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Hot Topics in Reimbursement and Highlights from Medicare's Inpatient Final Federal Fiscal Year (FFY) 2025 Rulings

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Agenda

- **Thank You**

- **A Major Difference in Our Presidential Candidates' Health Care Policy Views…**
  - ✓ **The Affordable Care Act or "ACA"**
    - The Goal, What it achieved and Why it is not liked by some…
    - Issues: Examples of Current Reimbursement Implications to Hospitals
      - Medicare Disproportionate Share / Uncompensated Care Payments (DSH/UCP)
      - Wage Index

- **Highlights from the Federal Fiscal Year (FFY) 2025 Inpatient Prospective Payment System (IPPS) Final Rulings**

- **The Rural Strategy**

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Our Candidates:
A Major Difference in their Health Care Policy Views

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A Major Difference relates to the Affordable Care Act (ACA)

Former President Trump **Opposes** the ACA

While Vice President Harris **Supports** the ACA

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ACA

What was a primary goal of the ACA?

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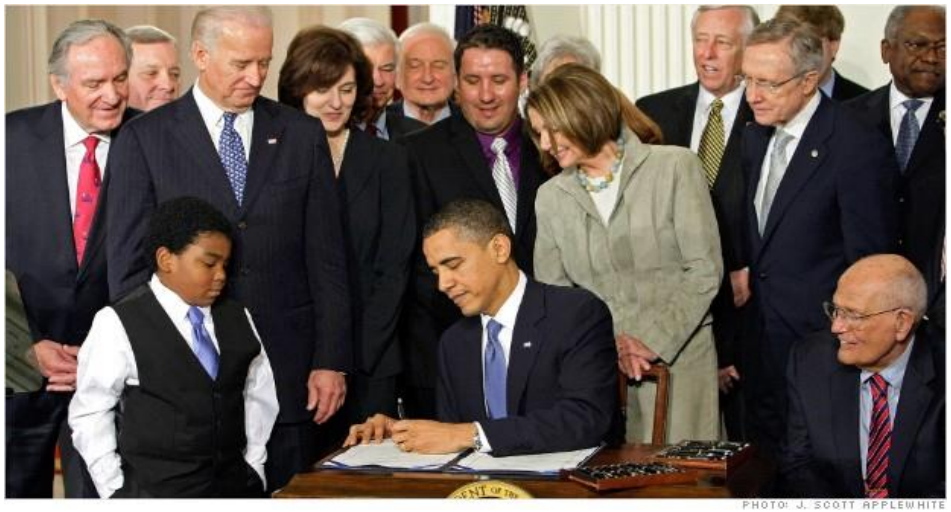
ACA
(aka Obamacare)

A primary goal of the ACA was to reduce the uninsured population in our country through Medicaid expansion programs. It was signed into law by President Barack Obama on March 23, 2010.



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ACA

Was the original GOAL of the ACA achieved?

Yes. The ACA resulted in a significant reduction in the number of people without health insurance, with estimates ranging from 20-24 million in a relatively short period of time.

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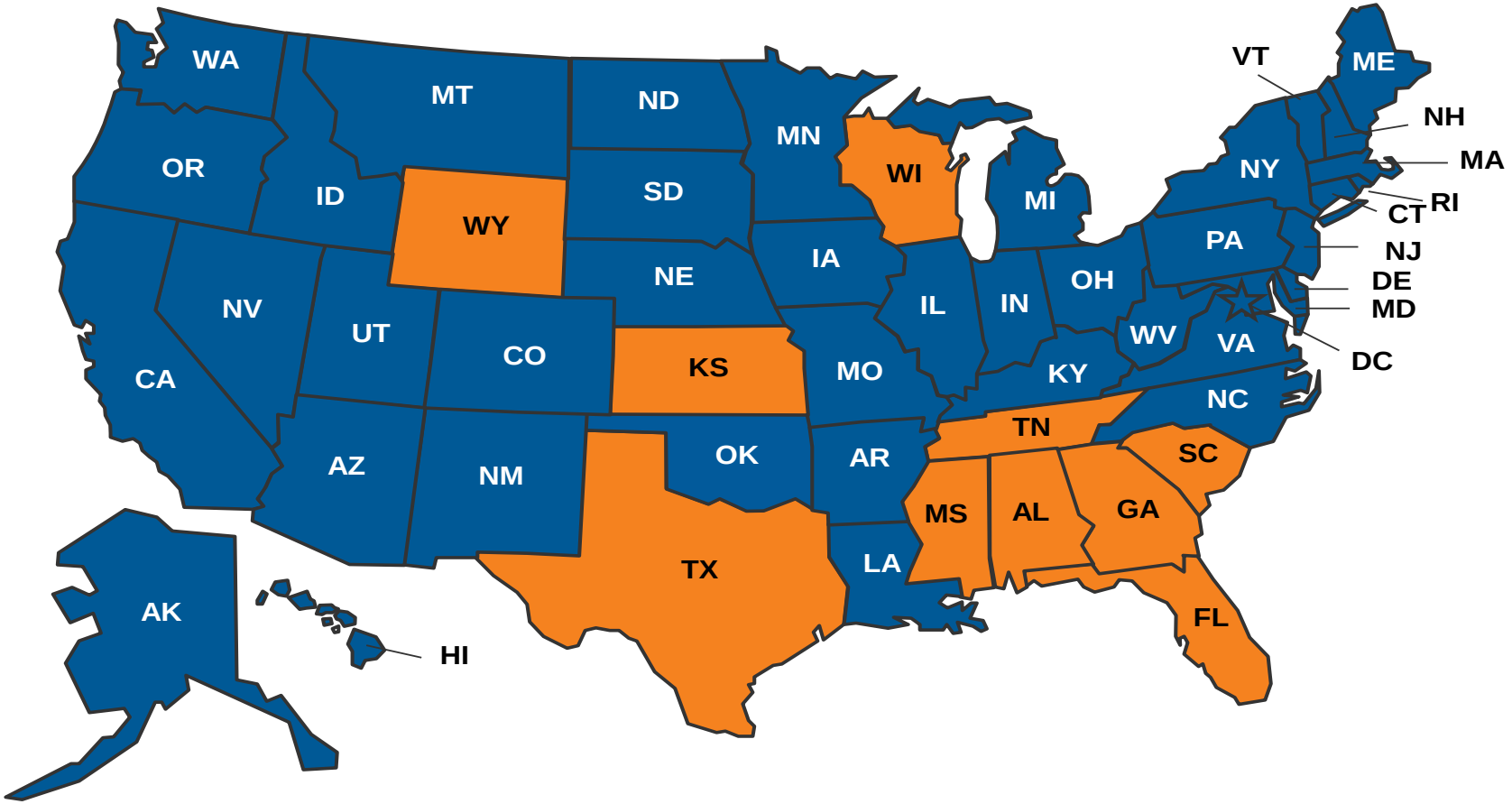
Status of State Medicaid Expansion

Adopted by 41 States including DC

(shown in blue below)



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ACA

Is the ACA perfect?

No. The ACA is not perfect. Nothing is perfect.

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Why is the ACA not liked by some?

Some Theories…

- ✓ Our government should not force people to buy health insurance.
- ✓ The ACA is perceived by some as a welfare program that is disguised as a healthcare program.
- ✓ Let's face it, Democrats and Republicans rarely see eye-to-eye on matters, and they appear to be always on the attack...

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ACA Issues

From our perspective, as healthcare finance/reimbursement professionals…

ACA Issues (examples)…

- Disproportionate Share (DSH)/Uncompensated Care Payments (UCP)
- Wage Index

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ACA Issues: DSH/UCP

So what's the issue?

WORKSHEET S-10

CMS is using Worksheet S-10 from the Medicare cost report to reimburse hospitals for DSH/UCP. When the S-10 is used, the Hospitals who are located in the States who have gone through Medicaid expansion are experiencing reductions in their Medicare DSH/UCP reimbursement.

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ACA Issues: DSH/UCP

DSH Background

Section 9105 of the Consolidated Omnibus Budget Reconciliation of 1985 (Public Law 99-272) amended the Social Security Act, known as the Medicare Disproportionate Share Hospital (DSH) adjustment provision, which became effective for discharges occurring on or after May 1, 1986.

Specifically, this provision allowed acute care hospitals that served a large number of low-income patients to receive additional reimbursement. If a hospital's Medicaid and Supplemental Security Income (SSI) inpatient utilization met or exceeded 15% of their total inpatient utilization, then they (the Hospital) would qualify for DSH. Once a hospital qualified for DSH, they would receive a 2.5% add-on to their IPPS reimbursement. As the hospital's Medicaid and SSI utilization increased, their DSH reimbursement would, also.

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ACA Issues: DSH/UCP

Why DSH changes were needed (from our government's perspective)…

Our government realized that over a few years, significantly more people would be on/eligible for Medicaid and SSI as part of the ACA. This was going to result in DSH payments (nationally) **increasing by 50%+.** As a result, they (our government) needed to come up with a plan to curb DSH spending. Our legislators called this new methodology, "Improvements for DSH Payments," which was enacted as part of the ACA.

ACA Issues: DSH/UCP

ACA Section 3133, Improvement to DSH payments closes with…

<u>LIMITATIONS ON REVIEW</u> –
There shall be no administrative, judicial or any other review of the following:

- Any estimate of the Secretary for purposes of determining the factors.
- Any period selected by the Secretary for such purposes.

ACA Issues: DSH/UCPs

How it works today…

- Reduced “Old School” (hospital-specific) methodology to 25% beginning in FFY 2014

- ACA DSH impact criteria (other 75%)
  - Other 75% is from an uncompensated care pool, which is based on 3 Factors:
    - ✓ Funds available
    - ✓ Percentage change in the uninsured population
    - ✓ Hospital’s % of uncompensated care costs or “UCC” (Worksheet S-10) vs. all other Hospitals’ UCC

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The Pool…

- 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” was $5.938 billion
- The FY 2025 “pool” is $5.706 billion

➢ **$232 million less than FY 2024**

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ACA Issues: DSH/UCP

Purpose of Worksheet S-10:

To calculate a Hospital's total unreimbursed and uncompensated care costs, which include:

1. Total unreimbursed cost for Medicaid, State Children's Health Insurance Program (SCHIP) and state/local indigent care programs.
2. Cost of charity care.
3. Cost of non-Medicare bad debt expense.

What Is the Issue Here?

#1 Above (Medicaid) is not being used for the Medicare DSH/UCP distribution. Many Hospitals in Medicaid expansion states are being adversely impacted.

Also, there was a transition from a hospital-specific payment methodology to a methodology where everyone is competing for their share of a pool of funds.

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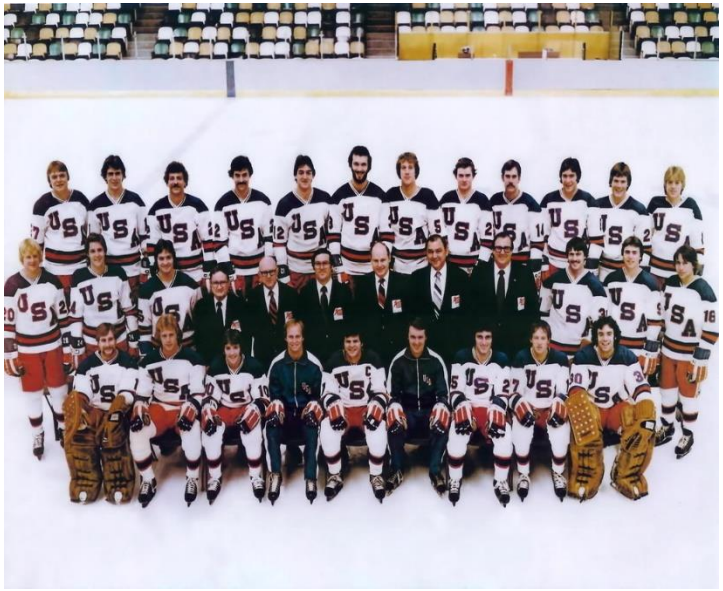
ACA ISSUES: The Wage Index



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ACA Issues: The Wage Index

Over the last 15 years+, CMS and our legislators acknowledged that the current “wage index” system is vulnerable to many inaccuracies and that reform was needed. It appears as if CMS has not made any final decisions on an “alternative” way yet. In any event, such proposals would need Congressional approval.

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The Wage Index…

EVERY PENNY COUNTS…

The Wage Index Factor (WIF) has a significant impact to Hospitals' Medicare reimbursement. There are markets where a one penny movement to the collective average hourly rate means over **$1 million** in reimbursement.

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ACA Issues: The Wage Index

- The purpose of the WIF is to adjust a provider's Medicare reimbursement to account for labor cost differences across the country. The WIF may also impact Hospitals' Medicaid and HMO reimbursement.

- Every acute care hospital's compensation and paid hours are included to develop their labor market's average hourly wage (AHW) for Medicare.

- To arrive at a labor market's WIF:
  - ABC labor market's average hourly rate ***divided by*** the national average hourly rate.

- The Wage Index values are **updated annually** based on data from the audited Worksheets S-3 part II through V of the Medicare cost reports. There is typically a four year lag. For example, today's data (2024) will impact FFY 2028 reimbursement.

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ACA Issues: The Wage Index

ILLUSTRATION: WAGE INDEX FACTOR IMPACT

HOSPITAL ABC
MEDICARE DISCHARGES = 10,000

SOURCE: Final FFY 2025 Rulings for Medicare Inpatient Prospective Payment System.

	Philadelphia	Atlantic City	New York City
LABOR RATE	$4,478.09	$4,478.09	$4,478.09
x MEDICARE WAGE INDEX FACTOR	1.0814	1.1548	1.3056
ADJUSTED LABOR	$ 4,842.61	$ 5,171.30	$ 5,846.59
ADD: NON-LABOR	$2,146.30	$2,146.30	$2,146.30
TOTAL ADJUSTED LABOR AND NON-LABOR	$ 6,988.91	$ 7,317.60	$ 7,992.89
x MEDICARE DISCHARGES	10,000	10,000	10,000
MEDICARE PAYMENT RATE FOR INPATIENT STAYS	$ 69,889,065	$ 73,175,983	$ 79,928,943
DIFFERENCE		$ (3,286,918)	$ (10,039,878)

***The reimbursement estimates above do not include the impact to "outpatient" & HMO volume and are pre-CMI and add-ons (e.g., IME and DSH).**

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ACA Issues: The Wage Index

Section 3137(b) of the ACA required CMS to submit to Congress, by December 31, 2011, a report that includes a plan to reform the wage index.

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ACA Issues: The Wage Index

So What's the Issue?

The issue is that almost 13 years have passed since the deadline of December 31, 2011 and there is still no "game plan" for wage index reform.

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ACA Issues: The Wage Index

From our perspective…
Why some type of wage index reform is needed:

✓ Things are not simplified and standardized for healthcare organizations.

- The rules are vague.
- Inconsistent treatments by Medicare Administrative Contractors (MACs) continue across the U.S.

✓ Isn't a primary purpose of the wage index factor to adjust for labor differences across the country?

- Example: There are Hospitals that have labor rates **40% below** their assigned market.

✓ There's no urgency to "GET IT RIGHT, the first time around…"

- The wage index information has no impact on my current year cost report settlement and besides, CMS gives us approximately 1 ½ years to go back and make revisions.

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Beginning with the FFY 2024 Final Rulings and Continuing in FFY 2025 State Rural Wage Index Factors…

Per the Final FFY 2024 Rulings, CMS acquiesced to several court decisions and is including the data of CFR 412.103 urban to rural reclassified (rural) providers in their State's rural WIF.

In any given state, an urban market's WIF cannot be below their state's rural WIF. In FFY 2025 Final Rulings, CMS indicates that 771 Hospitals may be impacted.

For the first time ever, there are 11 States where every Hospital in their state will be receiving the same wage index factor during FFY 2025: Arizona, Connecticut, Florida, Hawaii, Illinois, Indiana, Massachusetts, Nevada, New Hampshire, New York and Oklahoma.

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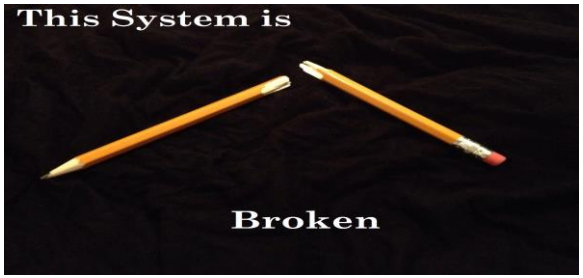
Office of the Inspector General ("OIG") Activity Related to the Wage Index

OIG Report Issued called:

"Significant Vulnerabilities Exist in the Hospital Wage Index System…"

The OIG Recommendations are:

- ✓ Comprehensive Reform
- ✓ Penalize Hospitals when Inaccurate Information is Filed
- ✓ Perform More In-Depth Audits
- ✓ Repeal the Rural Floor
- ✓ A Reclassified Hospital's Data should be Transferred Out of their Natural Market and it should be included in developing the Wage Index for the Market they are Reclassified to.



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MEDPAC

MedPAC's Plan for Wage Index Reform

- ✓ March 2023 Meeting – Theme: The Current Medicare Wage Index System is Broken.

- ✓ **Our Message:** This is nothing new…
  Per the ACA, the deadline was December 31, 2011 for CMS to submit the plan for Wage Index Reform to Congress. The deadline was almost 13 years ago….
- ✓ April 2023 Meeting – Unanimous vote. MedPAC will be submitting a report to Congress for Wage Index Reform, which will be a complete overhaul of the current System.

- ✓ **The MedPAC plan…**
  - ➢ Use of data from BLS and US Census Bureau (***vs***. the Cost Report)
  - ➢ Goal is to shift more reimbursement dollars from the higher wage areas to the lower wage areas in the U.S.
  - ➢ Estimated Impacts are not available. However, MedPAC believes the impact will range from **2% to 10%.**

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Final FFY 2025 IPPS Rulings

- **Display Copy Posted August 1, 2024**
- **Published August 28, 2024**
- ***There are Recent Correction Notices***
- ***Website: CMS.gov***

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FFY 2025 Rate Updates

- **The FFY 2025 Market-basket update equals 3.4 percent**
- **Reduced by the ACA's productivity factor of 0.5 percent**
- **Net update is 2.9 percent for those submitting quality requirements and are meaningful EHR users**

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How CMS Arrives at IPPS Rates

- The following table shows how CMS arrives at final payment rates
- Tables are in the Addendum of the Final Rulings

- Comment
  - The Addendum is a good place to start when digesting the final rulings.

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FFY 2025 Inpatient Rates

FY 2025 INTERIM FINAL ACTION Tables 1A-1E

TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.9 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.35 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.05 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.5 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,478.09	$2,146.30	$4,367.12	$2,093.11	$4,441.10	$2,128.57	$4,330.13	$2,075.38

TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.9 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.35 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 2.05 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.5 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,107.12	$2,517.27	$4,005.34	$2,454.89	$4,073.20	$2,496.47	$3,971.42	$2,434.09

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FFY 2025 IPPS Market Basket Increases

	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 (1/4 of MB)	**0.0**	**0.00**	**-0.85**	**-0.85**
Adjustment for Failure to be a Meaningful EHR User (3/4 of MB)	**0.0**	**-2.55**	**0.0**	**-2.55**

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FY 2025 IPPS Market Basket Increases

	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
Multi Factor Productivity (MFP) Adj	**-0.5**	**-0.5**	**-0.5**	**-0.5**
Applicable Percentage Increase Applied to Standardized Amount	**2.9**	**0.35**	**2.05**	**-0.5**

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FFY 2025 IPPS Rulings

- **Multiply the FY 2024 standardized base rate (combined labor & non-labor) of $7,073.98 to arrive at FY 2025 rates.**
- **Factors are identified in the following table:**

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Revised
FFY 2025 IPPS Rates

	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
FY 2025 Update Factor	**1.029**	**1.0035**	**1.0205**	**0.995**
FY 2025 MS-DRG Reclassification and Recalibration Budget Neutrality Factor	0.997190	0.997190	0.997190	0.997190
FY 2025 Cap Policy MS-DRG Weight Budget Neutrality Factor	0.999874	0.999874	0.999874	0.999874
FY 2025 Wage Index Budget Neutrality Factor	~~1.000114~~ 0.999981	~~1.000114~~ 0.999981	~~1.000114~~ 0.999981	~~1.000114~~ 0.999981
FY 2025 Reclassification Budget Neutrality Factor	~~0.962791~~ 0.962786	~~0.962791~~ 0.962786	~~0.962791~~ 0.962786	~~0.962791~~ 0.962786

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Revised
FFY 2025 IPPS Rates

	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
FY 2025 Cap Policy Wage Index Budget NA	~~0.999173~~ 0.999166	~~0.999173~~ 0.999166	~~0.999173~~ 0.999166	~~0.999173~~ 0.999166
FY 2025 Rural Demonstration Budget Neutrality Factor	~~0.999810~~ 0.999811	~~0.999810~~ 0.999811	~~0.999810~~ 0.999811	~~0.999810~~ 0.999811
FY 2025 Operating Outlier Factor	0.949000	0.949000	0.949000	0.949000
Totals	~~$6,606.51~~ **$6,624.39**	~~$6,442.80~~ $6,460.23	~~$6,551.94~~ $6,569.67	~~$6,388.22~~ $6,405.51

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FFY 2025 IPPS
Revised

	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
National Standardized Amount for FY 2025 **if Wage Index is Greater Than 1.0000;** Labor/Non-Labor Share Percentage (67.6/32.4)	**Labor: $4,478.09** **Nonlabor: $2,146.30**	**Labor: $4,367.12** **Nonlabor: $2,093.11**	**Labor: $4,441.10** **Nonlabor: $2,128.57**	**Labor: $4,330.13** **Nonlabor: $2,075.38**

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FY 2025 IPPS
Revised

	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
National Standardized Amount for FY 2025 **if Wage Index is less than or Equal to 1.0000;** Labor/Non-Labor Share Percentage (62.0/38.0)	**Labor: $4,107.12** **Non-labor: $2,517.27**	**Labor: $4.005.34** **Non-labor: $2,454.89**	**Labor: $4,073.20** **Non-labor: $2,496.47**	**Labor: $3,971.42** **Non-labor: $2,434.09**

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FY 2025 IPPS (Revised)

➢ FFY 2025	FFY 2024	Difference
▪ Large Urban		
$4,478.09	$4,392.49	
2,146.30	2,105.28	
$ 6,624.39	**$6,497.77**	**$126.62/ 1.95%**
▪ Other		
$4,107.12	$4,028.62	**$126.62/ 1.95%**
2,517.27	2,469.15	
$6,624.39	**$6,497.77**	

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FY 2025 IPPS—Outlier Payments

- CMS says FY 2023 actual **was 5.27 percent**.

- 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 **$46,217.**

The FFY 2024 threshold was $42,750.

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Labor Share of the Standardized Amount

- **Unchanged**
  - **Large urban labor at 67.6%**
  - **All others at 62%**

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Capital & Excluded Hospitals

- **Capital increased from $503.83 to $512.14**

- **Excluded hospitals increases by 3.4 percent**
  - **Children's hospitals**
  - **11 Cancer hospitals**
  - **Hospitals located outside 50 states & DC**

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Wage Index Low Wage Index Policy Changes

- **Initial Version of Final FFY 2025 Ruling (8/1/2024): Continuation of Low Wage Index Policy–**
  - 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.
  - Hospitals located in the top three quartiles were adversely impacted from this, from a budget neutrality perspective.

  - **HOWEVER, Based on a recent appellate court decision (Bridgeport Hospital vs. Becerra), CMS just issued a correction notice. They (CMS) plan to eliminate the Low Wage Index Policy effective October 1, 2025. There is a 60-day comment period.**

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Wage Index

Permanent Cap on Wage Index Decreases and Budget Neutrality Adjustment

A hospital's wage index **will not be less than 95%** of its final wage index from the prior year.

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Revisions Based on Reclassification

- MGCRB reclassified **470** hospitals starting in FY 2025.
- MGCRB wage index reclassifications are effective for 3 years, 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 2023, and **352** hospitals approved in FY 2024.
- Of all the hospitals approved for reclassification for FY 2025, FY 2024 and FY 2023, **1,078** hospitals are in a MGCRB reclassification status for FY 2025 (approximately 32.5 percent of all IPPS hospitals)

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Rural Referral Centers

- For rural hospitals with less than 275 beds
- CMI value of 1.7789 or regional, if lower
- CMIs for regions…

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

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Rural Referral Centers

- **Discharges:**
  - **5,000**
  - **National or regional, if lower**
  - **None Lower**

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Indirect Medical Education (IME)

- **IME Multiplier Unchanged at 1.35 – by law**

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MS-DRGs

- **Comments:**

- **This is another extensive and detailed section. This section is nearly 300 pages in the display version of the rule.**
- **You cannot overlook changes to the DRGs. They play a pivotal role in determining overall payments.**

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MS-DRGs

- 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;

MS-DRGs

- **Additions and Deletions to the Diagnosis Code Severity Levels on CMS web site**

  - 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

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The Rural Strategy…

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Is This Rural?

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Are These Rural?

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A Famous Phrase From A Late 1970s / Early1980s Sitcom…

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Why New Jersey Hospitals may be at an Unfair Disadvantage Here?

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Main Goals of the Rural Strategy…

TWO MAIN GOALS:

1. To provide financial relief for providers.

2. To provide for “relaxed” criteria in order to qualify for financial relief.

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Why has this become a HOT TOPIC in the U.S. over the last few years?

As a result of two court cases: Geisinger & Lawrence, CMS issued an interim and final rule (FFY 2017) that repealed the anti-stacking regulation. Currently, an urban Hospital may apply for geographic wage index reclassification with the Medicare Geographic Classification Review Board (MGCRB) while they are reclassified as rural. In addition, an urban Hospital with an existing wage index reclassification may obtain a rural reclassification and **will not lose** its wage index reclassification by doing so.

In simple terms…

2016 and prior years…
If an urban Hospital wanted to pursue the "Rural Strategy," they would be subject to their State's rural wage index factor.

Now (2017 and on-going)…
If an urban Hospital wants to pursue the "Rural Strategy" and they have a wage index geographic reclassification in place, they will not be subject to their State's rural wage index factor during the duration of their reclassification.

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Criteria to Qualify…

A Medicare participating acute care hospital may pursue the Rural Strategy if it meets one of the following criteria:

1. It has 275 or more beds during its most recently completed cost reporting year or;

2. Alternative Criteria

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Important Things to Think About…

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A Few Examples of the Pros & Cons with the Rural Strategy

Pros

- Relaxed rural Medicare Geographic Reclassification regulations
- Increased Medical Education payments due to 30% cap increase
- Ability to use rural status to add **new** Medical Education programs and adjust the FTE cap
- Reduced 340B DSH qualification threshold, if needed

Cons

- Loss of Capital DSH payments. However, Capital DSH reimbursement was reinstated on October 1, 2023.
- If qualification for 340B is needed at the reduced Rural/RRC threshold, then the ability to purchase orphan drugs through the 340B program is eliminated.
- Will be subject to their State Rural Wage Index Factor if an existing reclassification is not in place.

Thank You!

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