ASTRO
TARGETING CANCER CARE

251 18th St. South, 8th Floor
Arlington, VA 22202

Main: 703.502.1550 · Fax: 703.502.7852
www.astro.org · www.rtanswers.org

Inpatient Prospective Payment System (IPPS) 2025 Proposed Rule
Summary of Issues Impacting Radiation Oncology

On April 10, 2024, the Centers for Medicare and Medicaid Services (CMS) issued the Inpatient Prospective Payment System (IPPS) proposed rule. The proposed rule updates the Medicare reimbursements under IPPS by 2.6% (a 3.0% market basket update with a -0.4% productivity adjustment).

Why it matters: While radiation therapy reimbursement is typically tied to the Medicare Physician Fee Schedule (MPFS) or the Hospital Outpatient Prospective Payment System (HOPPS), the IPPS proposed rule often includes items of interest to radiation oncology related to new technologies and quality reporting. It also provides a preview of policy proposals, which may appear in the MPFS and HOPPS proposed rules this summer.

Items of interest in the 2025 IPPS proposed rule include:

- Intraoperative Radiation Therapy (IORT)
- Proposed Changes to the Hospital Wage Index for Acute Care Hospitals
- Proposed Continuation of the Low-Wage Hospital Policy
- Proposed Changes to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
- Hospital Inpatient Quality Reporting (IQR) Program
- New Technology Add-On Payments (NTAP) for New Services and Technologies
- CMS Specialty Care Strategy: TEAM Model
- Social Determinants of Health Diagnosis (SDOH) Codes

Go deeper on the proposed rule below.

Intraoperative Radiation Therapy (IORT)
CMS received a request to add procedure codes for IORT of the brain and IORT of the brain stem to the Chemotherapy Implant logic list in MS-DRG 023 (Craniotomy with Major Device Implant of Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator). The requestor stated that IORT is always performed as part of the surgery to remove a brain tumor during the same operation and described the procedure.

Currently, cases reporting excision of a brain tumor with IORT are mapped to different MS-DRGs (025, 026, and 027). The requestor asked that IORT be included in MS-DRG 023 since it adds complexity and cost to the surgery, similar to other procedures already in that category. However, there were no cases found where the use of IORT in the performance of a brain tumor excision were reported. Therefore, the Agency will maintain the current structure and monitor the claims data in consideration of any future changes to the MS-DRGs for which IORT may be reported.

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals
CMS is required to adjust the standardized amounts for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level—the "wage index." In the FY 2025 proposed rule, the Agency is proposing to revise the labor market areas used for the wage index based on updated core-based statistical areas (CBSA) from the Office of Management and Budget. These updated CBSAs incorporate data from the 2020 Census.

Under the IPPS, CBSAs define hospital labor market areas. A CBSA considers population, economic ties, and commuting patterns to define an area where workers can readily find jobs. Each CBSA has a wage index value assigned by CMS, reflecting the average hospital wage level in that area compared to the national average. A value of 1.0 represents the national average wage (locations with higher than average wages will have a value above 1.0, and vice versa). Hospitals located in CBSAs with a higher wage index receive a higher base payment under IPPS, and those in areas with a lower wage index receive a lower base payment.

Proposed Continuation of the Low-Wage Hospital Policy
In the 2020 IPPS Final Rule, CMS adopted a policy to increase the wage index values for certain hospitals with low wage index values (below the 25th percentile) and decrease the wage index values for hospitals above the 75th percentile (to maintain budget neutrality). At the time, CMS indicated the policy would be effective for at least four years, beginning in FY 2020, so that employee compensation increases implemented by these hospitals would have time to be reflected in the wage index calculation.

The Agency is proposing to extend this policy for at least three more years, beginning in FY 2025. It believes the policy needs to be in place for a longer time period after the end of the COVID-19 public health emergency to properly evaluate it.

Proposed Changes to the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program
The PCHQR Program is a quality reporting program for the eleven cancer hospitals that are statutorily exempt from the IPPS. For 2025, CMS is proposing the following for PCHQRs:

- Adopt the Patient Safety Structural Measure Beginning with the CY 2025 Reporting Period/FY 2027 Program Year;
- Modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Measure Beginning with the CY 2025 Reporting Period/FY 2027 Program Year;
- Move Up the Start Date for Public Display of the Hospital Commitment to Health Equity Measure.

Hospital Inpatient Quality Reporting (IQR) Program
CMS is proposing to adopt seven new quality measures, remove five existing quality measures, and modify one current electronic clinical quality measures (eCQMs). CMS is also proposing two changes to current policies related to data validation: an increase over two years in the total

number of mandatory eCQMs reported by hospitals and cross-program modifications to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure.

New Technology Add-On Payments (NTAP) for New Services and Technologies
Each year in the IPPS proposed rule, CMS presents its evaluation and analysis of New Technology Add-on Payment (NTAP) applications. The Agency does not issue application decisions in the rule, but rather describes any concerns it may have regarding whether a technology meets the criteria for payment as a new technology, and it seeks additional information as needed for use in decision making that will appear in the IPPS final rule.

A new medical service or technology may be considered for NTAP if the diagnosis related group (DRG) prospective payment rate is inadequate based on the estimated costs incurred with respect to services delivered involving a new medical service or technology. To secure a new technology add-on payment, the new medical service or technology must demonstrate that it is 1) new; 2) costly such that the applicable DRG rate is inadequate; and 3) represents a substantial clinical improvement over existing services or technologies.

To improve flexibility for applicants for NTAP, CMS is proposing 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 NTAPs and when extending NTAP for an additional year for technologies initially approved for NTAP in FY 2025 or subsequent years.

For FY 2025, 16 NTAP applications were received. There are no NTAPS directly related to radiation oncology, but the following are of interest to cancer care, generally:

- *ELREXFIO™ (elranatamab-bcmm)*
- *HEPZATO™ KIT (melphalan for injection/hepatic delivery system)*
- *AMTAGVI™ (lifileucel)*
- *Quicktome Software Suite (Quicktome Neurological Visualization and Planning Tool)*
- *TALVEY™ (talquetamab-tgvs)*
- *Odronextamab, First Indication: Relapsed or Refractory Diffuse Large B-Cell Lymphoma(R/R DLBCL)*
- *Odronextamab, Second Indication: Relapsed or Refractory Follicular Lymphoma (R/R FL)*

Proposed discontinuation of technologies approved for FY 2024 NTAPs no longer considered new for FY 2025 because 3-year anniversary date will occur prior to April 1, 2025

Technology	Newness Start Date	NTAP Start Date	3-Year Anniversary Date of Entry into U.S. Market	Previous Final Rule Citations

Rybrevant™ (drug used to treat adults with non-small cell lung cancer	5/21/21	10/1/21	5/21/24	86 FR 44988 - 44996 87 FR 48913 88 FR 58800

CMS Specialty Care Strategy: TEAM Model

In the 2025 IPPS proposed rule, CMS revisits the four elements of its specialty care strategy: enhance specialty care performance data transparency; maintain momentum on acute episode payment models and condition-based models; create financial incentives within primary care for specialist engagement; and create financial incentives for specialists to affiliate with population-based models and move to value based care.

As part of the overall strategy, the Transforming Episode Accountability Model (TEAM) seeks to build upon the existing Better Patient Care Incentive (BPCI) Advanced model and Comprehensive Joint Replacement (CJR) model. Proposed as a five-year program, beginning January 1, 2026, TEAM encompasses the following procedures: coronary artery bypass (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion. TEAM would test whether financial accountability for these episode categories reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

While the TEAM Model does not involve radiation oncology services, there are aspects of the model that are similar to requirements that were set forth in the RO Model, including mandatory participation for selected facilities and a payment methodology that includes discounts and quality performance adjustments. Key differences include a one-year glide path allowing TEAM participants to ease into full financial risk, as well as two different participation tracks that accommodate different levels of risk tolerance. Additionally, the TEAM model includes a voluntary Decarbonization and Resilience Initiative which is comprised of emissions reporting and technical assistance for participants seeking to improve their climate impact.

Social Determinants of Health Diagnosis (SDOH) Codes

ICD-10-CM contains Z-codes that describe a range of issues related to social determinants of health, including education and literacy, employment, housing, ability to obtain adequate amounts of food or safe drinking water, and occupational exposure to toxic agents, dust, or radiation. CMS is proposing to change the severity designation of SDOH codes that describe inadequate housing and housing instability from “non-complication or comorbidity” to “complication or comorbidity.” The Agency states that this is consistent with its annual updates to account for changes in resource consumption, treatment patterns, and the clinical characteristics of patients. This proposal recognizes inadequate housing and housing instability as indicators of resource utilization in the inpatient setting.

The proposed rule can be downloaded from the Federal Register at:

https://www.federalregister.gov/public-inspection/2024-07567/medicare-and-medicaid-programs-and-the-childrens-health-insurance-program-hospital-inpatient

For a fact sheet on the proposed rule, please visit:
https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective

The press release for the 2025 IPPS Proposed Rule can be found at the following link:
https://www.cms.gov/newsroom/press-releases/cms-proposes-new-policies-support-underserved-communities-ease-drug-shortages-and-promote-patient