years beginning in FY 2025. Note; this is for CMS' policies from FY 2011 and prior. The current low wage index adjustments expires December 31, 2024.
Separate IPPS Payment for Establishing and Maintaining Access to Essential Medicines	CMS is finalizing its proposal to make an IPPS payment adjustment for the additional resource costs that small, independent hospitals incur in establishing and maintaining access to a 6-month buffer stock of one or more essential medicine(s) beginning in FY 2025. This payment adjustment will **not** be budget neutral. CMS estimates that approximately 500 hospitals would qualify under this policy. CMS estimates that the cost to those hospitals to establish buffer stocks of essential medicines would, in aggregate summed across all 500 hospitals, be approximately $2.8 million. Under this provision, Medicare will pay its share of those costs (approximately 11 percent of that amount, or $0.3 million).
Uncompensated Care Payments	For FY 2025, CMS is finalizing the proposed updates to its estimates of the three factors used to determine uncompensated care payments. CMS is continuing to use uninsured estimates produced by CMS' Office of the Actuary (OACT) as part of the development of the National Health Expenditure Accounts (NHEA) in the calculation of Factor 2. As provided in the regulation at § 412.106(g)(1)(iii)(C)(*11*), for FY 2025, CMS is using 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.
Update to the IPPS Payment Rates and Other Payment Policies	As discussed in Appendix A, acute care hospitals are estimated to experience an increase of approximately **$3.2 billion** in FY 2025, primarily driven by the changes in FY 2025 operating payments and capital payments and the expiration of the temporary changes in the low-volume hospital program and the expiration of the MDH program on January 1, 2025.
Update to the LTCH PPS Payment Rates and Other Payment Policies	As discussed in Appendix A, based on the best available data for the 331 LTCHs in CMS' database, CMS estimates that the changes to the payment rates and factors that it presented in the preamble of and Addendum of this final rule, which reflect the update to the LTCH PPS standard Federal payment rate for FY 2025, would result in an estimated increase in payments in FY 2025 of approximately **$58 million**.
Distribution of Additional Residency Positions Under the Provisions of Section 4122 of Subtitle C of the Consolidated Appropriations Act, 2023 (CAA, 2023)	Section 4122(a) of the CAA, 2023 amended section 1886(h) of the Act by adding a new paragraph 1886(h)(10) requiring the distribution of additional residency positions (also referred to as slots) to hospitals. CMS refers readers to section V.J.2. of the preamble of this final rule for a summary of the provisions of section 4122 of the CAA, 2023 that CMS is implementing in this final rule. CMS estimates that the provisions it presents in the preamble of this final rule to implement section 4122 of the CAA, 2023 will result in an estimated cost of approximately $10 million for FY 2026.
Updates to the Hospital VBP Program	CMS estimates that there will be no net financial impact to the Hospital VBP Program for the FY 2025 program year in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount of base operating MS-DRG payment amount reductions for the FY 2025 program year and, therefore, the estimated amount available for value-based incentive payments for FY 2025 discharges is approximately **$1.67 billion**.
Changes to the Hospital IQR Program	Across 3,050 IPPS hospitals, CMS estimates that its changes for the Hospital IQR Program will result in a total information collection burden increase of 40,160 hours at a cost increase of $1,282,329 associated with its policies across a 4-year period from the CY 2025 reporting period/FY 2027 payment determination through the CY 2028 reporting period/FY 2030 payment determination.
Changes to the PCHQR Program	Across 11 PPS-exempt cancer hospital (PCHs), CMS estimates that the changes for the PCHQR Program will result in a total information collection burden increase of 166 hours at a cost increase of $4,047 beginning with the CY 2025 reporting
Changes to the LTCH QRP	Across 330 LTCHs, CMS estimates that the proposed changes for the LTCH QRP would result in a total information collection burden increase of 2,177 hours associated with policies and updated burden estimates and a total cost increase of approximately $138,231.88 for the FY 2028 LTCH QRP.
Changes to the Medicare Promoting Interoperability Program	Across 4,550 eligible hospitals and CAHs, CMS estimates that the changes for the Medicare Promoting Interoperability Program will result in an increase of 5,038 hours at a cost increase of $262,581 to the information collection burden for the EHR reporting period in CY 2028 and subsequent years.
Transforming Episode Accountability Model (TEAM)	CMS estimates that testing TEAM will result in saving the Medicare program **$481 million** across the 5 performance years.

Provision Description	Description of Costs, Transfers, Savings, and Benefits
CoP Requirements for Hospitals and CAHs to Report Acute Respiratory Illnesses	Across 6,384 hospitals and CAHs, CMS estimates that the changes will result in 248,976 hours and a total cost of $19,420,128 for the weekly reporting, which is $3,042 per facility yearly. CMS estimates for PHE reporting, if declared by the Secretary, low to high hours range 1,005,480 to 3,495,240 and total cost ranging from $ 78,427,440 to $ 272,628,720 depending on the frequency of reporting required.
Changes for the Add-On Payments for New Services and Technologies	CMS is changing the April 1 cutoff to October 1 for determining whether a technology would be within its 2- to 3-year newness period. Under the assumption that all of the FY 2025 new technology add-on payment applications that have been FDA-approved or -cleared or have a documented delay in market availability between October 1, 2023 and March 30, 2024 (as discussed in section II.E.5. and section II.E.6. of the preamble of this final rule), and that are first approved for new technology add-on payments in FY 2025, would continue to meet the specified criteria for new technology add-on payments for FY 2026 and FY 2027, based on information from the applicants at the time of this final rule, this change will increase IPPS spending by approximately $459 million in FY 2027. Also, CMS will no longer consider a hold status to be an inactive status for the purposes of eligibility for the new technology add-on payment. CMS notes that the cost impact of this provision is not estimable. CMS expects that some applicants who were ineligible in FY 2025 may apply for new technology add-on payments for FY 2026. Finally, for certain gene therapies indicated for and used in the treatment of sickle cell disease, CMS is temporarily increasing the new technology add-on payment percentage to 75 percent. CMS estimates that for the two gene therapy technologies that are approved for new technology add-on payments in this final rule that are indicated and used specifically for the treatment of SCD (as discussed in section II.E.5. of the preamble of this final rule), these changes to the calculation of the inpatient new technology add-on payment will increase IPPS spending by approximately $38 million in FY 2025.

I. CHANGES TO THE PROSPECTIVE PAYMENT RATES (Pages 893 and Addendum Page 2,660)

FY 2025 Inpatient Update (Page 893)

The applicable percentage increase under the IPPS for FY 2025 is equal to the rate-of-increase in the hospital market basket, subject to the following:

- **A reduction of one-quarter** of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) **for hospitals that fail** to submit quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act.
- **A reduction of three-quarters** of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) **for hospitals not considered to be meaningful EHR users** in accordance with section 1886(b)(3)(B)(ix) of the Act.
- An adjustment based on changes in economy-wide multifactor productivity (MFP) (the productivity adjustment).

Based on IGI second quarter 2024 forecast with historical data through the first quarter of 2024, the projected 2018-based IPPS market basket increase factor for FY 2025 is **3.4 percent**, which is 0.4 percentage point higher than the projected FY 2025 market basket increase factor in the proposed rule. (Page 901)

Based on more recent data available, the final FY 2025 productivity adjustment of 0.5 percent is based on IGI's forecast of the 10-year moving average of annual economy-wide private nonfarm business TFP. (Page 907)

Therefore, the market basket update equals **2.9 percent**. (3.4-0.5=2.9)

Comment

In responding to numerous comments, CMS still holds its ground that forecast error corrections are not helpful or needed. Something is greatly a amiss. For an organization that says it is trying be transparent

why is it so hesitant to do something positive by providing yearly prospective updates whether such changes are positive or negative. Is it because CMS saves the program from spending more?

CMS displays four possible applicable percentage increases as shown in the following table. (Page 908)

FY 2025 Applicable Percentage Increases for the IPPS

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 (Reduction of ¼ of market basket increase)	0.0	0.0	-0.85	-0.85
Adjustment for Failure to be a Meaningful EHR (Reduction of ¾ of market basket)	0.0	-2.55	0	-2.55
MFP Adjustment	-0.5	-0.5	-0.5	-0.5
Applicable Percentage Increase Applied to Standardized Amount	**2.9**	**0.35**	**2.05**	**-0.5**

Hospitals that do comply with the quality data submission requirements but are not meaningful EHR users would receive an update of **0.35 percent**, which includes a reduction of three-quarters of the market basket update and the reduction due to the productivity adjustment (3.4 – 2.25 = 0.85 – 0.5 productivity = 0.35).

Hospitals that fail to comply with the quality data submission requirements but are meaningful EHR users will receive an update of **2.05 percent**. This update includes a reduction of one-quarter of the market basket update for failure to submit this data (3.4 -0.85 = 2.55- 0.5 productivity = 2.05).

Further, hospitals that do not comply with the quality data submission requirements and also are not meaningful EHR users would receive an update of **-0.5 percent**. Market basket minus market basket minus 0.5 percent productivity adjustment (3.4-3.4 = 0-.5 = -0.5)**.**

The current (FY 2024) large urban labor rate is $4,392.49 and the non-labor rate is $$2,105.28 for a total of $6,497.77. The other area labor rate is $4,028.62 and the non-labor component is $2,469.15 also for a total of $6,497.77.

The following table (Page 2,737) illustrates the changes from the current FY 2024 national standardized amounts to the final FY 2025 national standardized amounts.

The $6,497.77 amounts are adjusted by dividing the outlier, geographic and the rural demonstration reclassification factors, etc. as shown in the table below resulting in a gross payment rate of $7,073.98 for FY 2024. This amount is then further adjusted by multiplying the FY 2025 adjustments.

Please note, we have added the labor/ combined non-labor amounts, and a row reflecting "totals."

Changes from the Current FY 2024 Standardized Amounts to the Final FY 2025 Standardized Amounts

	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**
	Hospital Submitted Quality Data and is a Meaningful EHR User	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User**	**Hospital Did NOT SubmitQuality Data and is a Meaningful EHR User**	**Hospital Did NOT Submit Quality Data and is NOT aMeaningful EHR User**
FY 2025 Base Rate after removing: 1. FY 2024 Geographic Reclassification Budget Neutrality (0.971295) 2. FY 2024 Operating Outlier Offset (0.949) 3. FY 2024 Rural Demonstration Budget Neutrality Factor (0.999463) 4. FY 2024 Lowest Quartile Budget Neutrality Factor (0.997402) 5. FY 2024 Cap Policy Wage Index Budget Neutrality Factor (0.999645)	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,782.01 Nonlabor (32.4%) $2,291.97 *(Combined labor and nonlabor = $7,073.98)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,385.87 Nonlabor (38%) $2,688.11 *(Combined labor and nonlabor = $7,073.98)*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,782.01 Nonlabor (32.4%) $2,291.97 *(Combined labor and nonlabor = $7,073.98)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,385.87 Nonlabor (38%) $2,688.11 *(Combined labor and nonlabor = $7,073.98*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,782.01 Nonlabor (32.4%) $2,291.97 *(Combined labor and nonlabor = $7,073.98)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,385.87 Nonlabor (38%) $2,688.11 *(Combined labor and nonlabor = $7,073.98*	If Wage Index is Greater Than 1.0000: Labor (67.6%) $4,782.01 Nonlabor (32.4%) $2,291.97 *(Combined labor and nonlabor = $7,073.98)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,385.87 Nonlabor (38%) $2,688.11 *(Combined labor and nonlabor = $7,073.98*
Proposed FY 2025 Update Factor	1.029	1.0035	1.0205	0.995
FY 2025 MS-DRG Weight Budget Neutrality Factor	0.997190	0.997055	0.997055	0.997055
FY 2025 Cap Policy MS– DRG Weight Budget Neutrality Factor	0.999874	0.999617	0.999617	0.999617
FY 2025 Wage Index Budget NeutralityFactor	1.000114	0.999957	0.999957	0.999957
FY 2025 Reclassification Budget Neutrality Factor	0.962791	0.976773	0.976773	0.976773
FY 2025 Low Wage Quartile Budget Neutrality Factor	0.997157	0.997498	0.997498	0.997498
FY 2025 Cap Policy Wage Index Budget Neutrality Factor	0.997173	0.997162	0.997162	0.997162
FY 2025 Rural Demonstration Budget Neutrality Factor	0.999810	0.999513	0.999513	0.999513
FY 2025 Operating Outlier Factor	0.949	0.949	0.949	0.949
Totals	$6,606.51	$6,442.80	$6,551.94	$6.388.22
National Standardized Amount for FY2025 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4)	**Labor: $4,466.00** **Nonlabor: $2,140.51**	**Labor: $4,355.33** **Nonlabor: $2,087.47**	**Labor: $4,429.11** **Nonlabor: $2,122.83**	**Labor: $4,318.44** **Nonlabor: $2,069.78**
National Standardized Amount for FY2025 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $4,096.04** **Nonlabor: $2,510.47**	**Labor: $3,994.54** **Nonlabor: $2,448.26**	**Labor: $4,062.20** **Nonlabor: $2,489.74**	**Labor: $3,960.70** **Nonlabor: $2,427.52**

The change between the final FY 2024 full market-basket rate of increase amount of $6,497.77 and the FY 2025 amount of $6,606.51 is $108.74, a 1.7 percent increase.

These amounts are before other adjustments such as the hospital value-based purchasing program, the hospital readmission program, and the hospital acquired conditions program.

Comment

CMS says 90 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2025 because they failed the quality data submission process or did not choose to participate, but are meaningful EHR users. (Page 2,843)

CMS says 82 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2025 because they are identified as not meaningful EHR users that do submit quality information under section 1886(b)(3)(B)(viii) of the Act.

CMS says 27 hospitals are estimated to not receive the full market basket rate-of-increase for FY 2025 because they are identified as not meaningful EHR users that do not submit quality data.

Outlier Payments (Page 2,732)

"Our current estimate, using available FY 2023 claims data, is that actual outlier payments for FY 2023 were approximately 5.27 percent of actual total MS-DRG payments. Therefore, the data indicate that, for FY 2023, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2023."

CMS is finalizing an outlier fixed-loss cost threshold for FY 2025 equal to the prospective payment rate for the MSDRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, estimated supplemental payment for eligible IHS/Tribal hospitals and Puerto Rico hospitals, and any add on payments for new technology, plus **$46,152.** The current threshold is $42,750. (Page 2,732)

Comment

Once again, CMS argues that to make retroactive adjustments for errors in forecasting outlier payments "would remove an important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized."

As we have said many times before, this rationale is absolutely absurd. There is a need to make adjustments for errors in estimations. They do not have to be made retroactively. The skilled nursing PPS has an error correction process that changes the SNF market basket factors prospectively. CMS should be doing the same for all its PPS programs, including errors in not only outlier payments, but the market basket payments as well.

Changes to the IPPS for Capital-Related Costs (Pages 1,125 & 2,744)

The national capital Federal rate is **$510.51** for FY 2025.

Comparison of Factors and Adjustments: FY 2024 Capital Federal Rate and the FY 2025 Capital Federal Rate

	FY 2024	FY 2025	Change	Percent Change
Update Factor[1]	1.0380	1.0310	1.0310	3.10
GAF/DRG Adjustment Factor[1]	0.9885	0.9856	0.9856	-1.44
Quartile/Cap Adjustment Factor[2]	0.9964	0.9958	0.9993	-0.07
Outlier Adjustment Factor[3]	0.9598	0.9577	0.9978	-0.22
Capital Federal Rate	$503.83	$510.51	1.0133	1.33[4]

1 The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rate. Thus, for example, the incremental change from FY 2024 to FY 2025 resulting from the application of the 0.9856 GAF/DRG budget neutrality adjustment factor for FY 2025 is a net change of 0.9856 (or -1.44 percent).
2 The lowest quartile/cap budget neutrality adjustment factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2025 lowest quartile/cap budget neutrality adjustment factor is 0.9958/0.9964 or 0.9993 (or -0.07 percent).
3 The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2025 outlier adjustment factor is 0.9577/0.9598 or 0.9978 (or -0.22 percent).
4 Percent change may not sum due to rounding.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2025 (Pages 1,129 & 2,762)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico are excluded from the IPPS, and are paid on the basis of reasonable costs subject to a rate-of-increase ceiling.

The rate of ceiling increase is **3.4 percent**, in accordance with the applicable regulations at 42 CFR 413.40.

Changes to MS–DRGs Subject to Post-acute Care Transfer Policy and MS–DRG Special Payments Policies (§ 412.4) (Page 884)

CMS is making the following DRG changes with respect to whether or not the DRG changes would be impacted by CMS' post-acute transfer policies.

List of New or Revised MS-DRGs Subject to Review of Post-acute Care Transfer Policy Status for FY 2025

New or Revised MS-DRG	MS-DRG Title	Total Cases	Post-acute Care Transfer Cases (55th percentile: 1,056)	Short-Stay Post-acute Care Transfer Cases	Percent of Short- Stay Post-acute Care Transfers to all Cases (55th percentile: 10.178%)	FY 2024 Post-acute Transfer Policy Status	Post-acute Care Transfer Policy Status
317	Concomitant Left Atrial Appendage Closure and Cardiac Ablation	1,815	313*	14	0.8%*	New	No
402	Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical	17,097	6,795	723	4.2%*	New	No
426	Multiple level combined anterior and posterior spinal fusion except cervical with MCC or Custom-Made Anatomically Designed Interbody Fusion Device	2,952	2,379	764	27.7%	New	Yes

List of New or Revised MS-DRGs Subject to Review of Post-acute Care Transfer Policy Status for FY 2025							
New or Revised MS-DRG	MS-DRG Title	Total Cases	Post-acute Care Transfer Cases (55th percentile: 1,056)	Short-Stay Post-acute Care Transfer Cases	Percent of Short- Stay Post-acute Care Transfers to all Cases (55th percentile: 10.178%)	FY 2024 Post-acute Transfer Policy Status	Post-acute Care Transfer Policy Status
427	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with CC	13,205	7,996	2,313	17.4%	New	Yes
428	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical without CC/MCC	8,363	3,494	329	3.0%*	New	Yes**
429	Combined Anterior and Posterior Cervical Spinal Fusion with MCC	623	485*	70	27.3%	New	No
430	Combined Anterior and Posterior Cervical Spinal Fusion without MCC	1,883	970*	128	6.8%*	New	No
447	Multiple Level Spinal Fusion Except Cervical with MCC or Custom- Made Anatomically Designed Interbody Fusion Device	2,248	1,843	797	35.5%	New	Yes
448	Multiple Level Spinal Fusion Except Cervical without MCC	15,552	8,396	1,663	10.7%	New	Yes
450	Single Level Spinal Fusion Except Cervical with MCC	1,216	915*	302	24.8%	Yes (as 459)	No
451	Single Level Spinal Fusion Except Cervical without MCC	14,852	6,364	751	5.1%*	Yes (as 460)	No
850	Acute Leukemia with Other Procedures	385	140*	46	12%	New	No

*Indicates a current post-acute care transfer policy criterion that the MS-DRG did not meet.
** As described in the policy at 42 CFR 412.4(d)(3)(ii)(D), MS-DRGs that share the same base MS-DRG will all qualify under the post-acute care transfer policy if any one of the MS-DRGs that share that same base MS-DRG qualifies.

CMS proposed that MS-DRGs 426, 427, 428, 447, 448, would be subject to the MS-DRG special payment methodology, effective for FY 2025. For this final rule, CMS has updated its analysis using data from the March 2024 update of the FY 2023 MedPAR file as reflected in the table below. (Page 891)

List of New or Revised MS-DRGs Subject to Review of Special Payment Policy Status for FY 2025						
New or Revised MS-DRG	MS-DRG Title	Geometric Mean Length of Stay	Average Charges of 1-Day Discharges	50 Percent of Average Charges for all Cases within MS-DRG	FY 2024 Special Payment Policy Status	Special Payment Policy Status
426	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC	7.6	$261,045	$235,444	New	Yes
427	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with CC	4	$212,068	$310,913	New	Yes

List of New or Revised MS-DRGs Subject to Review of Special Payment Policy Status for FY 2025						
New or Revised MS-DRG	MS-DRG Title	Geometric Mean Length of Stay	Average Charges of 1-Day Discharges	50 Percent of Average Charges for all Cases within MS-DRG	FY 2024 Special Payment Policy Status	Special Payment Policy Status
428	Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical without CC/MCC	2.6	$215,932	$116,596	New	Yes*
447	Multiple Level Spinal Fusion Except Cervical with MCC	8	$213,457	$145,90	New	Yes
448	Multiple Level Spinal Fusion Except Cervical without MCC	3.2	$149,396	$89,058	New	Yes*

* As described in the policy at 42 CFR 412.4(f)(6)(iv), MS–DRGs that share the same base MS–DRG will all qualify under the special payment transfer policy if any one of the MS–DRGs that share that same base MS–DRG qualifies.

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 914)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Case-mix

If rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2024, they must have a CMI value for FY 2023 that is

- **1.7789** (national--all urban); or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region	Case-MixIndex Values
1. New England (CT, ME, MA, NH, RI, VT)	1.49605
2. Middle Atlantic (PA, NJ, NY)	1.5554
3. East North Central (IL, IN, MI, OH, WI)	1.6382
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7271
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.6315
6. East South Central (AL, KY, MS, TN)	1.5962
7. West South Central (AR, LA, OK, TX)	1.78235
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7742
9. Pacific (AK, CA, HI, OR, WA)	1.7888

A hospital must also have the number of discharges for its cost reporting period that began during FY 2022 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- If less, the median number of discharges for urban hospitals in the census region in which the hospital is located.

CMS says that because the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges, under this final rule, 5,000 discharges is the minimum criterion for all hospitals, except for osteopathic hospitals for which the minimum criterion is 3,000 discharges.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 922)

Section 306 of the CAA, 2024 extended the modified definition of low-volume hospital and the methodology for calculating the payment adjustment through December 31, 2024. Beginning January 1, 2025, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011.

Based on historical data for hospitals that qualified during FYs 2005 – 2010, CMS estimates that fewer than 10 hospitals would qualify for the low-volume hospital payment adjustment for the portion of FY 2025 beginning on January 1, 2025 under current law. (Page 929)

A hospital that qualified for the low-volume hospital payment adjustment for FY 2024 may continue to receive a low-volume hospital payment adjustment for FY 2025 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for FY 2025 (that is, the discharge criterion and mileage criterion for the period beginning October 1, 2024 through December 31, 2024, as well as the discharge criterion and mileage criterion for the period beginning on January 1, 2025 through September 30, 2025, respectively). (Page 934)

Comment

Any extension of this adjustment would require Congressional action.

Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108) (Page 936)

Because section 307 of the CAA, 2024 extended the MDH program through December 31, 2024 only, beginning January 1, 2025, the MDH program will no longer be in effect. Since the MDH program is not authorized by statute beyond December 31, 2024, beginning January 1, 2025, all hospitals that previously qualified for MDH status under section 1886(d)(5)(G) of the Act will no longer have MDH status and will be paid based on the IPPS Federal rate.

CMS says that currently 173 MDHs, of which it estimates 114 would have been paid under the blended payment of the Federal rate and hospital-specific rate while the remaining 59 would have been paid based on the IPPS Federal rate.

In order for an MDH to receive SCH status effective January 1, 2025, the MDH must apply for SCH status at least 30 days before the expiration of the MDH program; that is, the MDH must apply for SCH status by December 2, 2024.

Comment

Any extension of this adjustment would require Congressional action.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Page 943)

Section 4122(a) of the ***Consolidated Appropriations Act*** (CAA), 2023 amended section 1886(h) of the Act by adding a new section 1886(h)(10) of the Act requiring the distribution of additional residency positions (also referred to as slots) to hospitals. Section 1886(h)(10)(A) of the Act requires that for FY 2026, the Secretary shall initiate an application round to distribute 200 residency positions. At least 100 of the positions made available under section 1886(h)(10)(A) shall be distributed for psychiatry or psychiatry subspecialty residency training programs.

In determining the qualifying hospitals for which an increase is provided, section 1886(h)(10)(B)(i) of the Act requires the Secretary to take into account the "demonstrated likelihood" of the hospital filling the positions made available within the first 5 training years beginning after the date the increase would be effective, as determined by the Secretary.

The law requires CMS to notify hospitals receiving residency positions under section 4122 by January 31, 2026. To meet that deadline, CMS is implementing policies that will govern the application and award process in a manner consistent with the statutory requirements. This policy will focus on health professional shortage areas to help bolster the health care workforce in rural and underserved areas to the extent slots are available. CMS estimates that this additional funding will total approximately $74 million in support for teaching hospitals from FY 2026 through FY 2036.

The IME formula multiplier remains unchanged at 1.35.

Comment

Those involved with this subject need to carefully review the material being presented. It is long and technical.

CMS spends more than 100 pages discussing its actions.

Reasonable Cost Payment for Nursing and Allied Health Education Programs (§413.85 and 413.87) (Page 1,042)

Under section 1861(v) of the Act, Medicare has historically paid providers for Medicare's share of the costs that providers incur in connection with approved educational activities. Approved nursing and allied health (NAH) education programs are those that are, in part, operated by a provider, and meet State licensure requirements, or are recognized by a national accrediting body. The costs of these programs are excluded from the definition of "inpatient hospital operating costs" and are not included in the calculation of payment rates for hospitals or hospital units paid under the IPPS, IRF PPS, or IPF PPS, and are excluded from the rate-of-increase ceiling for certain facilities not paid on a PPS.

Hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs may receive additional payments to account for Medicare Advantage enrollees. Section 541 of the BBRA limits total spending under the provision to no more than $60 million in any calendar year (CY).

Determining a hospital's NAH Medicare Advantage payment essentially involves applying a ratio of the hospital-specific NAH Part A payments, total inpatient days, and Medicare Advantage inpatient days, to national totals of those same variables, from cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year.

Below is CMS' factors for FY 2025.

Final CY 2023 NAH MA Rates	Final CY 2023	SOURCE
NAH Pass-Through	$ 275,652,648	Cost reports ending in FY 2021 HCRIS
Part A Inpatient Days	70,195,738	Cost reports ending in FY 2021 HCRIS
MA Inpatient Days	13,712,419	Cost reports ending in FY 2021 HCRIS
Part A Direct GME	$2,947,906,247	CY 2021 HCRIS + CPI-U + MA enrollment
MA Direct GME	$2,191,025,717	CY 2021 HCRIS + CPI-U + MA enrollment
Pool (not to exceed $60 million)	$60,000,000	((MA DGME /Part A DGME) * (NAH Pass-through))
Percent Reduction to MA DGME Payments	2.74%	Pool/MA direct GME

Payment Adjustment for Certain Clinical Trial and Expanded Access Use Immunotherapy Cases (§§ 412.85 and 412.312) (Page 1,047)

CMS is finalizing an adjustor of 0.33 for FY 2025, which will be multiplied by the final FY 2025 relative weight for MS–DRG 018 as part of the calculation of the payment for claims determined to be applicable clinical trial or expanded use access immunotherapy claims that group to MS–DRG 018.

Changes to the Calculation of the IPPS Add-On Payment for Certain End-Stage Renal Disease (ESRD) Discharges (§ 412.104) (Page 1,052)

CMS is finalizing without modification, to update the ESRD add-on payment methodology effective for cost reporting periods beginning on or after October 1, 2024 to use the annual CY ESRD PPS base rate (as published in the applicable CY ESRD PPS final rule or subsequent corrections, as applicable) multiplied by three to calculate the ESRD add-on payment for hospital cost reporting periods that begin during the Federal FY for the same year.

Separate IPPS Payment for Establishing and Maintaining Access to Essential Medicines (Page 1,057)

For cost reporting periods beginning on or after October 1, 2024, CMS is establishing a separate payment under the IPPS to small, independent hospitals for the additional resource costs involved in voluntarily establishing and maintaining access to 6-month buffer stocks of essential medicines, either directly or through contractual arrangements with a manufacturer, distributor, or intermediary.

The costs of buffer stocks that are eligible for separate payment are the costs of buffer stocks for one or more of the medicines on ARMI's List of 86 essential medicines. The separate payment will be for the IPPS share of the additional costs and could be issued in a lump sum, or as biweekly payments to be reconciled at cost report settlement.

The separate payment will not apply to buffer stocks of any of the essential medicines on the ARMI List that are listed as "Currently in Shortage" on the FDA Drug
Shortages Database, as communicated to hospitals by the MACs on a quarterly basis, unless a hospital had already established and was maintaining a 6-month buffer stock of that medicine prior to the shortage. Once an essential medicine is no longer in shortage, as communicated by the MACs for the calendar quarter, CMS' policy does not differentiate that essential medicine from other essential medicines, and hospitals would be eligible to establish and maintain buffer stocks for the medicine as they would have before the shortage. CMS is also finalizing to codify this payment adjustment in the regulations by adding new paragraph (g) to 42 CFR 412.113, as well as CMS' proposed conforming changes to 42 CFR 412.1(a) and 412.2(f), without modification. (Page 1,097)

Hospital Readmissions Reduction Program (Pages 1,098 & 2,896)

The Hospital Readmissions Reduction Program reduces payments to hospitals with excess readmissions. CMS did not propose any changes to the Hospital Readmissions Reduction Program.

CMS says that 2,342 hospitals will be subject to penalty under this provision.

Hospital Value-Based Purchasing (VBP) Program (Pages 1,099 & 2,899)

The Hospital VBP Program is a budget-neutral program funded by reducing participating hospitals' base operating DRG payments each fiscal year by 2.0 percent and redistributing the entire amount back to the hospitals as value-based incentive payments. CMS is:

- Finalizing the adoption of the updates to the HCAHPS Survey measure beginning with the FY 2030 program year.
- Finalizing the adoption of the updates to the HCAHPS Survey measure in the Hospital Inpatient Quality Reporting (IQR) Program, beginning with the FY 2027 program year.
- Finalizing the modification to the Hospital VBP Program's scoring of the HCAHPS Survey measure for the FY 2027 through FY 2029 program years to score hospitals on only those dimensions of the survey that will remain unchanged from the current version

The applicable percent reduction from each hospital for the FY 2025 program year is 2.00 percent. CMS estimates that the total amount available for value-based incentive payments for FY 2025 is approximately **$1.67 billion**.

Comment

The material in this section details much scoring objectives and contains numerous benchmarks and achievement thresholds.

Hospital-Acquired Condition (HAC) Reduction Program (Pages 1,113 & 2,902)

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by reducing payment by 1.0 percent for applicable hospitals that rank in the worst-performing quartile on select measures of hospital-acquired conditions. CMS did not propose any changes to the HAC Reduction Program for FY 2025.

CMS estimates 732 hospitals will be impacted negatively. (Page 2,903)

II. CHANGES TO THE HOSPITAL AREA WAGE INDEX FOR ACUTE CARE HOSPITALS (Page 669)

Implementation of Revised Labor Market Area Delineations (Page 670)

CMS is implementing revised OMB delineations as described in the July 21, 2023 OMB Bulletin No. 23–01, beginning with the FY 2025 IPPS wage index.

Comment

Note that CMS is implementing revised area delineation changes across all PPS programs. We have noted some inconsistencies in the CMS tables across the PPS programs. The tables below are those from the IPPS final rule. To avoid any confusion, please use your facilities wage index values as published on the CMS website.

2025 Tables 2, 3 and 4A and 4B (Wage Index Tables) **(ZIP)**:

- Table 2- Case-Mix Index and Wage Index Table by CMS Certification Number (CCN)
- Table 3- Wage Index Table by CBSA; Table 4A - List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act
- Table 4B - Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR COUNTIES)

Further, some of the tables below may have title errors saying items are proposed.

Change to County-Equivalents in the State of Connecticut (Page 675)

The Census Bureau announced that it was implementing the State of Connecticut's request to replace the 8 counties in the State with 9 "Planning Regions." Planning regions will now serve as county-equivalents within the CBSA system. OMB Bulletin No. 23-01 is the first set of revised delineations that referenced the new county-equivalents for Connecticut.

CMS is providing the following crosswalk for each hospital in Connecticut with the current and **proposed** FIPS county and county-equivalent codes and CBSA assignments. [We have not erred in saying proposed. It would appear CMS has may not have updated this table for the final rule.]

CCN	FIPS	Current County	Current CBSA	Proposed FIPS	Proposed Planning Area (County Equivalent)	Proposed CBSA
070002	09003	Hartford	25540	09110	Capitol	25540
070003	09015	Windham	49340	09150	Northeastern Connecticut	07
070004	09005	Litchfield	07	09160	Northwest Hills	07
070005	09009	New Haven	35300	09140	Naugatuck Valley	47930
070006	09001	Fairfield	14860	09190	Western Connecticut	14860
070007	09011	New London	35980	09180	Southeastern Connecticut	35980
070008	09013	Tolland	25540	09110	Capitol	25540
070010	09001	Fairfield	14860	09120	Greater Bridgeport	14860
070011	09005	Litchfield	07	09160	Northwest Hills	07
070012	09013	Tolland	25540	09110	Capitol	25540
070015	09005	Litchfield	07	09190	Western Connecticut	14860
070016	09009	New Haven	35300	09140	Naugatuck Valley	47930
070017	09009	New Haven	5300	09170	South Central Connecticut	35300
070018	09001	Fairfield	14860	09190	Western Connecticut	14860
070019	09009	New Haven	35300	09170	South Central Connecticut	35300
070020	09007	Middlesex	25540	09130	Lower Connecticut River Valley	25540
070021	09015	Windham	49340	09180	Southeastern Connecticut	35980
070022	09009	New Haven	35300	09170	South Central Connecticut	35300
070024	09011	New London	35980	09180	Southeastern Connecticut	35980
070025	09003	Hartford	25540	09110	Capitol	25540
070027	09003	Hartford	25540	09110	Capitol	25540
070028	09001	Fairfield	14860	09120	Greater Bridgeport	14860
070029	09003	Hartford	25540	09140	Naugatuck Valley	47930
070031	09009	New Haven	35300	09140	Naugatuck Valley	47930
070033	09001	Fairfield	14860	09190	Western Connecticut	14860
070034	09001	Fairfield	14860	09190	Western Connecticut	14860
070035	09003	Hartford	25540	09110	Capitol	25540
070036	09003	Hartford	25540	09110	Capitol	25540

CCN	FIPS	Current County	Current CBSA	Proposed FIPS	Proposed Planning Area (County Equivalent)	Proposed CBSA
070038	09009	New Haven	35300	09170	South Central Connecticut	35300
070039	09009	New Haven	35300	09170	South Central Connecticut	35300
07B010	09009	New Haven	35300	09170	South Central Connecticut	35300
07B022	09001	Fairfield	14860	09190	Western Connecticut	14860
07B033	*09005*	*Litchfield*	*07*	*09190*	*Western Connecticut*	*14860*

Urban Counties That Will Become Rural Under the Revised OMB Delineations (Page 677)

CMS' analysis shows that a total of 53 counties (and county equivalents) and 33 hospitals that were once considered part of an urban CBSA would be considered to be located in a rural area, beginning in FY 2025. The following chart lists the 53 urban counties that will become rural. CMS says that there are four cases (CBSA 14100 [Bloomsburg-Berwick, PA], CBSA 19180 [Danville, IL], CBSA 20700 [East Stroudsburg, PA], and CBSA 35100 [New Bern, NC]) where all constituent counties in an urban CBSA became rural under the revised OMB delineations.

Counties that Become Rural			
FIPS County Code	County Name	Current CBSA	Current CBSA Name
01129	Washington	33660	Mobile, AL
05025	Cleveland	38220	Pine Bluff, AR
05047	Franklin	22900	Fort Smith, AR-OK
05069	Jefferson	38220	Pine Bluff, AR
05079	Lincoln	38220	Pine Bluff, AR
10005	Sussex	41540	Salisbury, MD-DE
13171	Lamar	12060	Atlanta-Sandy Springs-Alpharetta, GA
16077	Power	38540	Pocatello, ID
17057	Fulton	37900	Peoria, IL
17077	Jackson	16060	Carbondale-Marion, IL
17087	Johnson	16060	Carbondale-Marion, IL
17183	Vermilion	19180	Danville, IL
17199	Williamson	16060	Carbondale-Marion, IL
18121	Parke	45460	Terre Haute, IN
18133	Putnam	26900	Indianapolis-Carmel-Anderson, IN
18161	Union	17140	Cincinnati, OH-KY-IN
21091	Hancock	36980	Owensboro, KY
21101	Henderson	21780	Evansville, IN-KY
22045	Iberia	29180	Lafayette, LA
24001	Allegany	19060	Cumberland, MD-WV
24047	Worcester	41540	Salisbury, MD-DE
25011	Franklin	44140	Springfield, MA
26155	Shiawassee	29620	Lansing-East Lansing, MI
27075	Lake	20260	Duluth, MN-WI
28031	Covington	25620	Hattiesburg, MS

Counties that Become Rural			
FIPS County Code	County Name	Current CBSA	Current CBSA Name
31051	Dixon	43580	Sioux City, IA-NE-SD
36123	Yates	40380	Rochester, NY
37049	Craven	35100	New Bern, NC
37077	Granville	20500	Durham-Chapel Hill, NC
37085	Harnett	22180	Fayetteville, NC
37087	Haywood	11700	Asheville, NC
37103	Jones	35100	New Bern, NC
37137	Pamlico	35100	New Bern, NC
42037	Columbia	14100	Bloomsburg-Berwick, PA
42085	Mercer	49660	Youngstown-Warren-Boardman, OH-PA
42089	Monroe	20700	East Stroudsburg, PA
42093	Montour	14100	Bloomsburg-Berwick, PA
42103	Pike	35084	Newark, NJ-PA
45027	Clarendon	44940	Sumter, SC
48431	Sterling	41660	San Angelo, TX
49003	Box Elder	36260	Ogden-Clearfield, UT
51113	Madison	47894	Washington-Arlington-Alexandria, DC-VA-MD-WV
51175	Southampton	47260	Virginia Beach-Norfolk-Newport News, VA-NC
51620	Franklin City	47260	Virginia Beach-Norfolk-Newport News, VA-NC
54035	Jackson	16620	Charleston, WV
54043	Lincoln	16620	Charleston, WV
54057	Mineral	19060	Cumberland, MD-WV
55069	Lincoln	48140	Wausau-Weston, WI
72001	Adjuntas	38660	Ponce, PR
72055	Guanica	49500	Yauco, PR
72081	Lares	10380	Aguadilla-Isabela, PR
72083	Las Marias	32420	Mayagüez, PR
72141	Utuado	10380	Aguadilia-Isabela, PR

Rural Counties That Will Become Urban Under the Revised OMB Delineations (Page 679)

OMBs statistical area delineations shows that a total of 54 counties (and county equivalents) and 24 hospitals that were located in rural areas will be located in urban areas under the revised OMB delineations. The following chart lists the 54 rural counties that will be urban under the revised OMB delineations. [Again, note the word Proposed."

Counties that Gain Urban Status			
FIPS County Code	County Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
01087	Macon	12220	Auburn-Opelika, AL
01127	Walker	13820	Birmingham, AL
12133	Washington	37460	Panama City-Panama City Beach, FL
13187	Lumpkin	12054	Atlanta-Sandy Springs-Roswell, GA

Counties that Gain Urban Status			
FIPS County Code	County Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
15005	Kalawao	27980	Kahului-Wailuku, HI
17053	Ford	16580	Champaign-Urbana, IL
17127	Massac	37140	Paducah, KY-IL
18159	Tipton	26900	Indianapolis-Carmel-Greenwood, IN
18179	Wells	23060	Fort Wayne, IN
20021	Cherokee	27900	Joplin, MO-KS
21007	Ballard	37140	Paducah, KY-IL
21039	Carlisle	37140	Paducah, KY-IL
21127	Lawrence	26580	Huntington-Ashland, WV-KY-OH
21139	Livingston	37140	Paducah, KY-IL
21145	McCracken	37140	Paducah, KY-IL
21179	Nelson	31140	Louisville/Jefferson County, KY-IN
22053	Jefferson Davis	29340	Lake Charles, LA
22083	Richland	33740	Monroe, LA
26015	Barry	24340	Grand Rapids-Wyoming-Kentwood, MI
26019	Benzie	45900	Traverse City, MI
26055	Grand Traverse	45900	Traverse City, MI
26079	Kalkaska	45900	Traverse City, MI
26089	Leelanau	45900	Traverse City, MI
27133	Rock	43620	Sioux Falls, SD-MN
28009	Benton	32820	Memphis, TN-MS-AR
28123	Scott	27140	Jackson, MS
30007	Broadwater	25740	Helena, MT
30031	Gallatin	14580	Bozeman, MT
30043	Jefferson	25740	Helena, MT
30049	Lewis And Clark	25740	Helena, MT
30061	Mineral	33540	Missoula, MT
32019	Lyon	39900	Reno, NV
37125	Moore	38240	Pinehurst-Southern Pines, NC
38049	McHenry	33500	Minot, ND
38075	Renville	33500	Minot, ND
38101	Ward	33500	Minot, ND
39007	Ashtabula	17410	Cleveland, OH
39043	Erie	41780	Sandusky, OH
41013	Crook	13460	Bend, OR
41031	Jefferson	13460	Bend, OR

Counties that Gain Urban Status			
FIPS County Code	County Name	Proposed FY 2025 CBSA	Proposed FY 2025 CBSA Name
42073	Lawrence	38300	Pittsburgh, PA
45087	Union	43900	Spartanburg, SC
46033	Custer	39660	Rapid City, SD
47081	Hickman	34980	Nashville-Davidson--Murfreesboro--Franklin, TN
48007	Aransas	18580	Corpus Christi, TX
48035	Bosque	47380	Waco, TX
48079	Cochran	31180	Lubbock, TX
48169	Garza	31180	Lubbock, TX
48219	Hockley	31180	Lubbock, TX
48323	Maverick	20580	Eagle Pass, TX
48407	San Jacinto	26420	Houston-Pasadena-The Woodlands, TX
51063	Floyd	13980	Blacksburg-Christiansburg-Radford, VA
51181	Surry	47260	Virginia Beach-Chesapeake-Norfolk, VA-NC
55123	Vernon	29100	La Crosse-Onalaska, WI-MN

Urban Counties That Will Move to a Different Urban CBSA Under the Revised OMB Delineations (Page 469)

In addition to rural counties becoming urban and urban counties becoming rural, some urban counties would shift from one urban CBSA to a new or existing urban CBSA. The following table lists the CBSAs where the CBSA name and number change but the constituent counties do not change (not including instances where an urban county became rural, or a rural county became urban).

FY 2024 CBSA Code	FY 2024 CBSA Name	FY 2025 CBSA Code	FY 2025 CBSA Name
45540	The Villages, FL	48680	Wildwood-The Villages, FL
23844	Gary, IN	29414	Lake County-Porter County-Jasper County, IN
15680	California-Lexington Park, MD	30500	Lexington Park, MD
35154	New Brunswick-Lakewood, NJ	29484	Lakewood-New Brunswick, NJ
39100	Poughkeepsie-Newburgh-Middletown, NY	28880	Kiryas Joel-Poughkeepsie-Newburgh, NY
17460	Cleveland-Elyria, OH	17410	Cleveland, OH

The following table lists the CBSAs that will be subsumed by an another CBSA.

FY 2024 CBSA Code	FY 2024 CBSA Name	FY 2025 CBSA Code	FY 2025 CBSA Name
31460	Madera, CA	23420	Fresno, CA
36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ
41900	San Germán, PR	32420	Mayagüez, PR

In other cases, some counties would shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. For example, Calvert County, MD would move from the current CBSA 12580 (Washington-Arlington-Alexandria, DC-VA-MD-WV) into CBSA 30500 (Lexington Park, MD).

The other constituent counties of CBSA 12580 would be split into urban CBSAs 47664 (Washington, DC-MD) and 11694 (Arlington-Alexandria-Reston, VA-WV).

The following chart lists the urban counties that would split from one urban CBSA and move to a newly or modified urban CBSA.

Counties That Change To Another CBSA					
FIPS County Code	**County Name**	**FY 2024 CBSA Code**	**FY 2024 CBSA Name**	**FY 2025 CBSA Code**	**FY 2025 CBSA Name**
11001	The District	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
12053	Hernando	45300	Tampa-St. Petersburg- Clearwater, FL	45294	Tampa, FL
12057	Hillsborough	45300	Tampa-St. Petersburg- Clearwater, FL	45294	Tampa, FL
12101	Pasco	45300	Tampa-St. Petersburg- Clearwater, FL	45294	Tampa, FL
12103	Pinellas	45300	Tampa-St. Petersburg- Clearwater, FL	41304	St. Petersburg-Clearwater-Largo, FL
13013	Barrow	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13015	Bartow	12060	Atlanta-Sandy Springs- Alpharetta, GA	31924	Marietta, GA
13035	Butts	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13045	Carroll	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13057	Cherokee	12060	Atlanta-Sandy Springs- Alpharetta, GA	31924	Marietta, GA
13063	Clayton	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13067	Cobb	12060	Atlanta-Sandy Springs- Alpharetta, GA	31924	Marietta, GA
13077	Coweta	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13085	Dawson	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13089	De Kalb	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13097	Douglas	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13113	Fayette	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13117	Forsyth	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13121	Fulton	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13135	Gwinnett	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13143	Haralson	12060	Atlanta-Sandy Springs- Alpharetta, GA	31924	Marietta, GA
13149	Heard	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13151	Henry	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13159	Jasper	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13199	Meriwether	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA

Counties That Change To Another CBSA					
FIPS County Code	County Name	FY 2024 CBSA Code	FY 2024 CBSA Name	FY 2025 CBSA Code	FY 2025 CBSA Name
13211	Morgan	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13217	Newton	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13223	Paulding	12060	Atlanta-Sandy Springs- Alpharetta, GA	31924	Marietta, GA
13227	Pickens	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13231	Pike	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13247	Rockdale	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13255	Spalding	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
13297	Walton	12060	Atlanta-Sandy Springs- Alpharetta, GA	12054	Atlanta-Sandy Springs- Roswell, GA
17097	Lake	29404	Lake County-Kenosha County, IL-WI	29404	Lake County, IL
21163	Meade	21060	Elizabethtown-Fort Knox, KY	31140	Louisville/Jefferson County, KY-IN
22103	St. Tammany	35380	New Orleans-Metairie, LA	43640	Slidell-Mandeville-Covington, LA
24009	Calvert	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	30500	Lexington Park, MD
24017	Charles	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
24033	Prince Georges	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	47764	Washington, DC-MD
24037	St. Marys	15680	California-Lexington Park, MD	30500	Lexington Park, MD
25015	Hampshire	44140	Springfield, MA	11200	Amherst Town-Northampton, MA
34009	Cape May	36140	Ocean City, NJ	12100	Atlantic City-Hammonton, NJ
37019	Brunswick	34820	Myrtle Beach-Conway-North Myrtle Beach, SC-NC	48900	Wilmington, NC
39123	Ottawa	45780	Toledo, OH	41780	Sandusky, OH
47057	Grainger	34100	Morristown, TN	28940	Knoxville, TN
51013	Arlington	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51043	Clarke	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51047	Culpeper	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51059	Fairfax	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51061	Fauquier	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51107	Loudoun	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51153	Prince William	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51157	Rappahannock	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51177	Spotsylvania	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51179	Stafford	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV

Counties That Change To Another CBSA					
FIPS County Code	County Name	FY 2024 CBSA Code	FY 2024 CBSA Name	FY 2025 CBSA Code	FY 2025 CBSA Name
51187	Warren	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51510	Alexandria City	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51600	Fairfax City	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51610	Falls Church City	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51630	Fredericksburg City	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51683	Manassas City	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
51685	Manassas Park City	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
53061	Snohomish	42644	Seattle-Bellevue-Kent, WA	21794	Everett, WA
54037	Jefferson	47894	Washington-Arlington- Alexandria, DC-VA-MD-WV	11694	Arlington-Alexandria-Reston, VA-WV
55059	Kenosha	29404	Lake County-Kenosha County, IL-WI	28450	Kenosha, WI
72023	Cabo Rojo	41900	San Germán, PR	32420	Mayagüez, PR
72059	Guayanilla	49500	Yauco, PR	38660	Ponce, PR
72079	Lajas	41900	San Germán, PR	32420	Mayagüez, PR
72111	Penuelas	49500	Yauco, PR	38660	Ponce, PR
72121	Sabana Grande	41900	San Germán, PR	32420	Mayagüez, PR
72125	San German	41900	San Germán, PR	32420	Mayagüez, PR
72153	Yauco	49500	Yauco, PR	38660	Ponce, PR

Comment

It is apparent that CMS has made changes between its proposed and this final rule when reading the rule's text. However, too many of the geographical tables above still address headings "as proposed." We therefore must ask why?

Occupational Mix Adjustment to the FY 2025 Wage Index (Page 719)

CMS says the FY 2025 Occupational Mix *Adjusted* National Average Hourly Wage is **$54.97.** (Page 725). It is currently $50.34.

The final FY 2025 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$60.40
National LPN and Surgical Technician	$35.02
National Nurse Aide, Orderly, and Attendant	$23.58
National Medical Assistant	$23.12
National Nurse Category	$50.14

1. Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act, Implemented at § 412.103 (Page 726)

Under section 1886(d)(8)(E) of the Act, a qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB.

CMS "reminds hospitals currently located in rural areas becoming urban under the adoption of the revised OMB delineations that if they have SCH, MDH, or RRC status, they may choose to apply for a § 412.103 urban to rural reclassification if qualifying criteria are met to maintain the SCH, MDH, or RRC status. We advise hospitals to evaluate their options and if desired, apply for § 412.103 urban to rural reclassification before the beginning of FY 2025, to avoid a lapse in SCH, MDH, or RRC status at the beginning of FY 2025"

(a) Update to Rural Criteria at § 412.103(a)(1) (Page 729)

Section 1886(d)(8)(E) of the Act describes criteria for hospitals located in urban areas to be treated as being located in a rural area of their state. The criterion at section 1886(d)(8)(E)(ii)(I) of the Act requires that the hospital be located in a rural census tract of a metropolitan statistical area.

CMS is amending the regulation text at 412.103(a)(1) to read: the hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, using the Rural-Urban Commuting Area codes and additional criteria, as determined by the Federal Office of Rural Health Policy (FORHP) of the Health Resources and Services Administration (HRSA).

(b) Policy for Canceling § 412.103 Reclassifications of Terminated Providers (Page 732)

CMS proposed that § 412.103 reclassifications will be considered cancelled for the purposes of calculating area wage index for any hospital with a CCN listed as terminated or "tied-out" as of the date that the hospital ceased to operate with an active CCN.

2. MGCRB Reclassification Issues for FY 2025 (Page 739)

There are 470 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2025. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2025, hospitals reclassified beginning in FY 2023 or FY 2024 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 256 hospitals approved for wage index reclassifications in FY 2023 that will continue for FY 2025, and 352 hospitals approved for wage index reclassifications in FY 2024 that will continue for FY 2025. In total 1,078 hospitals (approximately 32.5 percent of IPPS hospitals) are reclassified.

Applications for FY 2026 reclassifications are due to the MGCRB by September 1, 2024.

Comment

There is a significant amount of material in this section regarding the treatment of how hospitals currently reclassified will be effected by the implementation of OMB Bulletin No. 23-01.

Effects of Implementation of Revised OMB Labor Market Area Delineations on Redesignations Under Section 1886(d)(8)(B) of the Act (Page 762)

CMS notes that 54 currently rural counties will be added to new or existing urban CBSAs. Of those 54 counties, 22 are currently deemed urban under section 1886(d)(8)(B) of the Act. CMS proposed that

hospitals located in such a "Lugar" county, barring another form of wage index reclassification, are assigned the reclassified wage index of a designated urban CBSA. Section 1886(d)(8)(B) of the Act defines a deemed urban county as a "rural county adjacent to one or more urban areas" that meets certain commuting thresholds. Since CMS proposed to modify the status of these 22 counties from rural to urban, they would no longer qualify as "Lugar" counties. Hospitals located within these counties would be considered geographically urban under the revised OMB delineations. Refer CMS' table on page 763.

CMS determined that, as proposed, 33 rural counties (an approximately 11 hospitals) would lose "Lugar" status, as the county no longer meets the commuting thresholds or adjacency criteria specified in section 1886(d)(8)(B) of the Act. (Page 764) Refer table on this page.

CMS says it recognizes that the changes to the "Lugar" list may have negative financial impacts for hospitals that lose deemed urban status. CMS believes that the 5.0 percent cap on negative wage index changes would mitigate significant negative payment impacts for FY 2025. (Page 768)

Wage Index Adjustments: Rural Floor, Imputed Floor, State Frontier Floor, Out-Migration Adjustment, Low Wage Index, and Cap on Wage Index Decrease Policies (Page 769)

Rural Floor (Page 770)

By statute, no urban hospital can have a wage index lower than the statewide rural amount. CMS now estimates that 771 hospitals would receive the rural floor in FY 2025.

Imputed Floor (Page 774)

CMS adopted the imputed floor policy to address concerns from hospitals in all urban States that have stated that they are disadvantaged by the absence of rural hospitals to set a wage index floor for those States. CMS considers a hospital to be classified as rural under section 1886 of the Act if it is assigned the State's rural area wage index value.

States that will be all-urban States as defined in section 1886(d)(3)(E)(iv)(IV) of the Act, and thus hospitals in such States that will be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2025, are identified in Table 3 (on CMS' web). States with a value in the column titled "State Imputed Floor" are eligible for the imputed floor.

State Frontier Floor (Page 777)

For FY 2025, 41 hospitals will receive the frontier floor value of 1.0000 for their wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming.

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 777)

Table 2 (available on the CMS website) lists the out-migration adjustments for the FY 2025 wage index.

Continuation of the Low Wage Index Hospital Policy and Budget Neutrality Adjustment (Page 780)

The wage index for hospitals with a wage index value below the 25th percentile wage index value is increased by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals (the low wage index hospital policy). The FY 2025 25th Percentile Wage Index Value is 0.9007. (Page 802)

Permanent Cap on Wage Index Decreases and Budget Neutrality Adjustment (Page 802)

A hospital's wage index will not be less than 95 percent of its final wage index for the prior FY.

FY 2025 Wage Index Tables (Page 804)

CMS has included the following wage index tables: Table 2 titled "Case-Mix Index and Wage Index Table by CCN"; Table 3 titled "Wage Index Table by CBSA"; Table 4A titled ''List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act''; and Table 4B titled ''Counties redesignated under section 1886(d)(8)(B) of the Act (Lugar Counties).'' All are on the CMS website.

Labor-Related Share for the FY 2025 Wage Index (Page 805)

For FY 2025, CMS is not proposing to make any further changes to the labor-related share.

III. PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHS) FOR FY 2025 (§ 412.106) (Page 809)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

Section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the remaining estimate of 75 percent of uncompensated care payment is the product of three factors. The 3 factors are:

Calculation of Factor 1 for FY 2025 (Page 833)

This factor represents CMS' estimate of 75 percent of the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

The June 2024 OACT's estimate for Medicare DSH payments for FY 2024, without regard to the application of section 1886(r)(1) of the Act, is approximately $14.013 billion, an increase from the proposed amount of $13.943 billion.

Based on the June 2024 estimate, the estimate of empirically justified Medicare DSH payments for FY 2025, with the application of section 1886(r)(1) of the Act, was approximately $3.503 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2025).

Therefore, the final Factor 1 for FY 2025 is **$10,509,750,000**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2025 ($14,013,000,000 minus $3,503,250,000).

Calculation of Factor 2 for FY 2025 (Page 836)

The second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were uninsured in 2013 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of CMS) and the percent of individuals who were uninsured in the most recent period for which data are available (as so estimated and certified).

The calculation of the percent Factors 2 for FY 2025 are as follows:

- Percent of individuals without insurance for CY 2013: 14.0 percent.
- Percent of individuals without insurance for CY 2024: 7.3 percent.
- Percent of individuals without insurance for CY 2025: 7.7 percent.
- Percent of individuals without insurance for FY 2025 (0.25 times 0.073) + (0.75 times 0.077)= 7.6 percent. 1- |((0.076-0.14)/0.14)| = 1-0.457 = 0.5429 (54.29 percent)

CMS is finalizing that Factor 2 for FY 2025 would be 54.29 percent. The FY 2025 uncompensated care amount is equivalent to Factor 1 multiplied by Factor 2, which is **$5,705,743,275**

The following shows the 75 percent yearly amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" was $6.767 billion
- The FY 2019 "pool" was $8.273 billion
- The FY 2020 "pool" was $8.351 billion
- The FY 2021 "pool" was $8.290 billion
- The FY 2022 "pool" was $7.192 billion
- The FY 2023 "pool" was $6.874 billion
- The FY 2024 "pool" is $5.938 billion
- The FY 2025 "pool" will be $5.706 billion

The pool amount for FY 2025 will be $232 million less than the current FY 2024 amount.

Calculation of Factor 3 for FY 2025 (Page 846)

Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive Medicare DSH payments in the fiscal year for which the uncompensated care payment is to be made.

For purposes of this FY 2025 IPPS/LTCH PPS rule, CMS is using reports from the March 2024 HCRIS extract to calculate Factor 3.

For FY 2025, CMS will use 3 years of audited Worksheet S–10 data to calculate Factor 3 for all eligible hospitals.

IV. CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 44)

Changes to Specific MS-DRG Classifications (Page 47)

For the FY 2025 IPPS/LTCH PPS rule, CMS' MS-DRG analysis was based on ICD-10 claims data from the September 2023 update of the FY 2023 MedPAR file, which contains hospital bills received from October 1, 2022 through September 30, 2023.

CMS has finalized its proposal to remove the discussion of the Medicare Code Editor (MCE) from the annual IPPS rulemakings, beginning with FY 2025 rulemaking, and to generally address future changes or updates to the MCE through instruction to the MACs. (Page 55)

Listed below are specific MS-DRG items CMS is addressing in this rule.

(1) Logic for MS-DRGs 023 through 027 (Page 77)

As discussed in the FY 2025 IPPS/LTCH PPS proposed rule, CMS received a request to add ICD-10-PCS procedure codes D0Y0CZZ (Intraoperative radiation therapy (IORT) of brain) and D0Y1CZZ (Intraoperative radiation therapy (IORT) of brain stem), to the Chemotherapy Implant logic list in MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator).

CMS is continuing its analysis of the claims data with respect to MS-DRGs 023 through 027. CMS says it continues to seek public comments and feedback on other factors that should be considered in the potential restructuring of these MS-DRGs.

CMS is maintaining the current assignment of cases describing a neurostimulator generator inserted into the skull with the insertion of a neurostimulator lead into the brain (including cases involving the use of the RNS® neurostimulator), without modification.

(2) Intraoperative Radiation Therapy (IORT) (Page 83)

CMS says it is unable to evaluate whether the use of IORT directly impacts resource utilization. CMS is maintaining the current structure of MS-DRGs 023, 024, 025, 026, and 027 for FY 2025.

(3) Ultras Concomitant Left Atrial Appendage Closure and Cardiac Ablation (Page 67)

As discussed in the FY 2025 IPPS/LTCH PPS proposed rule, CMS received a request to create a new MS-DRG to better accommodate the costs of concomitant left atrial appendage closure and cardiac ablation for atrial fibrillation in MDC 05 (Diseases and Disorders of the Circulatory System).

CMS is creating new MS-DRG 317 (Concomitant Left Atrial Appendage Closure and Cardiac Ablation) in MDC 05, with modification, effective October 1, 2024, for FY 2025. Specifically, CMS is modifying the list of ICD-10-PCS procedure codes that describe cardiac ablation in the Version 42 GROUPER logic of new MS-DRG 317 by removing ICD-10-PCS codes 02590ZZ (Destruction of chordae tendineae, open approach), 02593ZZ, Destruction of chordae tendineae, percutaneous approach), and 02594ZZ (Destruction of chordae tendineae, percutaneous endoscopic approach) and adding ICD-10-PCS procedure code 02583ZF (Destruction of conduction mechanism using irreversible electroporation, percutaneous approach).

(4) Neuromodulation Device Implant for Heart Failure (Barostim™ Baroreflex Activation Therapy) (Page 105)

The BAROSTIM™ system is the first neuromodulation device system designed to trigger the body's main cardiovascular reflex to target symptoms of heart failure. CMS received a request to review the MS-DRG assignment of the ICD-10-PCS procedure codes that describe the implantation of the BAROSTIM™ system.

For FY 2025, CMS proposed to reassign all cases with one of the following ICD-10-PCS code combinations capturing cases reporting procedure codes describing the implantation of a BAROSTIM™ system, to MS-DRG 276, even if there is no MCC reported:

- 0JH60MZ (Insertion of stimulator generator into chest subcutaneous tissue and fascia, open approach) in combination with 03HK3MZ (Insertion of stimulator lead into right internal carotid artery, percutaneous approach); and

- 0JH60MZ (Insertion of stimulator generator into chest subcutaneous tissue and fascia, open approach) in combination with 03HL3MZ (Insertion of stimulator lead into left internal carotid artery, percutaneous approach).

CMS also proposed to change the title of MS-DRG 276 from "Cardiac Defibrillator Implant with MCC" to "Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator"

CMS is finalizing its proposal to reassign cases reporting one of the previously listed ICD-10-PCS code combinations describing the implantation of a BAROSTIM™ system to MS-DRG 276, even if there is no MCC reported, without modification, effective October 1, 2024. CMS is also finalizing the change to the title of MS-DRG 276 from "Cardiac Defibrillator Implant with MCC" to "Cardiac Defibrillator Implant with MCC or Carotid Sinus Neurostimulator" to reflect the modifications to MS-DRG assignments.

(5) Endovascular Cardiac Valve Procedures (Page 114)

CMS received a request to delete MS-DRGs 266 and 267 and to move the cases reporting transcatheter aortic valve replacement or repair (supplement) procedures currently assigned to those MS-DRGs into MS-DRGs 216, 217, 218, 219, 220, and 221.

CMS says it continues to believe that endovascular cardiac valve replacement and supplement procedures are clinically coherent in their currently assigned MS-DRGs.

CMS is maintaining the structure of MS-DRGs 266 and 267, without modification, for FY 2025.

(6) MS-DRG Logic for MS-DRG 215 (Page 127)

CMS received a request to review the GROUPER logic for MS-DRG 215 (Other Heart Assist System Implant) in MDC 05 (Diseases and Disorders of the Circulatory System). The requestor stated that when the procedure code describing the revision of malfunctioning devices within the heart via an open approach is assigned, the encounter groups to MS-DRG 215.

CMS is maintaining the GROUPER logic for MS-DRG 215 for FY 2025, without modification.

(7) MDC 06 (Diseases and Disorders of the Digestive System): Excision of Intestinal Body Parts (Page 132)

CMS proposed the reassignment of procedure codes 0DB83ZZ, 0DBA3ZZ, 0DBA4ZZ, 0DBB3ZZ, 0DBB4ZZ, 0DBC0ZZ, 0DBC3ZZ, and 0DBC4ZZ from MS-DRGs 347, 348, and 349 (Anal and Stomal Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 329, 330, and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 06, effective FY 2025.

CMS is reassigning procedure codes 0DB83ZZ, 0DBA3ZZ, 0DBA4ZZ, 0DBB3ZZ, 0DBB4ZZ, 0DBC0ZZ, 0DBC3ZZ, and 0DBC4ZZ from MS-DRGs 347, 348, and 349 (Anal and Stomal Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 329, 330, and 331 (Major Small and Large Bowel Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 06, without modification, effective October 1, 2024.

(8) MS-DRG Logic for MS-DRGs 456, 457, and 458 (page 136)

CMS proposed to add diagnosis codes M43.8X4, M43.8X5, M43.8X6, M43.8X7, and M43.8X8 to the "OR Secondary Diagnosis" logic list for MS-DRGs 456, 457, and 458, effective October 1, 2024 for FY 2025

CMS is adding diagnosis codes M43.8X4, M43.8X5, M43.8X6, M43.8X7, and M43.8X8 to the "OR Secondary Diagnosis" logic list for MS-DRGs 456, 457, and 458 effective October 1, 2024.

(9) Interbody Spinal Fusion Procedures (Page 139)

CMS proposed to delete MS-DRGs 453, 454, and 455 and proposed to create 8 new MS-DRGs.

CMS is creating new MS-DRG 426, MS-DRG 427, MS-DRG 428, MS-DRG 402, MS-DRG 429, MS-DRG 430, MS-DRG 447, and MS-DRG 448 (Page 171)

CMS is deleting MS-DRGs 453, 454, and 455 and to create new MS-DRGs 426, 427, and 428, with modification. Specifically, cases reporting the use of a custom-made anatomically designed interbody fusion device with a CC to new MS-DRG 426. (Page 195)

The finalized MS-DRG titles are MS-DRG 426 "Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with MCC or Custom-Made Anatomically Designed Interbody Fusion Device", MS-DRG 427 "Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical with CC" and MS-DRG 428 "Multiple Level Combined Anterior and Posterior Spinal Fusion Except Cervical without CC/MCC" effective October 1, 2024.

The finalized MS-DRG titles for MS-DRG 447 is "Multiple Level Anterior and Posterior Spinal Fusion Except Cervical with MCC or Custom-Made Anatomically Designed Interbody Fusion Device" and for MS-DRG 448 "Multiple Level Anterior and Posterior Spinal Fusion Except Cervical without MCC" effective October 1, 2024. (Page 196)

The finalized MS-DRG titles for MS-DRG 402 is "Single Level Combined Anterior and Posterior Spinal Fusion Except Cervical", MS-DRG 429 "Combined Anterior and Posterior Cervical Spinal Fusion with MCC" and MS-DRG 430 "Combined Anterior and Posterior Cervical Spinal Fusion without MCC" effective October 1, 2024. (Page197)

(10) Resection of Right Large Intestine (Page 197)

CMS proposed to add procedure codes 0DTF0ZZ and 0DTF4ZZ to MDC 10 in MS-DRGs 628, 629, and 630 effective October 1, 2024.

(11) MS-DRG 795 Normal Newborn (Page 198)

CMS proposed to reassign diagnosis code P05.19 from the "principal or secondary diagnosis" list under MS-DRG 794 to the "principal diagnosis" list under MS-DRG 795 (Normal Newborn). CMS also proposed to add diagnosis codes Q38.1 and Q82.5 to the "only secondary diagnosis" list under MS-DRG 795 (Normal Newborn). Cases with a principal diagnosis described by an ICD-10-CM code from category Z38 (Liveborn infants according to place of birth and type of delivery), followed by codes P05.19, Q38.1, or Q82.5 will be assigned to MS-DRG 795.

For clinical consistency, CMS is reassigning ICD-10-CM diagnosis codes Q81.0, Q81.1, Q81.2, Q81.8, and Q81.9 from MS-DRGs 606 and 607 in MDC 09 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast) and MS-DRG 795 (Normal Newborn) in MDC 15 to MS-DRGs 595 and 596 in MDC 09 and MS-DRG 794 in MDC 15, effective October 1, 2024. (Page 208)

(12) Acute Leukemia (Page 208)

CMS is reassigning diagnosis codes C94.20, C94.21, C94.22, C94.40, C94.41, and C94.42 from MS-DRGs 823, 824, and 825 (Lymphoma and Non-Acute Leukemia with Other Procedures with MCC, with CC, and without CC/MCC, respectively), and MS-DRGs 840, 841, and 842 (Lymphoma

and Non-Acute Leukemia with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 834, 835, and 836 (Acute Leukemia without Major O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) and MS-DRGs 837, 838, and 839 (Chemotherapy with Acute Leukemia as Secondary Diagnosis, or with High Dose Chemotherapy Agent with MCC, with CC or High Dose Chemotherapy Agent, and without CC/MCC, respectively) in MDC 17, without modification, effective October 1, 2024.

Under this finalization, diagnosis codes C94.20, C94.21, C94.22, C94.40, C94.41, and C94.42 will continue to be assigned to surgical MS-DRGs 820, 821, and 822 (Lymphoma and Leukemia with Major O.R. Procedures with MCC, with CC, and without CC/MCC, respectively). (Page 215)

CMS is adding the 12 procedure codes that describe bypass procedures from the cerebral ventricle to the subgaleal space or cerebral cisterns listed previously to MS-DRGs 820, 821, 822, 826, 827, and 828 in MDC 17, without modification, effective October 1, 2024. (Page 217)

CMS is creating new base surgical MS-DRG 850 (Acute Leukemia with Other Procedures) for cases reporting a principal diagnosis describing a type of acute leukemia with an ICD-10-PCS procedure code designated as an O.R. procedure that is not listed in the logic list of MS-DRGs 820, 821, and 822 in MDC 17, without modification, effective October 1, 2024. (Page 223)

CMS is designating the 189 codes describing stereotactic radiosurgery of various body parts as non-O.R. procedures affecting the MS-DRG as part of the logic for new MS-DRG 850. (Page 223)

CMS is revising the titles for medical MS-DRGs 834, 835, and 836 from "Acute Leukemia without Major O.R. Procedures with MCC, with CC, and without CC/MCC", respectively to "Acute Leukemia with MCC, with CC, and without CC/MCC", respectively.

(13) Review of Procedure Codes in MS-DRGs 981 through 983 and 987 through 989 (Page 223)

CMS is finalizing, without modification, its proposal to not move any cases from MS-DRGs 981 through 983 or MS-DRGs 987 through 989 into a surgical MS-DRGs for the MDC into which the principal diagnosis or procedure is assigned.

(14) Laparoscopic Biopsy of Intestinal Body Parts (Page 232)

CMS is changing the designation of procedure codes 0DBF4ZX, 0DBG4ZX, 0DBL4ZX, 0DBM4ZX and 0DBN4ZX from non-O.R. procedures to O.R. procedures, without modification, effective October 1, 2024.

(15) Laparoscopic Biopsy of Gallbladder and Pancreas (Page 235)

CMS is changing the designation of procedure codes 0FB44ZX and 0FBG4ZX from non-O.R. procedures to O.R. procedures, without modification, effective October 1, 2024.

(16) Changes to Severity Levels (Page 250)

CMS is finalizing changes to the severity levels for diagnosis codes Z59.10, Z59.11, Z59.12, Z59.19, Z59.811, Z59.812, and Z59.819, from Non-CC to CC for FY 2025, without modification.

Additions and Deletions to the Diagnosis Code Severity Levels for FY 2025 (Page 274)

The following tables identify the additions and deletions to the diagnosis code MCC severity levels list and the additions and deletions to the diagnosis code CC severity levels list for FY 2025 and are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

Table 6I. —Complete MCC List—FY 2025;
Table 6I.1—Additions to the MCC List— FY 2025;
Table 6I.2—Deletions to the MCC List— FY 2025; Table 6J. —Complete CC List—FY 2025;
Table 6J.1—Additions to the CC List— FY 2025; and
Table 6J.2—Deletions to the CC List—FY 2025.

CMS is adding suppression logic to exclude diagnosis codes N18.5 (Chronic kidney disease, stage 5) and N18.6 (End stage renal disease) from the logic list entitled "With Secondary Diagnosis" from acting as a CC or an MCC, respectively, when reported as a secondary diagnosis with one of the 13 previously listed principal diagnosis codes from the "Or Principal Diagnosis" logic lists in MS-DRGs 673, 674, and 675, without modification, effective October 1, 2024 for FY 2025. (Page 284)

In addition, CMS is adopting changes to the ICD-10 MS-DRGs Version 42 CC Exclusion List based on diagnosis code updates. (Page 276)

CMS has finalized CC Exclusions List as displayed in Tables 6G.1, 6G.2, 6H.1, 6H.2, and 6K to reflect the severity levels under V42 of the ICD–10 MS–DRGs.

Table 6G.1.— Secondary Diagnosis Order Additions to the CC Exclusions List—FY 2025;
Table 6G.2.—Principal Diagnosis Order Additions to the CC Exclusions List—FY 2025;
Table 6H.1.—Secondary Diagnosis Order Deletions to the CC Exclusions List—FY 2025; and
Table 6H.2.—Principal Diagnosis Order Deletions to the CC Exclusions List—FY 2025; and
Table 6K. Complete List of CC Exclusions-FY 2025.

These tables are on CMS' website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (Page 293)

CMS is also making available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html the following tables associated with this rule:

- Table 6A.—New Diagnosis Codes–FY 2025;
- Table 6B.—New Procedure Codes–FY 2025;
- Table 6C.—Invalid Diagnosis Codes–FY 2025;
- Table 6D.—Invalid Procedure Codes–FY 2025;
- Table 6E.—Revised Diagnosis Code Titles–FY 2025;
- Table 6F.—Revised Procedure Code Titles–FY 2025;

Replaced Devices Offered without Cost or with a Credit (Page 311)

The existing MS-DRGs currently subject to the replaced device policy is displayed in the rule's table on page 313.

Comment

The MS-DRG material above consumes nearly 300 pages. CMS has provided much information regarding its actions. Our analysis just tries to provide the changes being finalized.

Note, that not all items are addressed in our summaries. Since DRG assignments and weighting factors are a critical component of overall payments, providers need to analyze the changes being made.

This analysis has not addressed changes to Surgical Hierarchies and Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems.

V. PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY 2025 (Page 334)

Sections 1886(d)(5)(K) and (L) of the Act establish a process of identifying and ensuring adequate payment for new medical services and technologies (sometimes collectively referred to in this section as ''new technologies'').

FY 2025 Status of Technologies Receiving New Technology Add-On Payments for FY 2024 (Page 350)

CMS discusses the FY 2025 status of technologies approved for FY 2024 new technology add-on payments, as set forth in the tables that follow.

Continuation of Technologies Approved for FY 2024 New Technology Add-On Payments Still Considered New for FY 2025 Because 3-Year Anniversary Date Will Occur on or After April 1, 2025 (Page 361)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Maximum NTAP Amount for FY 2025	Coding Used to Identify Cases Eligible for NTAP
1	*Thoraflex™ Hybrid Device*	*04/19/2022*	*10/1/2022*	*04/19/2025*	87 FR 48974 through 48975 88 FR 58800	$22,750.00	X2RX0N7 in combination with X2VW0N7
2	*ViviStim® Paired VNS System*	*04/29/2022*	*10/1/2022*	*04/29/2025*	87 FR 48975 through 48977 88 FR 58800	$23,400.00	X0HQ3R8
3	*GORE® TAG® Thoracic Branch Endoprosthesis*	*05/13/2022*	*10/1/2022*	*05/13/2025*	87 FR 48966 through 48969 88 FR 58800	$27,807.00	02VW3DZ in combination with 02VX3EZ
4	*Cerament® G*	*05/17/2022*	*10/1/2022*	*05/17/2025*	87 FR 48961 through 48966 88 FR 58800	$4,918.55	XW0V0P7
5	*iFuse Bedrock Granite Implant System*	*05/26/2022*	*10/1/2022*	*05/26/2025*	87 FR 48969 through 48974 88 FR 58800	$9,828.00	XNH6058 or XNH6358 or XNH7058 or XNH7358 or XRGE058 or XRGE358 or XRGF058 or XRGF358
6	*CYTALUX® (pafolacianine) (ovarian indication)*	*04/15/2022*	*10/1/2023*	*04/15/2025*	88 FR 58804 through 58810	$2,762.50	8E0U0EN, 8E0U3EN, 8E0U4EN, 8E0U7EN, or 8E0U8EN
7	*CYTALUX® (pafolacianine) (lung indication)*	*06/05/2023*	*10/1/2023*	*06/05/2026*	88 FR 58810 through 58818	$2,762.50	8E0W0EN, 8E0W3EN, 8E0W4EN, 8E0W7EN, or 8E0W8EN
8	*EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm)*	*05/19/2023*	*10/1/2023*	*05/19/2026*	88 FR 58818 through 58835	$6,504.07	XW013S9, XW033P9, or XW043P9

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Dateof Entry onto U.S. Market	Previous Final Rule Citations	Maximum NTAP Amount for FY 2025	Coding Used to Identify Cases Eligible for NTAP
9	*Lunsumio™ (mosunetuzumab)*	*12/22/2022*	*10/1/2023*	*12/22/2025*	88 FR 58835 through 58845	$17,492.10	XW03358 or XW04358
10	*REBYOTA™ (fecal microbiota, live- jslm) and VOWST™ (fecal microbiota spores, live-brpk)*	*01/23/2023*	*10/1/2023*	*01/23/2026*	88 FR 58848 through 58868	$6,789.25	XW0H7X8 or XW0DXN9
11	*SPEVIGO® (spesolimab)*	*09/01/2022*	*10/1/2023*	*09/01/2025*	88 FR 58879 through 58885	$33,236.45	XW03308
12	*TECVAYLI™ (teclistamab-cqyv)*	*11/09/2022*	*10/1/2023*	*11/09/2025*	88 FR 58885 through 58891	$8,940.54	XW01348
13	*TERLIVAZ® (terlipressin)*	*10/14/2022*	*10/1/2023*	*10/14/2025*	88 FR 58891 through 58906	$16,672.50	XW03367 or XW04367
14	*Aveir™ AR Leadless Pacemaker*	*06/29/2023*	*10/1/2023*	*06/29/2026*	88 FR 58919 through 58923	$10,725.00	X2H63V9
15	*Aveir™ Dual-Chamber Leadless Pacemaker*	*06/29/2023*	*10/1/2023*	*06/29/2026*	88 FR 58923 through 58925	$15,600.00	X2H63V9 in combination with X2HK3V9
16	*Ceribell Status Epilepticus Monitor*	*05/23/2023*	*10/1/2023*	*05/23/2026*	88 FR 58927 through 58930	$913.90	XX20X89
17	*DETOUR System*	*06/07/2023*	*10/1/2023*	*06/07/2026*	88 FR 58930 through 58932	$16,250.00	X2KH3D9, X2KH3E9, X2KJ3D9, or X2KJ3E9
18	*DefenCath™ (taurolidine/heparin)*	*11/15/2023*	*1/1/2024*	*11/15/2026*	88 FR 58942 through 58944	$17,111.25	XY0YX28
19	*EchoGo Heart Failure 1.0*	*11/23/2022*	*10/1/2023*	*11/23/2025*	88 FR 58932 through 58935	$1,023.75	XXE2X19
20	*Phagenyx® System*	*04/12/2023*	*10/1/2023*	*04/12/2026*	88 FR 58935 through 58937	$3,250.00	XWHD7Q7
21	*REZZAYO™ (rezafungin for injection)*	*07/19/2023*	*10/1/2023*	*07/19/2026*	88 FR 58944 through 58946	$4,387.50	XW033R9 or XW043R9
22	*SAINT Neuromodulation System*	*09/01/2022*	*10/1/2023*	*09/01/2025*	88 FR 58937 through 58939	$12,675.00	X0Z0X18
23	*TOPS™ System*	*06/15/2023*	*10/1/2023*	*06/15/2026*	88 FR 58940 through 58942	$11,375.00	XRHB018 in combination with M48.062
24	*XACDURO® (sulbactam/durlobactam)*	*05/23/2023*	*10/1/2023*	*05/23/2026*	88 FR 58946 through 58948	$13,680.00	XW033K9 or XW043K9 in combination with one of the following: Y95 and J15.61; OR J95.851 and B96.83

The following table lists the technologies for which CMS will discontinue making new technology add-on payments for FY 2025 because they are no longer "new" for purposes of new technology add-on payments.

Discontinuation of Technologies Approved for FY 2024 New Technology Add-On Payments No Longer Considered New for FY 2025 Because 3-Year Anniversary Date Will Occur Prior To April 1, 2025 (Page 366)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
1	*Intercept® Fibrinogen Complex (PRCFC)*	*05/05/2021*	*10/1/2021*	*5/05/2024*	86 FR 45149 through 45150 86 FR 67875 87 FR 48913 88 FR 58800
2	*Rybrevant® (amivantamab)*	*05/21/2021*	*10/1/2021*	*05/21/2024*	86 FR 44988 through 44996 87 FR 48913 88 FR 58800
3	*StrataGraft®*	*06/15/2021*	*10/1/2021*	*06/15/2024*	86 FR 45079 through 45090 87 FR 48913 88 FR 58800
4	*aprevo® Intervertebral Body Fusion Device (TLIF indication)*	*6/30/2021 (TLIF)*	*10/1/2021*	*6/30/2024 (TLIF)*	86 FR 45127 through 45133 86 FR 67874 through 67876 87 FR 48913 88 FR 58800
5	*Hemolung Respiratory Assist System (RAS) (non- COVID-19 related use)*	*11/15/2021 (other)*	*10/1/2022*	*11/15/2024 (other)*	87 FR 48937 through 48948 88 FR 58800
6	*Livtencity™ (maribavir)*	*12/2/2021*	*10/1/2022*	*12/2/2024*	87 FR 48948 through 48954 88 FR 58800
7	*Canary Tibial Extension (CTE) with Canary Health Implanted Reporting Processor (CHIRP) System*	*10/04/2021*	*10/1/2023*	*10/04/2024*	88 FR 58925 through 58927

FY 2025 Applications for New Technology Add-On Payments (Traditional Pathway) (Page 367)

CMS received 16 applications for new technology add-on payments for FY 2025 under the new technology add-on payment traditional pathway.

Of the 16 applications received, one applicant was not eligible for consideration for new technology add-on payment and five applicants withdrew their application prior to the issuance of this final rule.

CMS is not approving new technology add-on payments for 6 technologies: CasgevyTM (exagamglogene autotemcel) for the indication of transfusion dependent β-thalassemia, DuraGraft®, FloPatch FP120, Lantidra™ (donislecel-jujn (allogeneic pancreatic islet cellular suspension for hepatic portal vein infusion), AMTAGVI™ (lifileucel), and Quicktome Software Suite.

Two technologies, ELREXFIO™ (elranatamab-bcmm) and TALVEY™ (talquetamab-tgvs), are considered substantially similar to TECVAYLI™ (teclistamab-cqyv), which were approved for new technology add-on payments for FY 2024 and are still considered "new" for purposes of new technology add-on payments for FY 2025. (Page 368)

CMS is addressing the remaining applications. They are:

(1) CASGEVY™ (exagamglogene autotemcel) First Indication: Sickle Cell Disease (SCD) (Page 368)

The maximum new technology add-on payment for a case involving the use of CasgevyTM for the treatment of SCD is $1,650,000 for FY 2025.

(2) ELREXFIO™ (elranatamab-bcmm) (Page 420)

The maximum new technology add-on payment for a case involving the use of ELREXFIO™, TALVEYTM, or TECVAYLI® is $12,899.59 for FY 2025.

(3) HEPZATO™ KIT (melphalan for injection/hepatic delivery system) (Page 441)

The maximum new technology add-on payment for a case involving the use of HEPZATO™ KIT is $118,625 for FY 2025.

(4) LYFGENIA™ (lovotibeglogene autotemcel) (Page 508)

The maximum new technology add-on payment for a case involving the use of Lyfgenia™ for the treatment of SCD is $2,325,000 for FY 2025.

(5) VADER® Pedicle System (Page 608)

The maximum new technology add-on payment for a case involving the use of the VADER® Pedicle System is $28,242.50 for FY 2025.

(6) ZEVTERA™ (ceftobiprole medocaril) (Page

The maximum new technology add-on payment for a case involving the use of ZEVTERATM is $8,625.00 for the indication of SAB and $2,812.50 for the indications of ABSSSI and CABP for FY 2025.

FY 2025 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 547)

CMS says it received 23 applications for new technology add-on payments for FY 2025 under the new technology add-on payment alternative pathway. (Page 548)

Of the 23 applications, seven applications were not eligible for consideration for new technology add-on payment and two applicants withdrew their applications prior to the issuance of the proposed rule.

The remaining are as follows:

(1) Annalise Enterprise Computed Tomography Brain (CTB) Triage – Obstructive Hydrocephalus (OH) (Page 550)

The maximum new technology add-on payment for a case involving the use of the Annalise Enterprise CTB Triage - OH is $241.39 for FY 2025

(2) ASTar® System (Page 558)

The maximum new technology add-on payment for a case involving the use of the ASTar® System would be $97.50 for FY 2025 (that is, 65 percent of the average cost of the technology).

(3) Edwards EVOQUETM Tricuspid Valve Replacement System (Transcatheter Tricuspid Valve Replacement System) (Page 564)

The maximum new technology add-on payment for a case involving the use of the EVOQUETM System would be $31,850 for FY 2025.

(4) GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device) (Page 569)

The maximum new technology add-on payment for a case involving the use of the TAMBE Device would be $47,238.75 for FY 2025.

(5) LimFlow™ System (Page 575)

The maximum new technology add-on payment for a case involving the use of the LimFlow™ would be $16,250 for FY 2025.

(6) Paradise™ Ultrasound Renal Denervation System (Page 581)

The maximum new technology add-on payment for a case involving the use of the Paradise™ Ultrasound Renal Denervation System would be $23,000 for FY 2025.

(7) PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter (Page 588)

The maximum new technology add-on payment for a case involving the use of the PulseSelect™ PFA Loop Catheter would be $6,337.50 for FY 2025.

(8) Symplicity Spyral™ Multi-Electrode Renal Denervation Catheter (Page 596)

The maximum new technology add-on payment for a case involving the use of the Symplicity SpyralTM Multi-Electrode Renal Denervation Catheter is $10,400.00 for FY 2025.

(9) TriClip™ G4 (Page 604)

The maximum new technology add-on payment for a case involving the use of TriClipTM G4 would be $26,000 for FY 2025.

Comment

The number of new technologies cited and approved above for FY 2025 do not equal the numbers CMS says it is approving.

Change to the Method for Determining whether a Technology will be Within its 2- to 3-Year Newness Period when Considering Eligibility for New Technology Add-on Payments (Page 623)

CMS sought public comment on its proposal to change the April 1 cutoff to October 1 for determining whether a technology would be within its 2- to 3-year newness period when considering eligibility for new technology add-on payments, beginning in FY 2026, effective for those technologies that are approved for new technology add-on payments starting in FY 2025 or a subsequent year.

CMS is finalizing its proposal beginning with new technology add-on payments for FY 2026.

VI. CHANGES TO THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) Program (Page 1,254)

CMS is adopting seven new quality measures, removing five existing quality measures, and modifying two current quality measures. CMS is also finalizing two changes to current policies related to data validation and increasing the total number of mandatory electronic clinical quality measures (eCQMs) reported by hospitals over three years.

CMS is adopting the following seven new measures:

(1) Adoption of the Patient Safety Structural Measure Beginning with the CY 2025 Reporting Period/FY 2027 Payment Determination for the Hospital Inpatient Quality Reporting (IQR) Program and the CY 2025 Reporting Period/FY 2027 Program Year for the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program (Pages 1,255-1,346)
(2) Age Friendly Hospital measure beginning with the CY 2025 reporting period/FY 2027 payment; (Pages 1,424-1,452)
(3) Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination; (Pages 1,455-1,464)
(4) Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations measure beginning with the CY 2026 reporting period/FY 2028 payment determination; (Pages 1,464-1,480)
(5) Hospital Harm - Falls with Injury eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination; (Page 1,480-1,498)
(6) Hospital Harm - Postoperative Respiratory Failure eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination; and (Page 1,498-1,515)
(7) 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. (Pages 1,515-1,536)

CMS is removing five measures: (Page 1,536)

(1) Removing the Death Among Surgical Inpatients with Serious Treatable Complications (CMS PSI-04) measure beginning with the July 1, 2023 June 30, 2025 reporting period/FY 2027 payment determination.
(2) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Acute Myocardial Infarction (AMI Payment).
(3) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Heart Failure (HF Payment).
(4) Hospital-level, Risk-Standardized Payment Associated with a 30-Day Episode of Care for Pneumonia (PN Payment).
(5) Hospital-level, Risk-Standardized Payment Associated with a 30-day Episode of Care for Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (THA/TKA Payment).

CMS is modifying the following two measures:

(1) Global Malnutrition Composite Score eCQM beginning with the CY 2026 reporting period/FY 2028 payment determination. This modification adds patients ages 18 to 64 to the current cohort of patients 65 years or older. (Pages 1,551-1,561)

(2) Modification of the HCAHPS Survey Measure for the Hospital IQR Program Beginning with the CY 2025 Reporting Period/FY 2027 Payment Determination and the PCHQR Program Beginning with the CY 2025 Reporting Period/FY 2027 Program Year. (Pages 1,346-1,411)

The modifications refines the current HCAHPS Survey measure by adding three new sub-measures, removing one existing sub-measure, and revising one existing sub-measure.

The new survey sub-measures would include: "Care Coordination," "Restfulness of Hospital Environment," and "Information about Symptoms." These three new sub-measures would be publicly reported beginning in October 2026. One current sub-sub-measure, "Care Transition," would be removed from reporting on Hospital Compare in January 2026. Additionally, the current "Responsiveness of Hospital Staff" sub-measure would be altered starting in January 2025, with the "Call Button" questions being removed from the survey and a new "Get Help" question being added.

Summary of Previously Finalized and New Hospital IQR Program Measures (Page 1,562)

CMS provides tables regarding IQR program measures for FYs 2026, 2027, 2028, and 2029.

Progressive Increase of Mandatory eCQM Reporting Beginning with CY 2026 Reporting Period/FY2028 Payment Determination (Page 1,571)

CMS is increasing the total number of eCQMs reported from six to eleven over two years. The following table identifies the eCQMs.

Newly Finalized ECQM Reporting and Submission Requirements (Page 1,581)

Reporting Period/ Payment Determinations	Total Number of eCQMs Reported	eCQMs Required to be Reported
CY 2026/ FY 2028	Eight	• Three self-selected eCQMs; and • Safe Use of Opioids - Concurrent Prescribing eCQM; • Cesarean Birth eCQM; and • Severe Obstetric Complications eCQM; and • Hospital Harm - Severe Hyperglycemia eCQM; • Hospital Harm - Severe Hypoglycemia eCQM
CY 2027/ FY 2029	Nine	• Three self-selected eCQMs; and • Safe Use of Opioids - Concurrent Prescribing eCQM; • Cesarean Birth eCQM; • Severe Obstetric Complications eCQM; and • Hospital Harm - Severe Hyperglycemia eCQM; • Hospital Harm - Severe Hypoglycemia eCQM; and • Hospital Harm - Opioid-Related Adverse Events eCQM
CY 2028/ FY 2030 And for Subsequent years	Eleven	• Three self-selected eCQMs; and • Safe Use of Opioids - Concurrent Prescribing eCQM; • Cesarean Birth eCQM; • Severe Obstetric Complications eCQM; and • Hospital Harm - Severe Hyperglycemia eCQM; • Hospital Harm - Severe Hypoglycemia eCQM; and • Hospital Harm - Opioid-Related Adverse Events eCQM • Hospital Harm – Pressure Injury eCQM • Hospital Harm - Acute Kidney Injury eCQM

VII. CHANGES TO THE PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING (PCHQR) PROGRAM (Page 1,599)

The PCHQR Program is a quality reporting program for the eleven cancer hospitals that are statutorily exempt from the IPPS.

CMS is finalizing the following:

- Adopting the Patient Safety Structural measure beginning with the CY 2025 reporting period/FY 2027 program year.
- Modifying the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure Beginning with the CY 2025 Reporting Period/FY 2027 Program Year
- Moving up the start date for publicly displaying hospital performance on the Hospital Commitment to Health Equity measure to January 2026 or as soon as feasible thereafter.

VIII. LONG-TERM CARE HOSPITAL QUALITY REPORTING PROGRAM (LTCH QRP) (Page 1,600)

The LTCH QRP currently has 18 adopted measures.

Collection of Four New Items as Standardized Patient Assessment Data Elements and Modification of One Item Collected as a Standardized Patient Assessment Data Element Beginning with the FY 2028 LTCH QRP. (Page 1,602)

CMS finalized the addition of four assessment items, the modification of one assessment item, and one administrative change on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS).

First, CMS finalized the adoption of four new assessment items in the SDOH category, to be collected via the LCDS when a patient is admitted to an LTCH beginning October 1, 2026: (1) Living Situation (one item), (2) Food (two items), and (3) Utility (one item).

Second, CMS finalized modifications of the Transportation SDOH assessment item, currently collected via the LCDS, beginning October 1, 2026. The finalized modifications of the Transportation item will improve and align data collection in three ways: (1) specify the look-back period for identifying if and when a patient experienced a lack of reliable transportation, (2) simplify the response options for the patient, and (3) require collection at admission only, which will decrease provider burden since the current assessment item is collected at both admission and discharge.

Third, CMS finalized extending the admission assessment window for the LCDS from three days to four days, beginning with LTCH admissions on October 1, 2026.

Comments

The quality material in Sections VI, VII and VIII are extensive consuming more then 400 pages.

A majority of the information being presented are comments to and responses from CMS involving the proposed rule.

To us, a portions of the material being presented are fragmented. Please note that some of our remarks and page numbers are not in sequence.

Additionally, finding information has been difficult. CMS needs to improve on its paragraph and sub paragraph numbering.

IX. MEDICARE PROMOTING INTEROPERABILITY PROGRAM (Page 1,658)

CMS is finalizing the following measures in the Medicare Promoting Interoperability Program for eligible hospitals and CAHs:

- Separation of the Antimicrobial Use and Resistance (AUR) Surveillance measure into two measures, Antimicrobial Use (AU) Surveillance and Antimicrobial Resistance (AR) Surveillance, beginning with the CY 2025 EHR reporting period; addition of a new exclusion for eligible

hospitals or CAHs that lack discrete electronic access to data elements that are required for AU or AR Surveillance reporting; modification to the applicability of the existing exclusions to either the AU or AR Surveillance measures, respectively; and treatment of the AU and AR Surveillance measures as two new measures with respect to active engagement beginning with the CY 2025 EHR reporting period.

- Adoption of two new eCQMs for eligible hospitals and CAHs to select as one of their three self-selected eCQMs, in alignment with the Hospital IQR Program, beginning with the CY 2026 reporting period:
    - Hospital Harm – Falls with Injury eCQM; and
    - Hospital Harm – Postoperative Respiratory Failure eCQM.

- Modification of the Global Malnutrition Composite Score eCQM, beginning with the CY 2026 reporting period.

- Modification of eCQM data reporting and submission requirements in alignment with the Hospital IQR Program by finalizing a progressive increase in the number of mandatory eCQMs eligible hospitals and CAHs will be required to report on beginning with the CY 2026 reporting period.

CMS is also finalizing an increase to the performance-based scoring threshold for eligible hospitals and CAHs reporting to the Medicare Promoting Interoperability Program, with modification, from 60 points to 70 points for the CY 2025 EHR reporting period and from 70 points to 80 points beginning with the CY 2026 EHR reporting period.

X. CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2025 (Pages 1,144 & 2,764)

Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Classifications and Relative Weights for FY 2025 (Page 1,155)

The MS-LTC-DRGs for FY 2025 are the same as the MS-DRGs for use under the IPPS for FY 2025.

Table 11, which is available on CMS' website lists the MS-LTC-DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used to identify Short Stay Outliers (SSO) cases under § 412.529(a)) for FY 2025.

Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2025 (Page 1,185)

Based on IGI's second quarter 2024 forecast, the FY 2025 market basket percentage increase for the LTCH PPS using the 2022-based LTCH market basket is **3.5 percent**. The current estimate of the productivity adjustment for FY 2025 based on IGI's second quarter 2024 forecast is 0.5 percentage point. Therefore, under the authority of section 123 of the BBRA as amended by section 307(b) of the BIPA, consistent with 42 CFR 412.523(c)(3)(xvii), CMS is establishing an annual market basket update to the LTCH PPS standard Federal payment rate for FY 2025 or **3.0 percent**. (Page 1,200)

For LTCHs that fail to submit quality reporting data CMS will reduce the annual update to the LTCH PPS standard Federal payment rate by 2.0 percentage points for an overall increase of 1.0 percent.

Rebasing of the LTCH Market Basket (Page 1,201)

CMS is rebasing and revising the 2017-based LTCH market basket to reflect a 2022 base year, which would maintain a historical frequency of rebasing the market basket every 4 years.

Comment

CMS spends more then 50 pages explaining the market basket changes from 2017 to 2022.

Development of the FY 2025 LTCH PPS Standard Federal Payment Rate (Page 2,765)

CMS is applying an update factor of 1.030 to the FY 2024 LTCH PPS standard Federal payment rate of $48,116.62 to determine the FY 2025 LTCH PPS standard Federal payment rate. (Page 1,696)

CMS has determined the FY 2025 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 0.9964315

Thus, the LTCH PPS standard payment rate for FY 2025 is **$49,383.26** (calculated as $48,116.62 x 1.03 x 0.9964315). (Page 1,697)

For LTCHs that fail to submit quality . data, the LTCH PPS standard Federal payment rate is **$48,424.36** (calculated as $48,116.62 x 1.01 x 0.9964315).

The FY 2025 wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS web site.

Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Page 2,785)

As required by section 1886(m)(7) of the Act, the fixed-loss amount for HCO payments is set each year so that the estimated aggregate HCO payments for LTCH PPS standard Federal payment rate cases are 99.6875 percent of 8.0 percent (that is, 7.975 percent) of estimated aggregate LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

The fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2025 will be **$77,048.** The current amount is $59,873. (Page 2,801)

CMS says that actual high-cost outlier payments accounted for 8.8 percent of total LTCH PPS standard Federal payment rate payments in FY 2024.

High-Cost Outlier Payments for Site Neutral Payment Rate Cases (Page 2,809)

The applicable HCO threshold for site neutral payment rate cases is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. That is, a fixed-loss amount for site neutral payment rate cases of **$46,152** which is the same as the FY 2025 IPPS fixed-loss amount

XI. OTHER PROVISIONS INCLUDED IN THIS PROPOSED RULE

Transforming Episode Accountability Model (TEAM) (Page 1,716)

CMS says it is "finalizing several of the provisions from the proposed rule but not all of them, and we intend to address and finalize some provisions of the proposed rule in future rulemaking. We also note that some of the public comments were outside of the scope of the proposed rule. These out-of-scope public comments are not addressed in this final rule. We have summarized the public comments that are within the scope of the proposed rule and our responses to those public comments. However, we note

that in this final (IPPS) rule we are not addressing most comments received with respect to the provisions of the proposed rule that we are not finalizing at this time."

This item extends more then 700 pages. The material below is from the rule's regulatory analysis section. (Page 2,831)

CMS will begin testing a new alternative payment model called the **Transforming Episode Accountability Model (TEAM).**

"Section 1115A of the Act authorizes the testing of innovative payment and service delivery models that preserve or enhance the quality of care furnished to Medicare, Medicaid, and CHIP beneficiaries while reducing program expenditures. The underlying issue addressed by the model is that under FFS, Medicare makes separate payments to providers and suppliers for items and services furnished to a beneficiary over the course of an episode. Because providers and suppliers are paid for each individual item or service delivered, this may lead to care that is fragmented, unnecessary or duplicative, while making it challenging to invest in quality improvement or care coordination that would maximize patient benefit. We anticipate the model may reduce costs while maintaining or improving quality of care by bundling payment for items and services for a given episode and holding TEAM participants accountable for spending and quality performance, as well as by providing incentives to promote high quality and efficient care.

"The model builds on and incorporates certain model features from other CMS Innovation Center episode-based payment models such as the Bundled Payments for Care Improvement (BPCI) Advanced Model and the Comprehensive Care for Joint Replacement (CJR) Model. Testing this new model allows us to learn more about the patterns of potentially inefficient utilization of health care services, as well as how to improve the beneficiary care experience during care transitions and incentivize quality improvements for common surgical episodes. This information may inform future Medicare payment policy and potentially establish the framework for managing clinical episodes as a standard practice in Traditional Medicare.

"Under the model, acute care hospitals will be accountable for five-episode categories: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment excluding lower extremity joint replacement, and spinal fusion. We believe the model may benefit Medicare beneficiaries through improving the coordination of items and services paid for through Medicare FFS payments, encouraging provider investment in health care infrastructure and redesigned care processes, and incentivizing higher value care across the inpatient and post-acute care settings for the episode.

"The model will also provide an opportunity to evaluate the nature and extent of reductions in the cost of treatment by providing financial incentives for providers to coordinate their efforts to meet patient needs and prevent future costs. The model may benefit beneficiaries by holding hospitals accountable for the quality and cost of care for 30-day episodes after a beneficiary is discharged from the inpatient stay or hospital outpatient procedure, which could encourage investment in infrastructure and redesigned care processes the promote high quality and efficient service delivery that focuses on patient-centered care."

As noted in the Summary of Costs table, CMS estimates that testing TEAM will result in saving the Medicare program $481 million across the 5 performance years.

Tables Referenced in this Final Rule Generally Available through the Internet on the CMS Website

The following IPPS tables for this final rule are generally available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled "FY 2025 IPPS Final Rule Home Page" or "Acute Inpatient -Files- for Download."

Table 2.—Final Case-Mix Index and Wage Index Table by CCN—FY 2025 Final Rule
Table 3.—Final Wage Index Table by CBSA—FY 2025 Final Rule

Table 4A.—Final List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act—FY 2025 Final Rule
Table 4B.—Final Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR Counties)—FY 2025 Final Rule

Table 5.—Final List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay—FY 2025 Final Rule

Table 6A.—New Diagnosis Codes--FY 2025
Table 6B.—New Procedure Codes--FY 2025
Table 6C.—Invalid Diagnosis Codes--FY 2025
Table 6D. — Invalid Procedure Codes--FY 2025
Table 6E.—Revised Diagnosis Code Titles--FY 2025
Table 6F. —Revised Procedure Code Titles--FY 2025
Table 6G.1.— Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2025
Table 6G.2.— Principal Diagnosis Order Additions to the CC Exclusions List--FY 2025
Table 6H.1.— Secondary Diagnosis Order Deletions to the CC Exclusions List--FY 2025
Table 6H.2.— Principal Diagnosis Order Deletions to the CC Exclusions List--FY 2025
Table 6I. – Complete MCC List – FY 2025
Table 6I.1.— Additions to the MCC List--FY 2025
Table 6J. – Complete CC List –FY 2025
Table 6J.1.— Additions to the CC List--FY 2025
Table 6J.2.— Deletions to the CC List--FY 2025
Table 6K. – Complete CC Exclusions List –FY 2025
Table 6P. — ICD-10-CM and ICD-10-PCS Codes for Final MS-DRG Changes and Analysis with Application of the Non-CC Subgroup Criteria—FY 2025 (Table 6P contains multiple tables, 6P.1a. through 6P.4d that include the ICD-10-CM and ICD-10-PCS code lists relating to specific final MS-DRG changes or other analyses). These tables are referred to throughout section II.C. of the preamble of this final rule.
Table 8A.— Final FY 2025 Statewide Average Operating Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals (Urban and Rural)
Table 8B.— Final FY 2025 Statewide Average Capital Cost-to-Charge Ratios (CCRs) for Acute Care Hospitals
Table 16A.—Updated Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2025
Table 18.— Final FY 2025 Medicare DSH Uncompensated Care Payment Factor 3

The following LTCH PPS tables for this FY 2025 final rule are available through the Internet on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1808-F:

Table 8C.— Final FY 2025 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)

Table 11.— Final MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from October 1, 2024, through September 30, 2025
Table 12A.— Final LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2024, through September 30, 2025
Table 12B.— Final LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2024, through September 30, 2025

FINAL COMMENTS

This is probably the longest final IPPS and LTCH update rule since the IPPS began in FY 1984. Two reasons are apparent for the increase – first CMS has included material on its TEAM project that extends 732 pages, and second the inclusion of commenters and CMS' responses in each section of the rule.

This analysis has not discussed a number of issues including (1) resources for treating patients with inadequate housing, (2) hospital and CAH respiratory infection data, (3) changes to the provider reimbursement board, (4) maternity care, (5) Changes to the Payment Error Rate Measurement (PERM), and (6) CoP Requirements for Hospitals and CAHs to Report Acute Respiratory Illnesses.

We have found several errors, some of which are payment related and others which appear simply as formatting in nature. CMS has "proposed" in many table headings that should read "Final."

It is interesting that CMS talks about the industry fragmentation in the TEAM section. This rule has rearranged many of its subjects to different areas. For example, the issue of outlier payments had been located within the rule's preamble and within the rule's Addendum. They are not duplicated in each section, but one has to search each area to understand the total changes being made. This year, the relevant discussions for setting rates and for the thresholds are located only in the rule's Addendum.

The Addendum is a very helpful tool with much information not found in the preamble.

This rule should be called Medicare 101 with all its history and redundancies. We have argued for many years that these annual updates contain too much old, redundant and unneeded historical material. While some may find such information helpful, we believe most just find it laborious to read through.

While the rule focuses on the hospital market basket rate update and its offsetting productivity, it does not address or clearly state a number of important and significant other payment factors.

The rule addresses that the rate of increase will be 3.0 percent, it does clearly show the $232 million in reduced payments estimated to be made for DSH hospitals. Furthermore, the rule does reflect the extensive increase in the outlier threshold.

The amount of quality provisions continues to grow. CMS says its goal is to produce payments reflecting quality, but again, we must ask is it?

CMS is not at all helpful in providing easier access to pertinent sections, because the rule does not contain a table of contents.

CMS spends consider effort in describing changes of adopting OMB's latest area delineations. It's is apparent CMS does not consider the extent of these changes to be significant in that the 5.0 percent cap in any provider's area wage index will mitigate area revisions and changes.

Here are some stats: CMS says "we appreciate" 300 times, "thanks" 600 times and in this final rule, "proposed" 5,233 times.