American College of Radiology

Fiscal Year 2025 Inpatient Prospective Payment System Final Rule
Detailed Summary

On Thursday, August 1st, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2025 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System Final Rule. The final rule provides updates for Medicare fee-for-service payment rates and policies for inpatient hospitals and long-term care hospitals for FY 2025. CMS pays acute care for inpatient stays under the IPPS. Under this payment system, CMS sets base payment rates for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge through Medicare Severity Diagnosis-Related Groups (MS-DRGs).

Finalized Payment for FY 2025
CMS finalized a base FY 2024 update of +2.9%. This is based on a market basket update of 3.4% and the multifactor productivity (MPF) adjustment, which CMS estimates to be a 0.5 percentage point reduction. CMS finalized an update of 0.35 percent for hospitals that submit quality data and are not considered "meaningful EHR users," finalized update of 2.05 percent for hospitals that fail to submit quality data but are considered "meaningful EHR users". For hospitals that fail to submit quality data and are not considered "meaningful EHR users" have a finalized update of -0.5%. For FY 2025, CMS expects the changes in operating and capital IPPS payment rates will generally increase hospital payments by $3.2 billion.

Data Used in Rate Setting
CMS finalized their proposal to use the FY 2023 Medicare Provider Analysis and Review (MedPAR) claims file as well as the Medicare cost report data files from the March 2024 update of the FY 2022 Healthcare Cost Report Information System (HCRIS) dataset for purposes of FY 2025 ratesetting. This is consistent with CMS's historical practice of using the HCRIS dataset that is 3 years prior to the IPPS fiscal year.

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

FY 2025 Applications for New Technology Add-On Payments
To improve flexibility for applicants for NTAP, CMS finalized their proposal to use the start of the fiscal year, October 1, instead of April 1, to determine whether a technology is within its 2- to 3-

year newness period. This change would be effective starting in FY 2026 for new applicants for NTAP and when extending NTAP for an additional year for technologies initially approved for NTAP in FY 2025 or subsequent years. Beginning with applications for NTAP for FY 2026, CMS is no longer considering an FDA marketing authorization hold status to be an inactive status for the purpose of the NTAP application eligibility. CMS estimates that additional payments for inpatient cases involving new medical technologies will increase by approximately $0.3 billion in FY 2025, primarily driven by the approval of new technology add-on payments for several technologies.

CMS finalized the proposal to approve NTAP add-on payments for the Annalise Enterprise CTB Triage – OH, a software application that uses an AI algorithm to aid in the triage and prioritization of studies with features suggestive of obstructive hydrocephalus (OH) in non-contrast computed tomography (NCCT) brain scans. The maximum NTAP add-on payment for eligible cases is $241.39 for FY2025, which is 65% of the average cost of the technology under § 412.88(a)(2). Table II.E.-01 of the rule shows the technologies CMS finalized to continue NTAP add-on payments for FY2025.

Finalized Changes to the Hospital Wage Index for Acute Care Hospitals
For FY 2025, CMS will revise the labor market areas used for the wage index based on the most recent core-based statistical area delineations issued by the Office of Management and Budget (OMB) based on 2020 Census data.

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

CMS also finalized the proposal with modification for FY 2025 (and subsequent fiscal years) for calculating the per-discharge amount for interim uncompensated care payments. CMS will use the average of the most recent 2 years of discharge data. Accordingly, for FY 2025, CMS will use an average of discharge data from FY 2022 and FY 2023.

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

CMS finalized their proposal to separate one existing measure into two distinct measures, to adopt two new eCQMs, to modify one current eCQM, and to increase the performance-based scoring threshold, notifying eligible hospitals and CAHs of one Request for Information. CMS is also increasing the total number of mandatory eCQMs reported by hospitals over three years.

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

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

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

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

Hospital Readmissions Reduction Program

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

Hospital Inpatient Quality Reporting (IQR) Program

New Measures

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

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

Reporting and Submission Requirements for eCQMs
CMS modified its proposal to progressively increase the mandatorily reported electronic clinical quality measures (eCQMs) over two years. As proposed, the increase would have begun in CY 2026 and continued in CY 2027. Instead, CMS finalized that in CY2026, hospitals will be required to report on eight total eQCMs, comprised of the following:

- Three self-selected eCQMs
- Safe Use of Opioids
- Safe Obstetric Complications
- Cesarean Birth
- Hospital Harm - Severe Hypoglycemia
- Hospital Harm – Severe Hyperglycemia

For the CY 2027 reporting period, hospitals must submit data for the eight eCQMs and the Hospital Harm - Opioid-Related Adverse Events eCQM. Further, beginning with the CY 2028 reporting period, CMS will require hospitals to submit data for these nine eCQMs in addition to the Hospital Harm – Pressure Injury and Hospital Harm - Acute Kidney Injury eCQMs, for a total of eleven eCQMs.

If a hospital or facility does not have patients meeting the measure denominator criteria for any of the proposed eCQMs, it will submit a zero-denominator declaration for the measure, allowing it to meet the reporting requirements for a particular eCQM.

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

Request for Information to Advance Patient Safety and Outcomes Across the Hospital Quality Programs
CMS requested comments in the proposed rule on ways to build on current measures in several quality reporting programs that account for unplanned patient hospital visits to encourage

hospitals to improve discharge processes. While CMS's hospital quality reporting and value-based purchasing programs currently encourage hospitals to address concerns about unexpected returns through several existing measures, CMS recognizes that these measures do not comprehensively capture unplanned patient returns to inpatient or outpatient care after discharge. CMS is interested in input on adopting measures that better represent the range of outcomes of interest to patients, including unplanned returns to the emergency departments and receipt of observation services within 30 days of a patient's discharge from an inpatient stay. The final rule outlines the comments received from stakeholders.