MOSSADAMS

Medicare Regulatory Update: 2025 IPPS Final Rule

Presenter: Eric Lucas

Agenda

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04 WAGE INDEX

05 MEDICARE DSH/UNCOMPENSATED CARE/BAD DEBT

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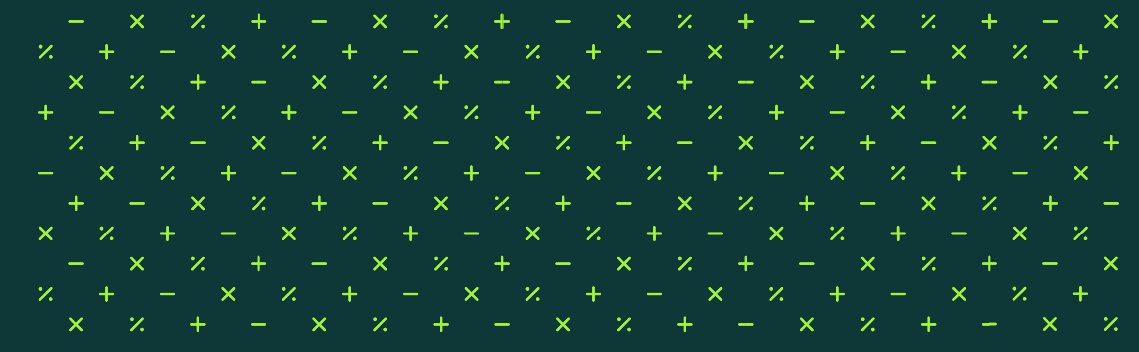
Payment Rates



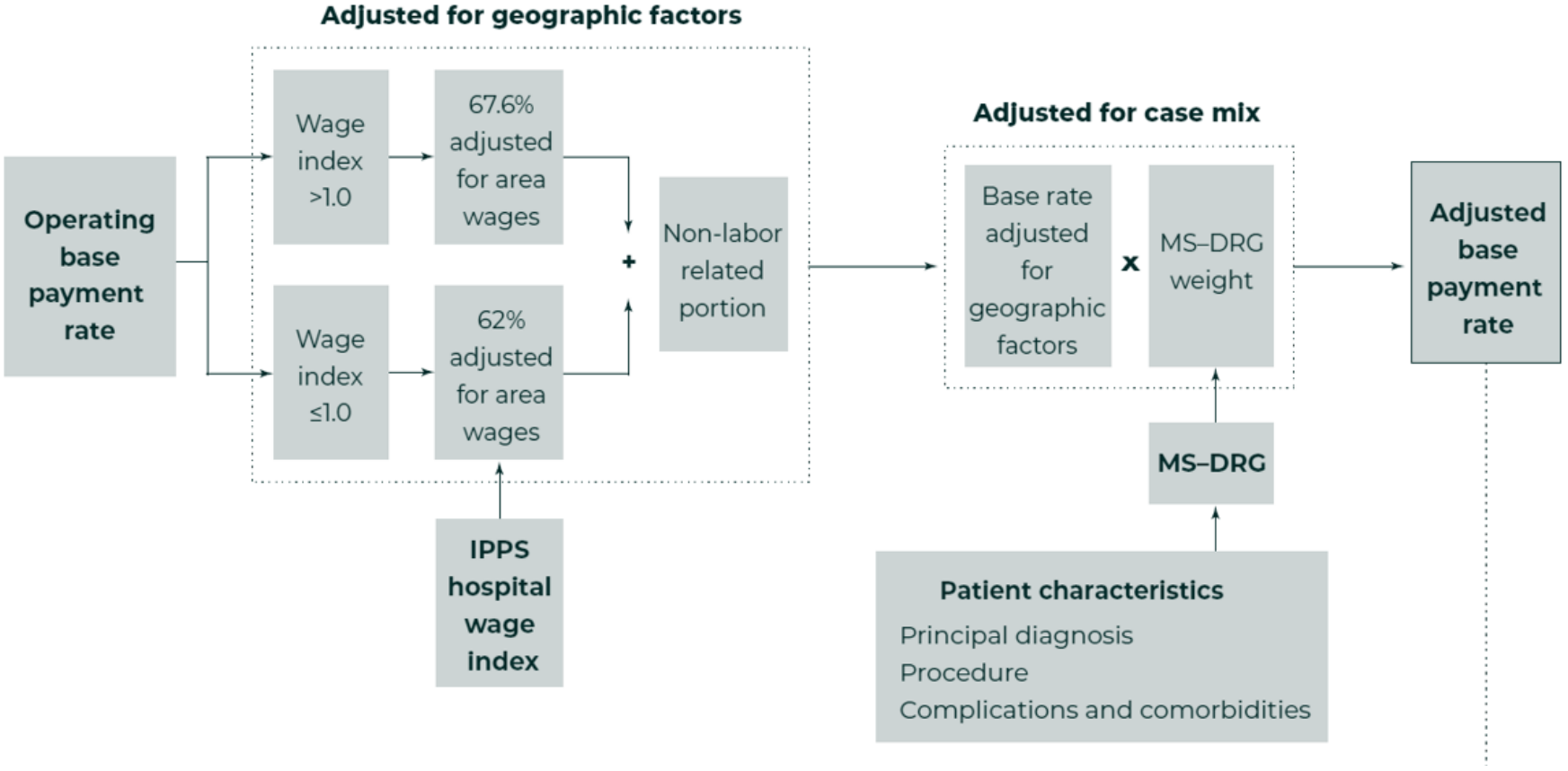
CMS FY 2025 Final Rule Percentage Change – Inpatient Payments

- IPPS operating payment rates to increase by 2.9 percent in FY 2025 relative to FY 2024
  - Successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and meaningful electronic health record (EHR) users.
  - This increase is the result of a 3.4% market basket update, and a productivity cut of 0.5%. Overall, the agency will increase hospital payments by $2.9b compared to FY 2024.
- Prior year IPPS payment rate increase was 3.1%
- Market basket vs. Inflation

Final FFY 2025 Update

	Quality Data Submitted and Meaningful User	Quality Data Submitted / NOT a Meaningful User	Quality Data NOT Submitted / Meets Meaningful Use	Quality Data NOT Submitted / NOT a Meaningful User
MB “Rate of Increase”	3.4%	3.4%	3.4%	3.4%
Failure to submit Quality Data	0.00	0.00	-0.85	-0.85
Failure to meet Meaningful Use	0.00	-2.25	0.00	-2.25
MFP Adjustment	-0.5	-0.4	-0.5	-0.5
Net Percent Increase/Decrease	***2.9%***	***0.35%***	***2.05%***	***-0.5%***

Adjusted Base Payment Rate



DRG Payment Rates (Quality Data/MU met)

Wage Index > 1.0000

	FFY 2025 Final Rule	FFY 2024 Final	Percentage Change Y/Y
Labor-Related	$4,466.00	$4,392.49	1.67%
Non-Labor	2,140.51	2,105.28	1.67%
Capital	510.51	503.83	1.33%
Total Payment Rate	$7,117.02	$7,001.60	1.65%

Wage Index <= 1.0000

	FFY 2025 Final Rule	FFY 2024 Final	Percentage Change Y/Y
Labor-Related	$4,096.04	$4,028.62	1.67%
Non-Labor	2,510.47	2,469.15	1.67%
Capital	510.51	503.83	1.33%
Total Payment Rate	$7,117.02	$7,001.60	1.65%

Labor/Non-Labor DRG Rates: Wage Index > 1.0000

Description (for FFY 2025 Final Rule)	Labor	Non-Labor
FY2025 Base Rate, after removing PY Reduction Factors	$4,782.01	$2,291.97
FY2025 Update Factor	1.029	1.029
MS-DRG Recalibration Budget Neutrality Factor (BNF)	0.99719	0.99719
Cap Policy MS-DRG Weight Budget Neutrality Factor	0.999874	0.999874
Wage Index Budget Neutrality Factor (BNF)	1.000114	1.000114
Reclassification 'BNF'	0.962791	0.9962791
Lowest Quartile 'BNF'	0.997157	0.997157
Cap Policy Wage Index Budget Neutrality Factor	0.999173	0.999173
Operating Outlier Factor	0.949000	0.949000
Rural Demonstration Budget Neutrality Factor	0.99981	0.99981
Sections 414 (MACRA) and 15005 of PL 114-255 (+.50%)	1.00001	1.00001
National Standardized Amount FY2025 DRG Payment Rate	$4,466.00	$2,140.51

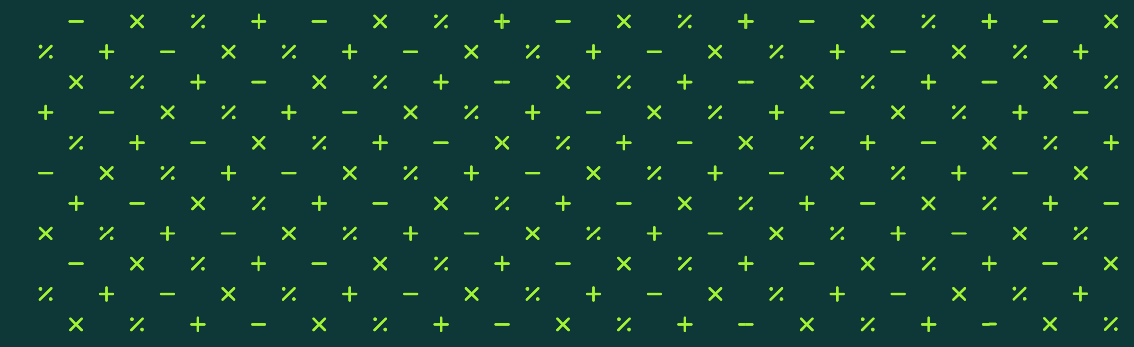
Capital Federal Rate Factor Comparison

Description	Final FFY 2025	FFY 2024	% Change
Update Factor	1.0310	1.0380	
GAF/DRG Adjustment Factor	0.9856	0.9885	
Quartile/Cap Adjustment Factor	0.9958	0.9964	
Outlier Adjustment Factor	0.9577	0.9598	
Capital Federal Rate	**$510.51**	**$503.83**	**1.33%**

Outliers: Fixed Loss Threshold

- Outlier percentage above target in FFY22: 6.8% v 5.1%
- Final outlier threshold for FFY 2025 is $46,152
  - Down from proposed $49,237
- Final outlier threshold for FFY 2024 is $42,750
- Increase of 8% to threshold
- Outlier reconciliation
  - Cost reports starting after October 2024
  - Outliers > $500,000 AND 20% change to CCR
  - New Hospitals

MS-DRGs



MS-DRG Update

- DRG weights re-calibrated on annual basis using claims data and cost report data
  - FY 2023 MedPAR claims and the FY 2022 cost reports, for the FFY 2025 rate
- Changes to MS-DRG
  - Twelve (12) new MS-DRGs
  - Five (5) MS-DRGs expired
- Relative Weight Impacts vs FFY24
  - 40 MS-DRGs increase between 5-10%
  - 27 MS-DRGs increase more than 10%
  - 47 MS-DRGs decrease between 5-10%
  - **31 MS-DRGs decreased by 10%**

Final MS-DRG – Top 5 Relative Weight Gains

MS-DRG	Final FFY 2024 Weight	Final FFY 2025 Weight	%
MS-DRG 010: PANCREAS TRANSPLANT	4.8136	7.9726	65.63%
MS-DRG 933: EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITHOUT SKIN GRAFT	3.032	4.3267	42.70%
MS-DRG 770: ABORTION WITH D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	0.7987	1.0759	34.71%
MS-DRG 509: ARTHROSCOPY	1..3661	1.7565	28.58%
MS-DRG 599: MALIGNANT BREASE DISORDERS WITHOUT CC/MCC	0.6728	0.8549	27.07%

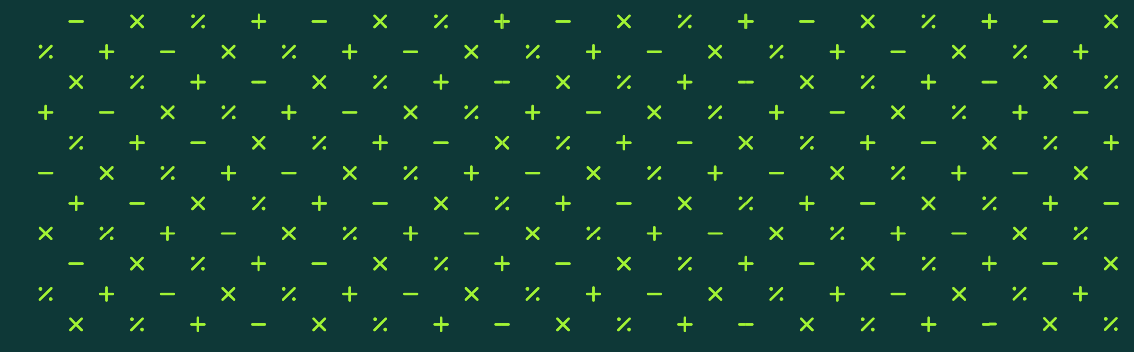
MS-DRG Update

- GROUPER Software Version 42
- Medicare Severity DRG policy
- Nine guiding principles: CC/MCC
- SDOH – expansion to diagnosis codes that move from non-CC to CC

New Technology Add-On Payments

- The NTAP program provides for additional payment to hospitals for cases involving eligible new and relatively high-cost technologies utilized during inpatient hospital stays.
- CMS is continuing twenty-four (24) previously approved technologies and discontinuing seven (7) previously approved technologies.
- 5 NTAP under traditional pathway
- 12 NTAP under alternative pathway
- Estimated Impact for New Technology Add-On Payments: $769,530,626

TEAM Model



Transforming Episode Accountability Model (TEAM)

Mandatory payment model for acute care hospitals paid under IPPS, located in 189 randomly-selected Core Based Statistical Areas (CBSAs).

Participants in BPCI-A or CJR may voluntarily opt in (any location) – January 2025

Goal: Reduce cost, improve quality/outcomes. Requirement to refer patients back to primary care, to reduce fragmentation, improve care transitions, reduce readmissions.

Timeline: Begins January 1, 2026, will run for (5) years.

Patients: Medicare fee-for-service only.

Payment Model: Bill FFS as usual. CMS sets a Target Price annually, for (5) surgery types, 30-day episodes (post discharge), all Medicare Parts A & B costs, both IP & OP settings, with quality & social risk score adjustment:

- Lower Extremity Joint Replacement
- Surgical Hip Femur Fracture Treatment
- Spinal Fusion
- Coronary Artery Bypass Graft
- Major Bowel Procedure

Transforming Episode Accountability Model (TEAM), continued

Increasing risk and reward, details TBD:

- Track 1 – no downside risk, low level of reward
- Track 2 – low level of risk & reward; may qualify for Advanced APM status if using CEHRT
- Track 3 – high level of risk & reward; may qualify for Advanced APM status if using CEHRT

Model Overlap: A patient can be included in both TEAM and ACO – no payment adjustment.

Year	1	2	3	4	5
Rural or Safety Net Hospitals	Track 1	Track 1 or 2	Track 1 or 2	Track 2	Track 2
All Others	Track 1 or 3	Track 3	Track 3	Track 3	Track 3

Quality Measures: readmissions, patient safety, patient-reported outcomes

Decarbonization and Resilience Initiative: Voluntarily report metrics related to greenhouse gas emissions to CMS. CMS will provide individualized feedback reports to TEAM participants, public recognition of their participation in the initiative & technical assistance/resources.

Transforming Episode Accountability Model (TEAM), continued

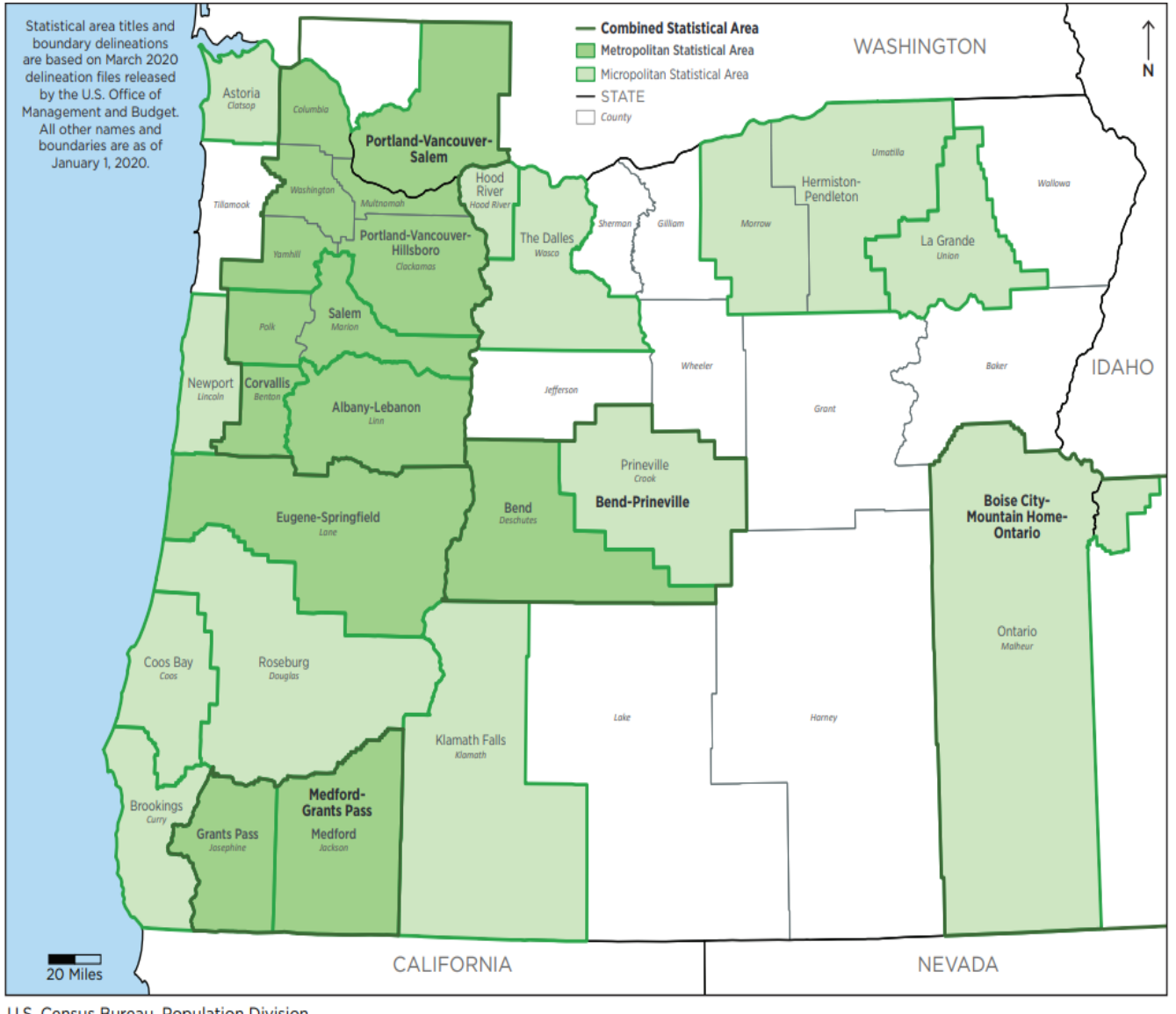
How to Prepare and Succeed?

- **Confirm your participation**
- **Identify stakeholders & project manager** – Clinical/Surgery, Finance, Quality, Analytics, Managed Care/Value-Based Care
- **Benchmark** – Compare your hospital's episodic cost to national benchmark and local competitors
- **Operational planning** – Develop/expand care transition, coordination & planning capacity; Increase provider education & collaboration amongst surgical specialists, primary care, therapists; Understand & prepare to report quality measures
- **Service line optimization** – Pre- & post-op planning/workflows to enhance communication, reduce care variation, reduce length of stay & increase efficiency
- **Data-driven approach** – Develop capacity/workflow to receive & analyze claims and utilization data from CMS; Identify high-value post-acute care partners (SNF, rehab, home health, etc.); Develop internal reporting to provide transparency & incentivize physicians

CBSAs Selected:

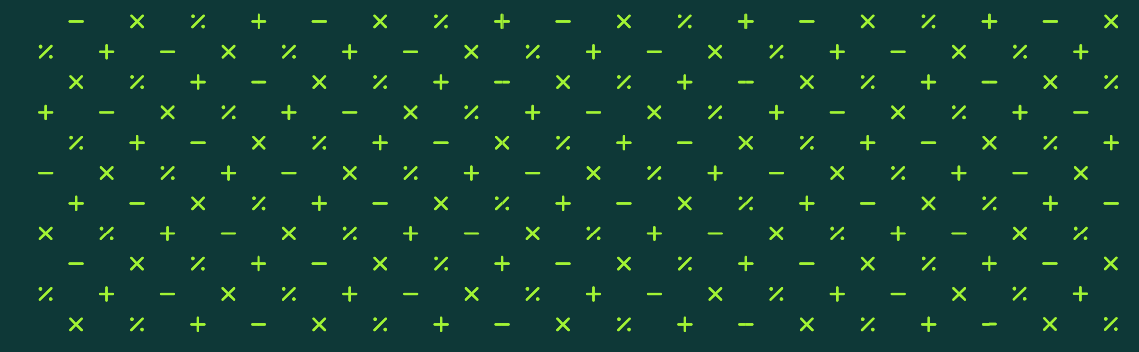
All acute providers within following CBSAs

1. Portland – Vancouver – Hillsboro (38900)
2. Bend (13460)
3. Klamath Falls (28900)

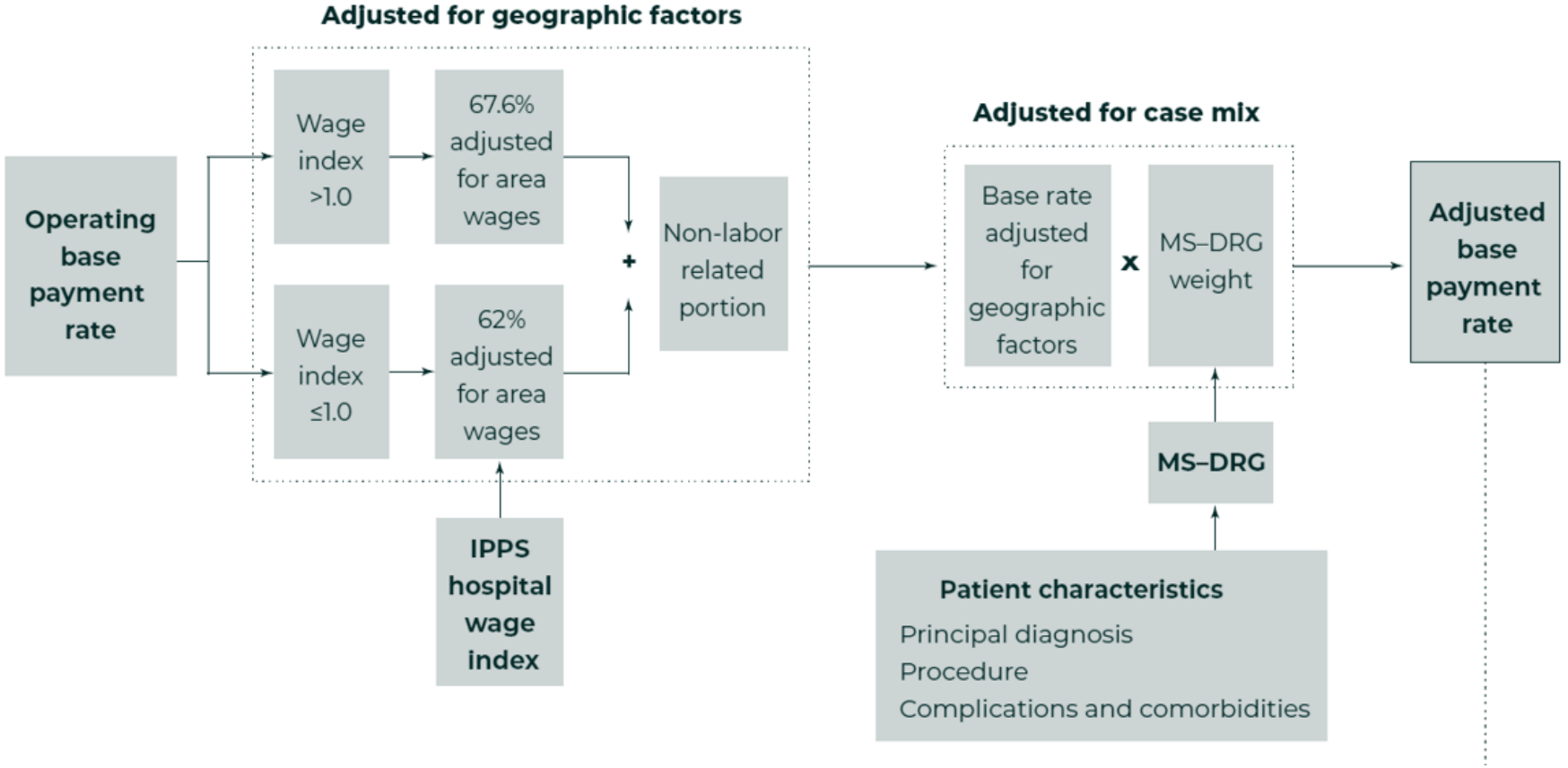


U.S. Census Bureau, Population Division

Medicare Wage Index Update



Current Use of Medicare Area Wage Index (AWI) Data (Refresher)



FY 2025 Worksheet S-3 Wage Data

- Generally, wage index policies are unchanged from prior years.
- There is wage data from 3,074 hospitals used to construct the wage index values from FY 2021 submitted cost reports.
- Occupational mix surveys for 2,956 hospitals included, representing a 96% "response" rate
- Hospital that submitted "erroneous or aberrant data" were excluded and replaced by proxy data.
- CMS admits the FY 2021 wage data spans the COVID-19 public health emergency (PHE)
  - Data suggests a higher proportion of Providers had an increase in their average hourly wage as compared to prior years.
  - CMS admits it is not clear how wage changes from COVID-19 PHE could be isolated and adjusted accordingly

Wage Index Values

- The wage index update uses wage data from cost reporting periods beginning in FY 2021.
- The method used to compute the wage index without an occupational mix adjustment follows the same methodology that was used to compute the wage indexes without an occupational mix adjustment in the FY 2024 IPPS/LTCH PPS final rule.
- The FY 2025 unadjusted national average hourly wage is $**55.03**. This is an 8.7% increase to the previous year
- Use of **CY 2022 Medicare Wage Index Occupational Mix Survey** for the FY 2025 wage index.
- Final FY 2025 occupational mix adjusted national average hourly wage is $**55.97**

Wage Index Values - Oregon

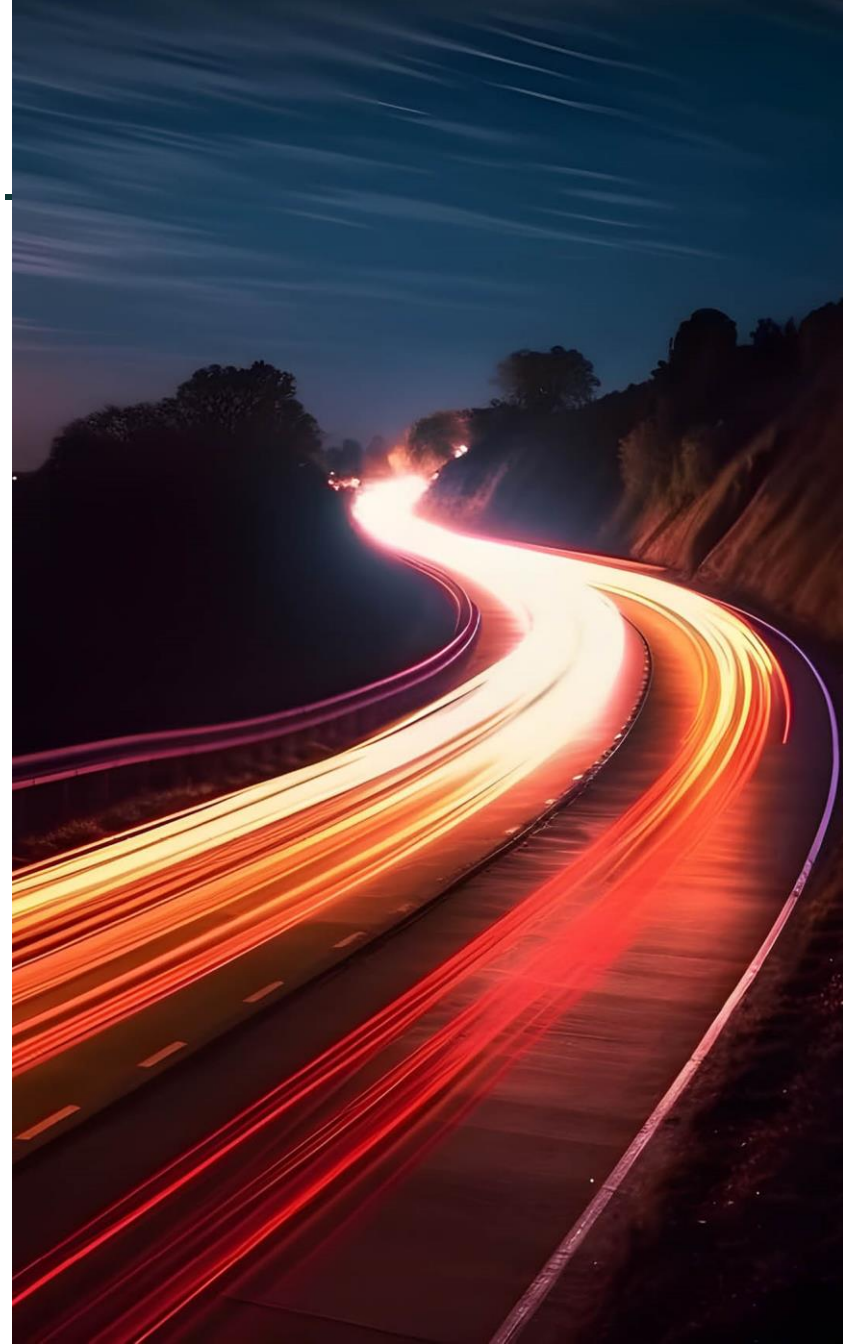
CBSA	Area Name	FY 2025 Average Hourly Wage	3-Year Average Hourly Wage (2023, 2024, 2025)
38	OREGON	57.7053	52.9415
10540	Albany, OR	58.4054	55.4182
13460	Bend, OR	60.8860	55.6770
18700	Corvallis, OR	59.5380	56.5284
21660	Eugene-Springfield, OR	63.8038	59.5369
24420	Grants Pass, OR	59.8758	54.3023
32780	Medford, OR	59.9256	55.8186
38900	Portland-Vancouver-Hillsboro, OR-WA	63.6867	61.0708
41420	Salem, OR	61.9289	57.7728

Wage Index Values - Oregon

CBSA	Area Name	2025 Wage Index	2024 Wage Index	%
38	OREGON	1.1284	1.0872	3.8%
10540	Albany, OR	1.1284	1.0872	3.8%
13460	Bend, OR	1.1284	1.0872	3.8%
18700	Corvallis, OR	1.1284	1.0889	3.6%
21660	Eugene-Springfield, OR	1.1345	1.1824	-4.1%
24420	Grants Pass, OR	1.1284	1.0872	3.8%
32780	Medford, OR	1.1284	1.0872	3.8%
38900	Portland-Vancouver-Hillsboro, OR-WA	1.1325	1.1986	-5.5%
41420	Salem, OR	1.2030	1.1135	8.0%

FY 2025 Core Based Statistical Areas -

- CMS adjusts IPPS payments for geographic area differences in the cost of hospital labor - the wage index.
- CMS uses Office of Management and Budget (OMB) Core-Based Statistical Area (CBSA) delineations as labor market areas. CMS is currently using OMB delineations from 2015 (based on the 2010 census) updated by OMB Bulletin numbers 13-01, 15-01, 17-01, 18-04 and 20-01.
- On July 21, 2023, OMB released Bulletin No. 23-01. Bulletin No. 23-01 reflects changes to CBSA delineations based on the 2020 Standards for Delineating Core Based and the application of those standards to Census Bureau population and journey to- work data.
- **CMS is finalizing proposal to use these revised delineations to calculate the IPPS wage index beginning in FY 2025.**



FY 2025 Core Based Statistical Areas – Reshuffled (Cont.)

- There are 53 counties currently urban that will become rural in FY 2025 (impacts 33 hospitals). These hospitals will be included in their state's rural floor wage index calculation.
  - 17 of these 53 counties are "Lugar" counties which means they are deemed urban to the adjacent county where the plurality of their workers commute. For purposes of calculating the wage index, these hospitals are treated as geographically reclassified to the urban area where the county is deemed.
  - Hospitals that were once deemed urban but are later deemed to be geographically located in a rural area are no longer eligible for capital DSH payments
- There are 54 counties currently rural that will become urban in FY 2025 (impacts 24 hospitals). These hospitals will be included in the calculation of the urban CBSA wage index where these hospitals are now located. These hospitals will become eligible for capital DSH payments if they also meet the 100-bed requirement.
- Some urban counties are moving to a different urban CBSA based upon OMB Bulletin No. 23-01.

FY 2025 Core Based Statistical Areas – Oregon

- No Urban counties moving to Rural
- However, two Rural counties moving to Urban
  - 41013 CROOK → 13460 Bend
  - 41031 JEFFERSON → 13460 Bend

FY 2025 Core Based Statistical Areas – Reshuffled (Cont.)

Other Considerations

- Critical Access Hospitals (CAH) – If they are slated to become urban, they will lose their CAH status unless they apply for an urban to rural reclassification.
  - Existing regulations provide for a two-year period for CAHs to apply for an urban to rural reclassification in order to maintain CAH status.
- Other special hospital designations (such as Sole Community Hospital and Medicare Dependent Hospital) that require rural status may also end if the hospitals do not apply for an urban to rural reclassification.
  - These hospitals should apply for urban to rural reclassification before October 1, 2024 to avoid a termination of their special status.
- Transition – There is no transition period applicable for these changes, however, the 5% cap on any decrease to a hospital's wage index from its prior year wage index would be applicable.

Geographic Reclassifications

Geographic reclassification is a process where hospitals apply to use another area's wage index. To use another area's wage index, the applying hospital must be within a specified distance (15 miles for urban hospitals and 35 miles for rural hospitals) and have wages that are different than its own area and comparable to the wages of the requested area:

- Urban Hospitals: Average hourly wage that is at least 108 percent of other hospitals in its geographic area and 84 percent of the requested area.
- Rural Hospitals: Average hourly wage that is at least 106 percent of other hospitals in its own geographic area and 82 percent of the requested area.

The MGCRB decides whether hospitals meet the criteria for reclassification. Geographic reclassifications are effective for 3 years but may be temporarily withdrawn or terminated. If a hospital accepts a new MGCRB reclassification, any prior ones are permanently terminated.

Geographic Reclassifications (Cont.)

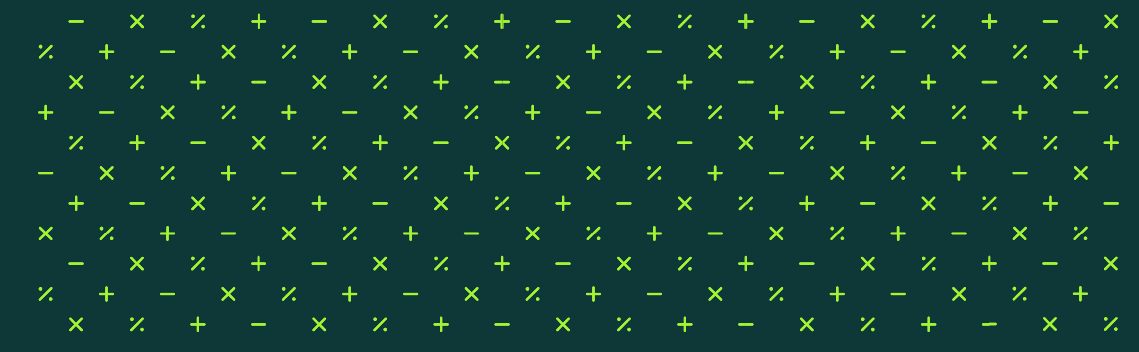
Geographic Reclassification Opportunities From OMB Bulletin No. 23-01

1. Urban to Rural Reclassification (Not Limited to Wage Index). Hospitals that meet specific criteria in statute may request that a CMS Regional Office treat an urban hospital as rural for purposes of IPPS payment.
   - Unlike MGCRB reclassifications that are effective on the basis of a fiscal year, urban to rural reclassifications are effective upon the date the application was submitted to the CMS Regional Office.
2. Lugar" Counties and Hospitals. A "Lugar" county is a rural county adjacent to one or more urban areas that is deemed to be part of the urban area where the highest number of its workers commute. A Lugar hospital is a hospital located in a Lugar county.
   - A Lugar hospital is treated as reclassified to the urban area where the highest number of its workers commute. This process is automatic and will occur with no action on the part of the hospital.
   - Under the proposed new CBSA delineations, 22 Lugar counties will become urban and no longer be considered Lugar counties.
   - In most cases, these counties are becoming part of an urban area or a substantially similar one to which they were previously deemed. Hospitals in these counties will now be considered urban for purposes of the wage index and all other IPPS purposes.

FY 2025 Continuation of Low Wage Index Hospital Policy

- CMS elects to continue its low wage index hospital policy in FY 2025 that it first adopted in FY 2020. CMS is extending this policy three years through FFY 2027 to obtain adequate data intended to measure the results of this policy.
- Under this policy, CMS makes upward adjustments to the wage indices of hospitals with a wage index value below the 25th percentile.
- The adjustment for each eligible hospital is equal to half of the difference between the otherwise applicable final wage index value for the hospital and the 25th percentile wage index value for all hospitals that same year.
- As in past years, CMS is funding these adjustments by making a budget neutrality adjustment to the standardized amount.
- ***Bridgeport Hospital v. Becerra***

Medicare DSH/Uncompensated Care



Uncompensated Care – Final Factor 1

- Baseline FY 2021 - $13.401 billion

FY	Update	Discharge	Case Mix	Other	Total	DSH
2022	1.025	0.946	0.997	0.9940	0.9611	12.880
2023	1.043	0.946	0.990	1.0501	1.0259	13.214
2024	1.031	0.984	1.005	1.0230	1.0434	13.787
2025	1.029	0.981	1.005	1.0022	1.0164	14.013

Update column is determined as follows:

FY	MB	Prod	D&C	Total
2022	2.7	0.7	0.5	2.5
2023	4.1	0.3	0.5	4.3
2024	3.3	0.2	0.0	3.1
2025	3.4	0.5	0.0	2.9

Uncompensated Care – Factor 1 Trends

FFY	DSH Estimate	25% EJ DSH	Factor 1
2014	$12,790,922,790	$3,197,730,698	$9,593,192,093
2015	$13,383,462,196	$3,345,865,549	$10,037,596,647
2016	$13,411,096,528	$3,352,774,132	$10,058,322,396
2017	$14,396,635,710	$3,599,158,928	$10,797,476,783
2018	$15,552,939,524	$3,888,234,881	$11,664,704,643
2019	$16,339,055,838	$4,084,763,960	$12,254,291,879
2020	$16,583,455,657	$4,145,863,914	$12,437,591,743
2021	$15,170,673,476	$3,792,668,369	$11,378,005,107
2022	$13,984,752,729	$3,496,188,182	$10,488,564,547
2023	$13,948,974,706	$3,496,188,182	$10,461,731,029
2024	$13,353,588,029	$3,338,397,007	$10,015,191,022
2025	$14,013,000,000	$3,503,250,000	$10,509,750,000

Uncompensated Care – Final Factor 2

CY 2024 uninsured: 7.3% (Proposed 8.5%)

CY 2025 uninsured: 7.7% (Proposed 8.8%)

FY 2025 weighted uninsured: (7.3% x .25) + (7.7% x .75) = 7.6%

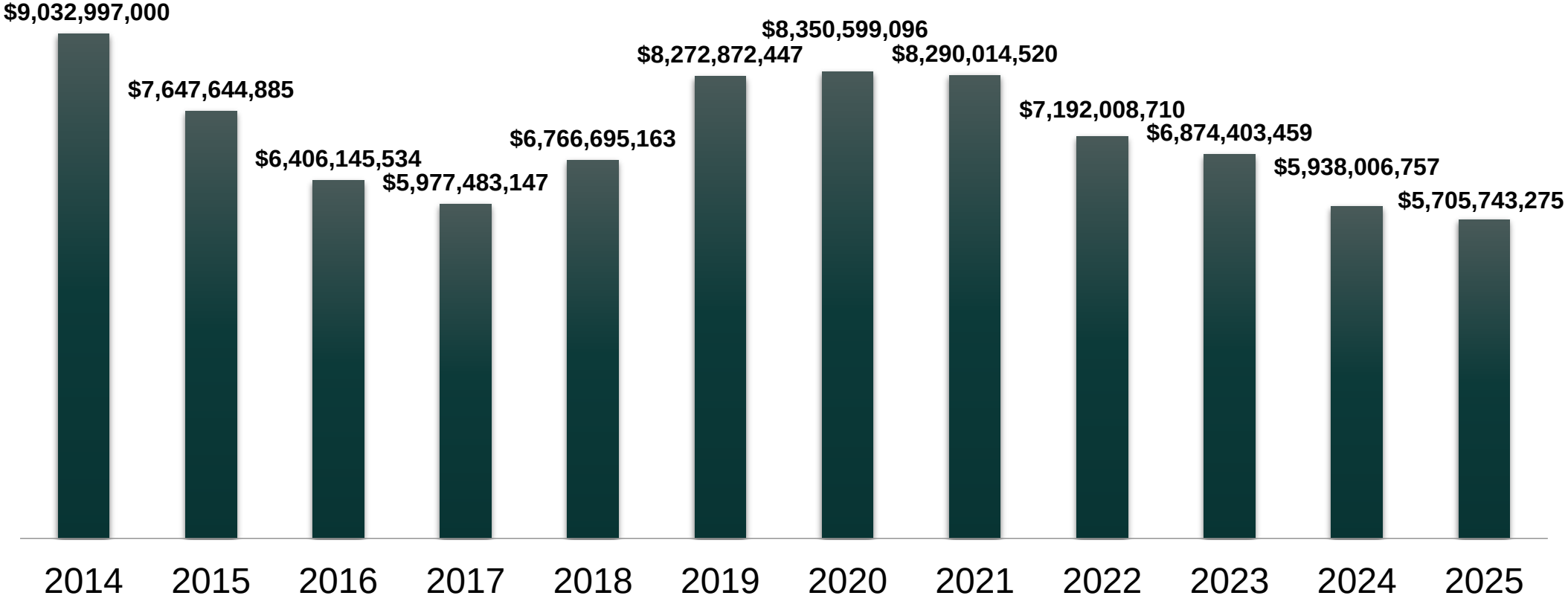
2013 uninsured: 14%

1-|((7.6%-14%) / 14%| = 1-45.7% = **54.29%**

Uncompensated Care – Final UC Pool Total

- 2025 Final Factor 1 = $10,509 Billion (Proposed 10.457B)
- 2025 Final Factor 2 = 54.29% (Proposed 62.14%)
- 2025 Final UC Amount $10,509 * 54.29% = $5.705 Billion (Proposed 6.498B)
  - Distributed to approximately 2,400 hospitals
  - Decrease of $232 Million (4%) from 2024 final rule

UC Pool Trends



Uncompensated Care – Final Factor 3

- FFY 2019, FFY 2020, & FFY 2021 Line 30 S-10 data to derive Factor 3 for FY 2025
  - Using the average of the audited FFY 2019, FFY 2020, & FFY 2021
  - Addresses concerns from stakeholders regarding year-to-year fluctuations in UC payments
- Interim Uncompensated Care Payments
  - Based on average of FY 2022 and FY 2023 discharges (Proposed included FY 2021)
  - In 2026 and subsequent years, CMS will return to a 3-year average
- Future S-10 Use
  - Use a three-year average of UC data from the three most recent audited fiscal years

FFY 2019, 2020, & 2021 S-10 Cost Report Comparison – Pre & Post Audit

Change in Line 30 UC

FFY	Providers	Providers with Change	Change	Percent
2019	2,395	2,284	$(1,598,058,256)	-4.54%
2020	2,411	2,282	$(2,013,510,549)	-5.87%
2021	2,422	2,135	$(1,137,450,684)	-3.52%

FFY 2019, 2020, & 2021 S-10 Cost Report Comparison – Pre & Post Audit (Cont.)

Charity Care Changes Line 20

				Uninsured		Insured		Total	
FFY	Providers	No Change	Revised	Change	Percent	Change	Percent	Change	Percent
2019	2,284	148	2,136	$1,748,542,983	1.73%	$(1,539,564,189)	-28.12%	$208,978,794	.19%
2020	2,411	267	2,144	$1,465,582,294	1.54%	$(1,989,142,181)	-36.96%	$(523,559,887)	-.49%
2021	2,422	402	2020	$724,870,100	.77%	$(849,943,742)	-26.61%	$(125,073,642)	-.12%

- Insured (coinsurance/deductible/copay) charity not subject to the cost to charge ratio
- Dollar for dollar impact on Line 30 total

FFY 2019, 2020, & 2021 S-10 Cost Report Comparison – Pre & Post Audit (Cont.)

Bad Debt Line 26

FFY	Providers	No Change	Revised	Change	Percent
2019	2,284	384	1,900	$(1,561,211,010)	-3.91%
2020	2,411	597	1,814	$(1,312,480,405)	-3.63%
2021	2,422	830	1,592	$(698,606,331)	-2.46%

Implications of Medicaid Redeterminations

Shifting payor mix

- Medicaid ⇨ Uninsured & Exchange

340B Qualifications

Federal DSH payment qualification

- Empirically justified DSH
- UC Payment qualification

UC payment calculation implications (CMS estimates)

- Factor 1 – projected DSH
- Factor 2 – national uninsured rate

Cost Report Update- Transmittal 18

- Medicare DSH Traditional
  - All hospitals required to submit exhibit if eligible for DSH or LIP
- Medicare DSH UC
  - Part I is the uncompensated care for the entire hospital complex (current S-10)
  - Part II is the inpatient and outpatient services billable under the hospital CMS certification number (ProvNum)
- Medicare Bad Debt
- What we've learned

OIG December 2022 Report

- Office of Inspector General (OIG) conducted an audit of the nearly $10 billion in Medicare reimbursement claims made by providers during the 2016-2018 federal fiscal years

- Randomly selected 67 cost reports

  - Selected a nonstatistical sample of 148 bad debts and reviewed provider's documentation of the collection efforts performed

  - Reviewed sampled provider's policies and procedures for collecting Medicare bad debts to ensure that the policies and procedures included reasonable collection efforts

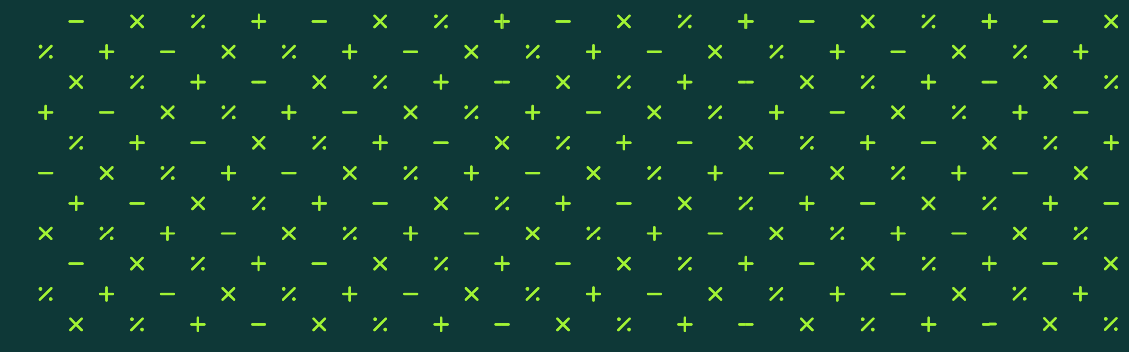
OIG December 2022 Report - Findings

- 86 sampled accounts were for beneficiaries whom provider had deemed indigent and, therefore, no reasonable collection efforts were required
- Providers did not comply with Federal requirements when claiming 18 of the remaining 62 Medicare bad debts.
- OIG identified 4 additional bad debts for which the amounts that providers claimed did not reflect the amounts owed by the beneficiaries
- CMS inappropriately reimbursed these amounts because the MACs did not concentrate on reviewing bad debts when performing audits of cost reports during the audit period

OIG December 2022 Report - Recommendations

- OIG recommended that CMS consider issuing instructions or guidance to the MACs that require or encourage more review of Medicare bad debts claimed on cost reports
- Such as defining thresholds beyond which individual Medicare bad debts would trigger an audit, and that directs the MACs to revise their cost report audit work plans accordingly
- CMS agreed with OIG recommendation and stated that it would consider their findings when issuing future guidance to the MACs regarding the review of Medicare bad debt

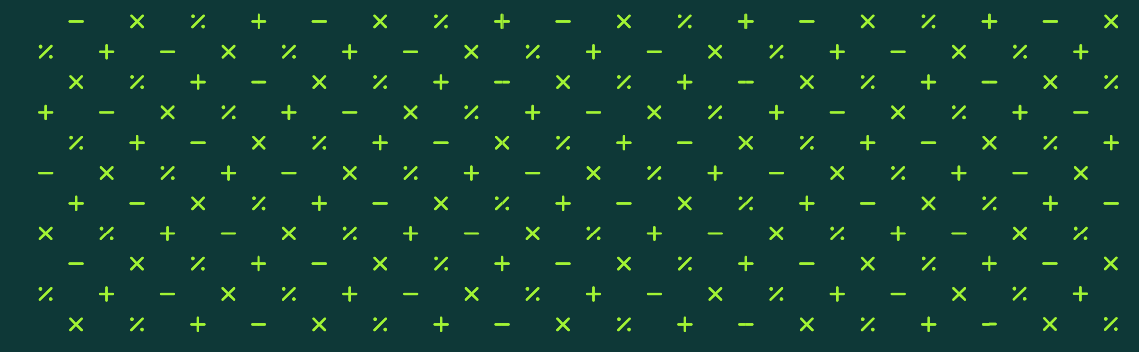
GME



Graduate Medical Education

- New Programs
- CMS to distribute 200 additional slots to teaching hospitals
  - At least 100 shall be for psychiatry or psychiatry subspecialty residency training programs
  - Notify hospitals by January 31, 2026
  - Effective July 1, 2026
  - Likelihood of filling within first 5 training years
  - At least 10% to
    - Rural hospitals
    - States in states with new or expanded medical schools
    - Hospitals in HPSA markets
    - Hospitals currently exceeding limit

Quality Programs



IQR

- Seven (7) New Quality Measures
  - Patient-safety related

- Five (5) Measures Discontinued

- Two (2) Modified Measures

Value-Based Payments, Readmissions, HAC

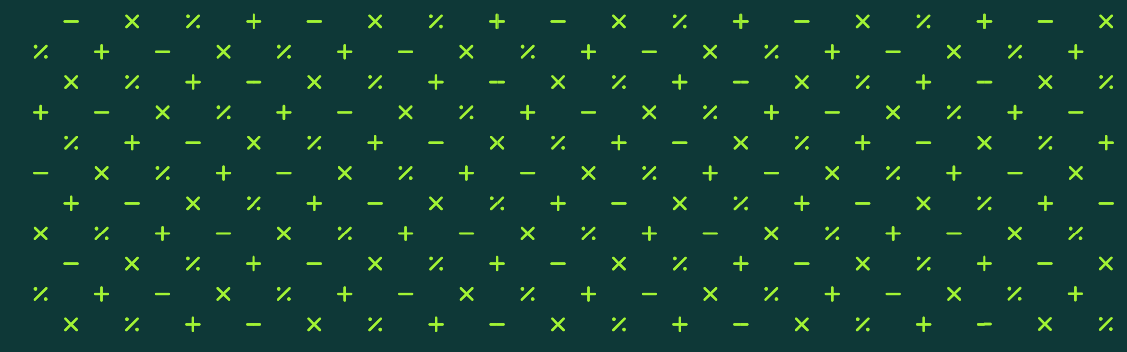
- Hospital Equity Adjustment to reward providers serving underserved patient populations
  - To be implemented in FY26
  - Provide bonus point to a hospitals Total Performance VBP score

- Change to HCAHPS for VBP

- No new change to Readmission or HAC

- Reporting requirements for Acute Respiratory Infections

Other Payment and Regulatory Items for Consideration



Health Equity Changes

- Social Determinants of Health (“SDOH”) diagnosis codes
  - SDOH Z codes
  - Which SDOH codes increase resource use?
  - Homelessness

- Seven New Diagnosis codes to impact severity

- LTCH Quality program

Other Items

- Long term Acute Care Hospital: 3% increase
- Additional IPPS payment for buffer stock of essential medicines
- MDH Update – MDH program will expire for discharges on or after January 1, 2025
- Low-Volume hospital add-on payment.
  - Legislative extension for low volume hospital payment adjustment policy expires on December 31, 2024. Beginning January 1, 2025, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that where in effect prior to FY 2011
- ESRD Add-on

CMS FY 2025 Final Rule Percentage Change – Inpatient Rehab Payments

- IRF standard payment rates proposed to increase by 3.0 percent in FY 2025 relative to FY 2024
  - This increase is the result of a 3.5% market basket update and a productivity cut of 0.5

- CBSA Update applied
  - Transition provided to IRFs that lose rural adjustment
  - 5% cap on negative wage indices

- Outlier Threshold Update

- Cost and Benefit
  - FY 2025 IRF PPS payment rate update
    - Overall economic impact is an estimated $280 million in increased payments.
    - Includes $300 million
    - LESS: $20 million from outlier threshold update

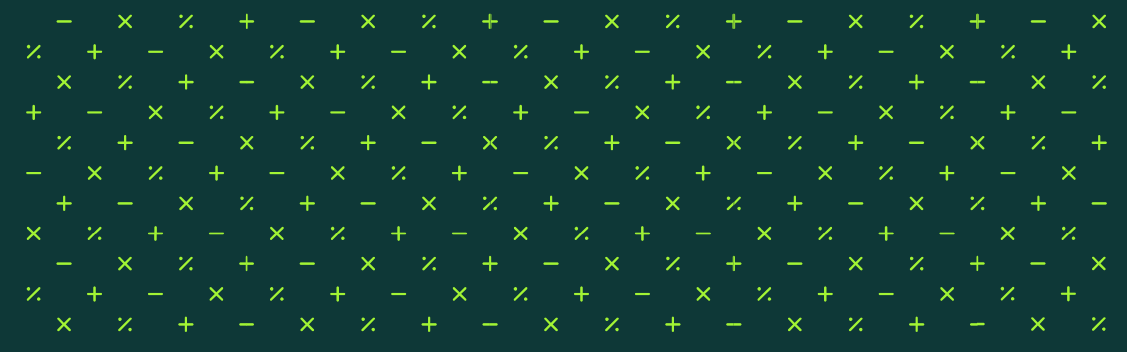
CMS FFY 2025 Proposed Rule Percentage Change – Inpatient Psychiatric Payments

- IPF standard payment rates to increase by 2.8 percent in FFY 2025
  - This increase is the result of a 3.3% market basket update and a productivity cut of 0.5%
  - Updating outlier threshold result in a 0.3% decrease in aggregate payments.
  - Estimated payments overall to increase by 2.5% (or $65m) relative to fFY2024 when applying outlier update

- Patient-level adjustment factors
  - Historically based on 2005 factors; Updated to claims data from 2019 – 2021
  - Increase to Electroconvulsive Therapy payments; approx. 70% increase

- CBSA Update applied
  - Transition provided to IPFs that lose rural adjustment

Next Steps, Closing Thoughts & Questions



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- Moss Adams Events & Webcasts
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- Moss Adams Provider Reimbursement
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Cost Report Appeals, Filing, & Management	Month End Close Support	Volume Decrease Adjustment
Home Office Cost Allocations & Reporting	Outsourcing & Staff Augmentation	Wage Index Preparation & Reviews
Medical Education Program Implementation, Expansion, & Reviews	Regulatory Analysis & Interpretation	Worksheet S-10: Charity Care & Bad Debt & Audit Support

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340B Program-Related Services	Expense Controls & Performance Improvement	Medicaid Matching	Revenue Cycle Processes
AR Valuations	Formulate Third-Party Reserves for Financial Reporting Purposes	Net Patient Revenue Analysis & Calculations	Roll Forward Analysis
Charge Master Standardization & Maintenance	Geographic Reclassifications	Organ Acquisition & Transplant Programs	Service Line Impact Analysis
Cliff Impact Analysis	Government Payment Programs Training	Outlier Reconciliations	State Provider Tax Programs
Clinical Pathway Reviews for Inpatient & Outpatient Service Lines	Government Programs Profitability Analysis	Payment Rate Reviews & Third-Party Payment Variance Analysis	Strategic Business Planning
Contractual Model Reviews for Compliance & Accuracy	Ground Ambulance Data Collection	Provider-based & Outpatient Service Line Assessments	Succession Planning
Due Diligence	Medicaid DSH reviews	Rate Setting & Application of Overhead Rates	

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- Medical Education
- Uncompensated Care / Bad Debt
- Medicare DSH Analysis & Appeals
- Worksheet S-10
- Wage Index Reviews
- Outsourced Reimbursement & Staff Augmentation

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