bakertilly

Medicare reimbursement updates for fiscal year 2025

September 24, 2024

Meet the presenters

Keith Hutcheson, CPA,

Partner

M: +1 (817) 307 2087
E: keith.hutcheson@bakertilly.com

Brian Restivo, MBA, CHFP

Director

P: +1 (703) 923 8397
E: brian.restivo@bakertilly.com

Learning objectives

- Key impacts from the CMS' IPPS FY 2025 final rule on Medicare inpatient reimbursement
- Understand the implications the IPPS final rule on wage index that impacts inpatient, outpatient and many other services
- Learn about new Metropolitan Statistical Areas (MSA) that will change Hospitals locations for Urban to Rural and visa versa.
- Key impacts from the CMS OPPS CY 2025 proposed rule on Medicare outpatient reimbursement

Agenda

- FY 2025 final rule
- DSH/uncompensated care
- Other IPPS Changes
- Establishing and Maintaining Access to Essential Medicines
- Transforming Episode Accountability Model (TEAM)
- New Technology Add-on Payments
- Wage index updates
- IME-GME updates
- CY 2025 OPPS proposed rule changes


Medicare
inpatient FFY
2025 final rule

Final FFY 2025 IPPS increases

- Commonly publicized rate increase by CMS beginning October 1, 2024 is a 3.4% increase less: (0.5%) adjustment for productivity with a final increase of 2.9%
  - Comment from AHA - Economy-wide inflation grew by 12.4% from 2021 through 2023 — more than two times faster than Medicare rates for hospital outpatient care, which increased by 5.9% during the same time
- However, when you factor all the budget neutrality factors published in the final rule, the actual increase between FFY 2025 and FFY 2024 is: **1.67%**
  - FFY 2025 Base Rate: $6,606.51
  - FFY 2024 Base Rate: $6,497.77
- Capital Rate is increasing 1.33%
  - FFY 2025 Capital Base Rate: $510.51
  - FFY 2024 Base Rate: $503.83

FFY 2025 neutrality factors

Summary of FY 2025 Budget Neutrality Factors	
MS-DRG Reclassification and Recalibration Budget Neutrality Factor	0.997190
Cap Policy MS-DRG Weights Budget Neutrality Factor	0.999874
Wage Index Budget Neutrality Factor	1.000114
Reclassification Budget Neutrality Factor	0.962791
*Rural Floor Budget Neutrality Factor	0.977499
Low Wage Index Hospital Policy Budget Neutrality Factor	0.997157
Cap Policy Wage Index Budget Neutrality Factor	0.999173
Rural Demonstration Budget Neutrality Factor	0.999810

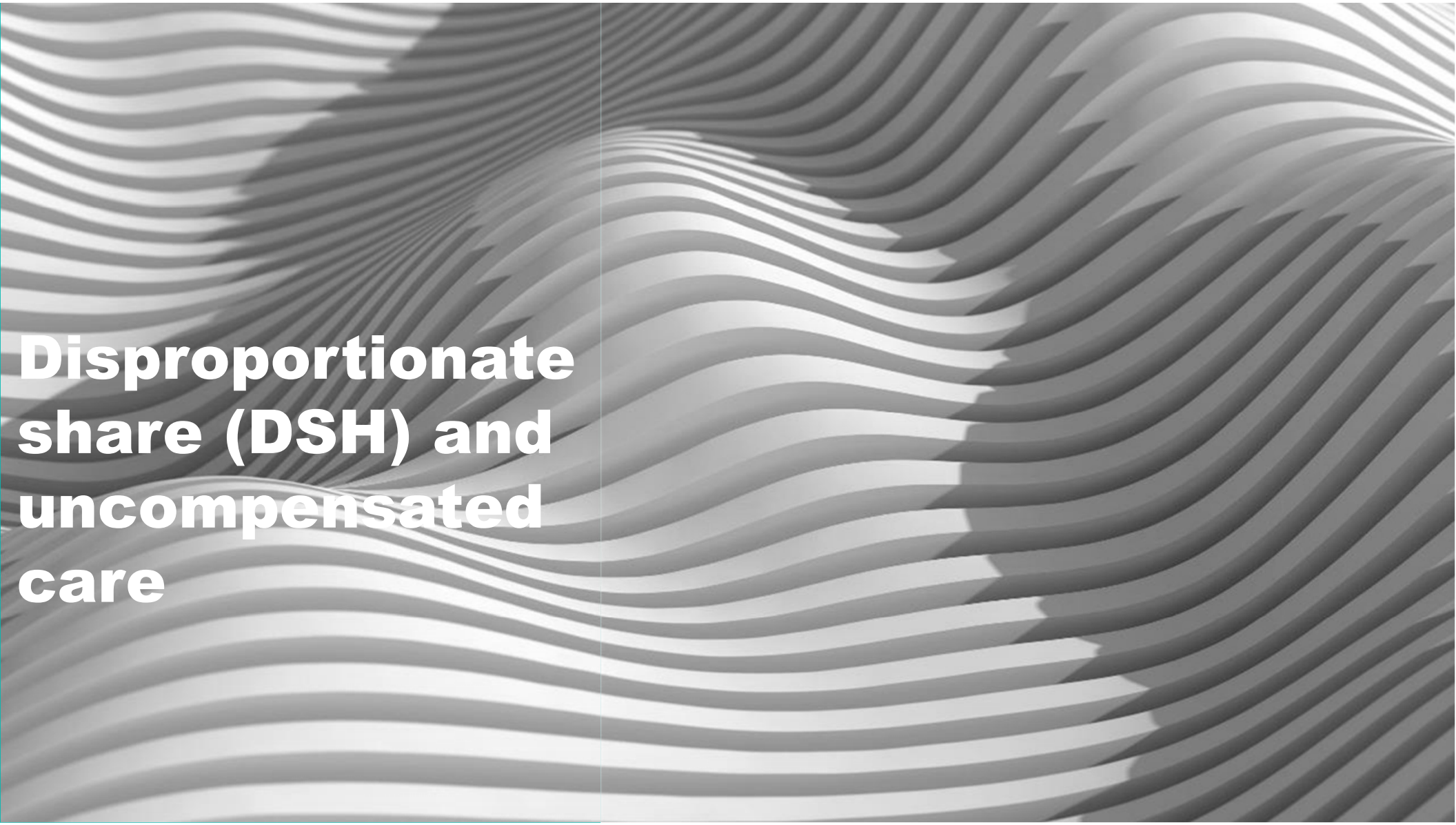
*The rural floor budget neutrality factor is applied to the national wage indexes while the rest of the budget neutrality adjustments are applied to the standardized amounts.

Outlier updates: fixed loss threshold

Final outlier threshold for FFY 2024 was $42,750.

Final outlier Threshold for FFY 2025 is $46,452.

- FFY 2025 proposed increase was 15% to $49,237. Final Outlier threshold is an 8.6% increase to $46,452.


Disproportionate share (DSH) and uncompensated care

S-10 uncompensated care DSH updates

Factor 3:

- FFY 2025: Based on average of the audited FFY 2021, FFY 2022, and FFY 2023 S-10 reports
- Three-year average will be used to reduce year-over-year fluctuation.

New and merged hospitals

- Factor 3 will be determined at cost report settlement where the numerator of the newly merged hospital's factor 3 will be based on the cost report of only the surviving (merged) hospital for the current year.

Uncompensated care data

Factor 3 - discharges

- 2020 data will not be used for the number of discharges for payment. The 3-year average of discharges will be based on FY 2021, FY 2022 and FY 2023 historical discharge data.

Final payment

- The interim uncompensated care payments made to a hospital during the fiscal year will be reconciled following the end of the year to ensure final payment amount is consistent with the hospital's prospectively determined uncompensated care payment.
- If actual discharges are less than the 3-year average used for payment the hospital will receive an additional settlement on the cost report.
- If actual discharges are more than the 3-year average used for payment the hospital will pay the amount received in excess of the prospectively determined amount back through the cost report settlement.

Uncompensated care pool trends

	2025	2024	2023	2022	2021
Factor 1					
Medicare DSH payments for FY2020, without regard to ACA estimate of empirically justified Medicare DSH payments for FY 2020 with regard to the ACA ("25%")	$ 14,013,000,000	$ 13,353,588,029	$ 13,948,974,706	$ 13,984,752,729	$ 15,170,673,476
	(3,503,250,000)	(3,338,397,007)	(3,487,243,676)	(3,496,188,182)	(3,792,668,369)
Factor 1	**$ 10,509,750,000**	**$ 10,015,191,022**	**$ 10,461,731,030**	**$ 10,488,564,547**	**$ 11,378,005,107**
Factor 2					
Baseline year of 2013	14.00%	14.00%	14.00%	14.00%	14.00%
PY	7.30%	7.70%	8.90%	9.80%	10.30%
CY	7.70%	8.50%	9.30%	9.50%	10.20%
Weighted Average of Uninsured	7.60%	8.30%	9.20%	9.60%	10.20%
Factor 2	**54.29%**	**59.29%**	**65.71%**	**68.57%**	**72.86%**
Uncompensated Care Pool	**$ 5,705,292,857**	**$ 5,938,006,757**	**$ 6,874,403,460**	**$ 7,192,008,710**	**$ 8,290,014,521**
Change over Prior Year ($)	**$ (232,713,900)**	**$ (936,396,703)**	**$ (317,605,250)**	**$ (1,098,005,811)**	**$ (60,584,575)**
Change over Prior Year (%)	-3.92%	-13.62%	-4.42%	-13.24%	-0.73%
Proposed Rule	$ 560,128,393	$ (161,443,366)			
Difference	$ (792,842,293)	$ (774,953,337)			
Variance	-13.90%	-13.05%			

Pennsylvania Uncompensated Care Data

	FFY 2025	FFY 2024	FFY 2023	FFY 2022
Total UCC for PA	$106,076,827	$115,667,150	$141,250,409	$146,377,401
PA Hospitals receiving UCC	90	93	99	96
Average per Hospital	$1,178,631	$1,243,733	$1,426,772	$1,524,765
National Pool	$5,705,292,857	$5,938,006,757	$6,874,403,460	$7,192,008,710
Pennsylvania % of National	1.86%	1.95%	2.05%	2.04%

Uncompensated care data

Change in Payment

- The proposed rule for FFY 2025 included a $560,128,393 or 3.12% increase in uncompensated care payments.
- The final rule for FFY 2025 included a reduction of ($232,713,900) or (3.92%) in uncompensated care payments or a change of (13.90%)
- The final rule for FFY 2024 included a ($936,396,703) or (13.62%) reduction in uncompensated care payments or decrease of ($774,953,337) in additional cuts from the proposed rule.


Other
IPPS
changes

Other final changes

Low-Volume Payment

The Consolidated Appropriations Act of 2024 extended temporary changes to low-volume hospital qualifying criteria and payment adjustment under the IPPS through Dec. 31, 2024.

- Current Criteria: Less than 3,800 discharges and located more than 15 road miles from the nearest IPPS hospital

Beginning Jan. 1, 2025, the low-volume hospital qualifying criteria reverts to the prior statutory requirements that were in effect prior to FY 2011

- Specifically, starting Jan. 1, 2025, a low-volume hospital must be more than 25 road miles from another eligible acute care inpatient hospital and have fewer than 200 discharges during the fiscal year.
- Estimates that all but 10 hospitals would continue to qualify unless congressional action is taken

Hospitals had to submit written requests by 9/1/2024 to receive LVH adjustments for 10/1/2024-12/31/2024

- If deadline is missed, the effective date will be 30 days from the MAC determination

Other changes

Medicare Dependent Hospital Payment

The CAA, 2023 extended the MDH program through the end of CY 2024.

Therefore, starting Jan. 1, 2025, the MDH program will no longer be in effect, and all MDH hospitals will no longer have MDH status and will be paid based on the IPPS federal rate.

- Need congressional action for CMS to extend
- Has been set to expire many times previously, before being extended, by Congress (sometimes retroactively)
- Impacts approximately 173 hospitals

Hospitals can apply for Sole Community Hospital (SCH) status. To receive SCH status by Jan. 1, 2025, current MDH hospitals must apply by Dec. 2, 2024.

Pennsylvania MDH and LVA Hospitals

2024 PA Medicare Dependent Hospitals (11)

- Chan Soon- Shiong Medical Center At Windber
- Grove City Hospital
- Moses Taylor Hospital
- St Luke's Hospital - Easton Campus
- St Luke's Miners Memorial Hospital
- St Luke's Hospital - Upper Bucks Campus
- UPMC Hanover
- Washington Health System Greene
- WellSpan Gettysburg Hospital
- Wellspan Waynesboro Hospital

2024 PA Low Volume Hospitals (11)

- Clarion Hospital
- Grove City Hospital
- Jennersville Hospital
- Penn Highlands Huntingdon
- Punxsutawney Area Hospital
- Washington Health System Greene
- Warren General Hospital
- Wayne Memorial Hospital
- UPMC Bedford Memorial
- UPMC Kane
- UPMC Somerset

Rural Referral Center (RRC) Qualifications

- RRC are awarded benefits for wage index reclassification, and DSH payments
- To qualify as an RRC a hospital
  - Be a rural hospital or treated as rural (through an urban to rural reclassification) and:
  - Have more than 275 beds

  or
  - Meet CMI, Discharge and other criteria surrounding medical staff
    - Must have more than 5,000 discharges (3,000 for an osteopathic hospital)
- CMS annually revises case mix index data to qualify:

Census Region	CMI Value
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

Census Region	CMI Value
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


Establishing
and
Maintaining
Access to
Essential
Medicines

Medicine Buffer Stock – Essential Medicines

In this rule, CMS is creating a separate payment under IPPS to account for the additional cost of establishing and maintaining 6-month buffer stocks of 86 essential medicines.

This change would begin with cost reporting periods starting in FY 2025 (on or after Oct. 1, 2024). The payment would cover only the additional resource costs of maintaining the buffer stock, not the cost of the drugs themselves.

The payment would be provided as either a lump sum upon cost report settlement or through biweekly payments that would be reconciled upon cost report settlement.

The program is not expected to be budget-neutral.

Medicine Buffer Stock – Essential Medicines

This payment would be available only to independent hospitals with 100 beds or fewer as defined by 412.105(b) on the cost report.

Independent hospital status would be determined by whether a hospital was identified as part of a chain organization on its cost report. (Cost report worksheet S-2, Part 1 lines 140-143)

CMS believes that these smaller, independent hospitals lack the resources available to larger hospitals or systems.

CMS estimates 500 hospitals would qualify and cost $2.8 million (Medicare would pay approximately 11 percent of that, or $300,000).

Advanced Regenerative Manufacturing Institute's (ARMI's) prioritized 86 essential medicines into a list that is critical for minimum patient care. This list is not permanent and it will be updated.

Medicine Buffer Stock – Essential Medicines

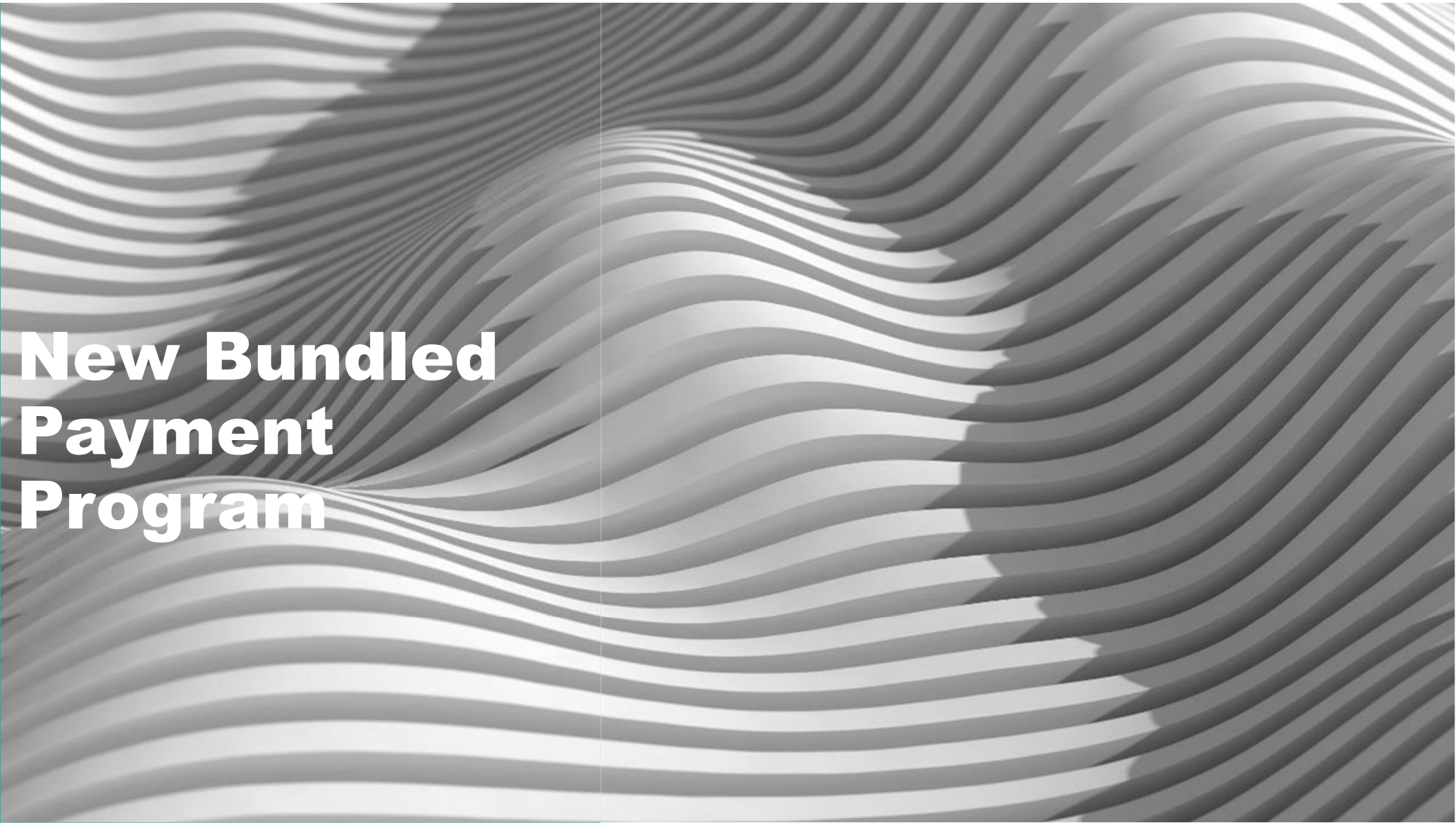
In response to concerns about hospitals hoarding essential medicines in the event of a shortage,

- CMS would not separately pay hospitals to establish a buffer stock for a drug that is currently in shortage, per the FDA Drug Shortages Database.
- Drugs listed as “Currently in Shortage” would not be eligible for a separate payment during the shortage.
- Because hospitals may lack the space, equipment and staff necessary to maintain the buffer stock themselves directly, any arrangements with pharmaceutical manufacturers, intermediaries or distributors to maintain the stock would be eligible for payment under this change.

Medicine Buffer Stock – Essential Medicines

Special Payment for Essential Medicines

- Contract arrangements with pharmaceutical manufacturers, intermediaries or distributors to maintain the stock would be eligible for payment under this change.
- Payment is only for the IPPS share of the costs of establishing and maintaining access to buffer stock(s) of one or more essential medicine(s).
  - IPPS Share = the percentage of inpatient Medicare costs to total hospital costs (Medicare estimates this to be 11% on average)


New Bundled
Payment
Program

Transforming Episode Accountability Model (TEAM)

- Five-year, mandatory, episode-based payment model based on geographic regions beginning January 1, 2026
  - 771 Hospitals, located in 186 different CBSA will be participating
- 30-day risk-bearing bundle from the date of the triggering procedure to 30 days post-procedure for five surgical episodes
  - Hospitals will continue to bill Medicare fee-for-service (FFS) but will receive a target price based on all non excluded Medicare Parts A & B items and services included in an episode
  - Target prices are based on regional data adjusted for certain hospital and patient-specific factors
  - Procedures:
    - Lower Extremity Joint Replacement
    - Surgical Hip Femur Fracture Treatment
    - Spinal Fusion
    - Coronary Artery Bypass Graft
    - Major Bowel Procedure
  - Hospital quality performance factors into payment and recoupment
    - Readmissions, patient safety, and patient-reported outcomes

Transforming Episode Accountability Model (TEAM)

- Hospitals may earn additional payments, subject to a quality performance adjustment if their spending is below the target price.
- Participants may owe CMS a repayment amount, subject to a quality performance adjustment, if their spending is above the target price.

Track 1	Track 2	Track 3
No downside risk and lower levels of reward for **Year 1** for all participants and up to three years for safety net hospitals	Lower levels of risk and reward for certain TEAM participants, such as safety net hospitals or rural hospitals**, for years two through five.	Higher levels of risk and reward for years one through five.
10% stop-gain limit (no loss)	10% stop-gain and stop-loss limit	Track 3: 20% stop-gain and stop-loss limit

- **Safety Net Hospitals, Rural Hospitals (including urban to rural reclassified hospitals), Rural Referral Center (RRC), Medicare Dependent Hospitals (MDH), Sole Community Hospitals (SCHs) or essential access community hospitals

Transforming Episode Accountability Model (TEAM)

CBSA
• Harrisburg-Carlisle, PA • Reading, PA • Erie, PA

Rural Hospitals:
• Edgewood Surgical Hospital • Geisinger Medical Center • Geisinger Lewiston Hospital • Geisinger St. Lukes • Grove City Hospital • Indiana Regional Medical Center • Leigh Valley Hospital-Schuylkill • Meadville Medical Center • Penn Highlands Dubois • Penn State Health St. Joseph • Sharon Regional Health • St. Luke's Miners Memorial Hospital • UPMC Horizon • UPMC Kane • UPMC Northwest • Warren General Hospital


New
technology
add-on
payments

New technology add-on payments

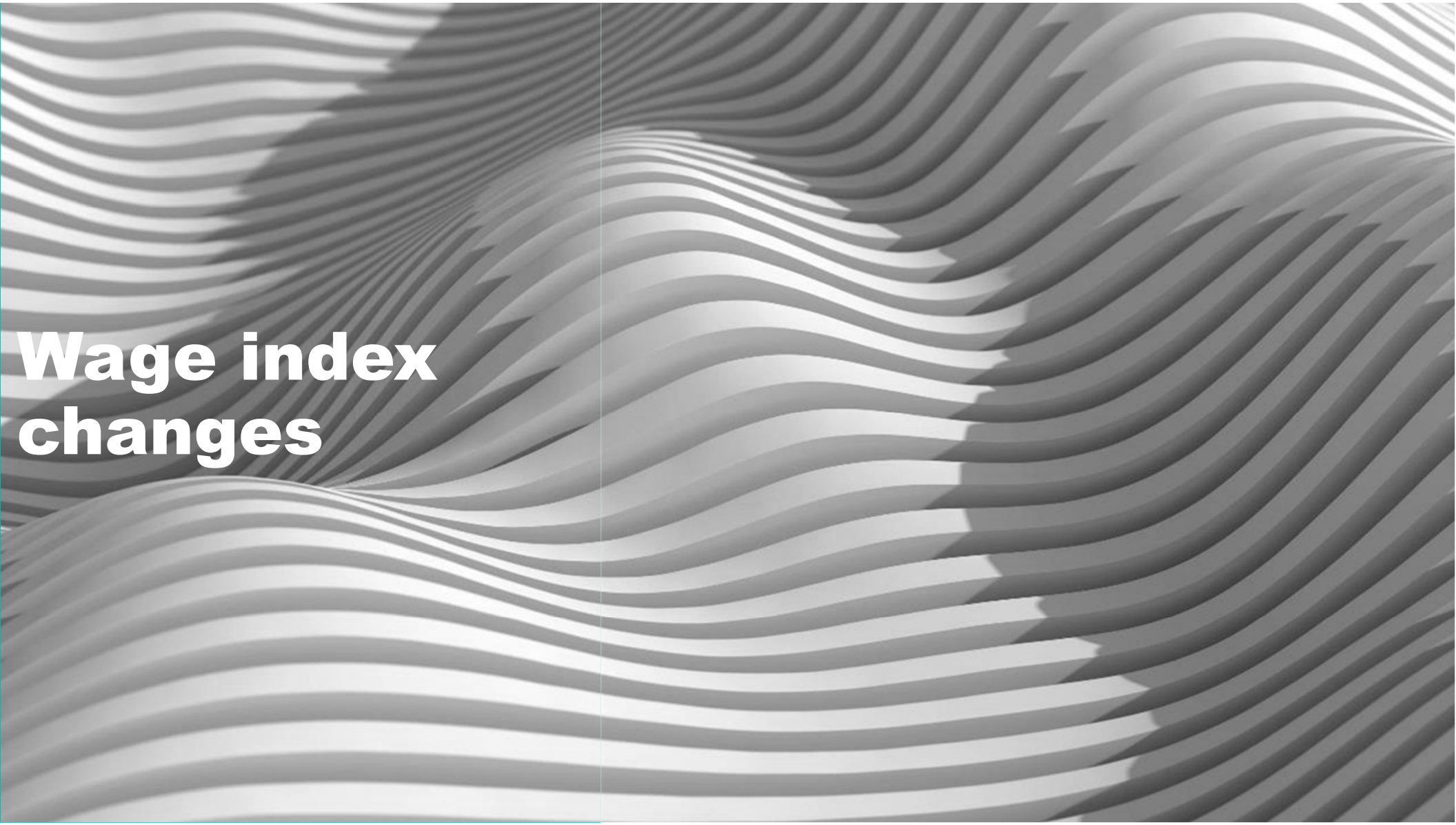
- Newness period to start October, 1 vs. April to determine whether a technology is within its newness period
  - Effective Federal Fiscal Year 2026 for new NTAP applicants and for extensions
- CMS finalized increasing the NTAP percentage from 65 percent to 75 percent of the estimated costs of the new technology for gene therapies indicated and used for the treatment of sickle cell disease beginning in FY 2025 and ending at the conclusion of the newness period of the therapy

New technology add-on payment

Medicare will make an add-on payment equal to the lesser of: (1) 75 percent of the costs of the

new medical service or technology; or (2) 75 percent of the amount by which the costs of the

case exceed the standard DRG payment.


Wage index
changes

Wage index updates – FFY 2025

- **CMS finalized to use updated delineations based on the 2023 bulletin No. 23-01 which is data derived from the 2020 Census**
  - Previously, CMS used OMB delineations from 2015 (2010 Census)
- FFY 2025 wage index will use FFY 2021 Cost Report data
  - 9/30/2021; 12/31/2021; 3/31/2022; 6/30/2022
- FFY 2025 wage index will use 2022 Occupational Mix Data
  - 2022 Occupational Mix Data will be used for the next 3 –years
  - 96% of hospitals submitted data
- Average hourly wage increases 9.2% over the prior year with final rule data
- 1,076 hospitals (32.5%) have approved wage index reclassifications for 2025
  - 87 hospitals cancelled reclassifications after the publication of the final rule

National occupational mix adjusted average hourly wage (AHW)						
	2025	**2024**	**2023**	**2022**	**2021**	**2020**
	$54.97	$50.34	$47.73	$46.47	$45.23	$44.15
Change over prior year ($)	$ 4.63	$ 2.61	$ 1.26	$ 1.24	$ 1.08	
Change over prior year (%)	9.20%	5.47%	2.71%	2.74%	2.45%	

Central Pennsylvania Wage Index Comparison

	2025 Wage Index	2025 Rural Floor	2024 Wage Index	2024 Rural Floor	Year Over Year Variance (%)
39: PENNSYLVANIA	0.9366		0.9211		1.68%
11020: Altoona, PA	0.9366	Y	0.9211	Y	1.68%
25420: Harrisburg-Carlisle, PA	0.9366	Y	0.9263		1.11%
29540: Lancaster, PA	0.9366	Y	0.9211	Y	1.68%
39740: Reading, PA	0.9366	Y	0.9211	Y	1.68%
48700: Williamsport, PA	0.9366	Y	0.9211	Y	1.68%
49620: York-Hanover, PA	0.9428		0.9713		(2.93%)
30140: Lebanon, PA	0.9795		1.0190		(3.88%)
23900: Gettysburg, PA	1.0020		1.0334		(3.04%
16540: Chambersburg, PA	1.0563		1.1070		(4.58%)
44300: State College, PA	1.1484		1.0083		13.89%

Impact of Update to 2020 Census

Can impact hospital in multiple ways

- Ability to qualify for grants
- Ability to qualify or maintain special provider type designations: Critical Access Hospital (CAH), Medicare Dependent Hospital (MDH)

53 urban counties became rural causing 33 hospitals that were previously urban to become rural

- No 3-year transition period as in years past because of the 5% Wage index Reduction cap in place.

17 counties became “Lugar” counties which are deemed to be urban for wage index

DSH payments to these new 33 rural hospitals could be affected depending on the bed size of the hospital

- Phase-down of any reduction in DSH payments over 3 years
  - 2/3 of the urban DSH adjustment and 1/3 of the rural adjustment in the first year; 1/3 of the urban DSH adjustment and 2/3 of the rural adjustment in the second year and 100 percent of the rural DSH adjustment in the third year

Impact of Update to 2020 Census

54 counties (and county equivalents) and 29 CAH hospitals that were previously located in rural areas would be in urban areas under the revised OMB delineations.

- Any Critical Access Hospitals (CAH) located in any of these counties will lose their CAH status unless they apply for an urban to rural reclassification within two years of the final rule
- Any MDH or SCH impacted by this change must apply for an urban to rural reclassification prior to **10/1/2024** to avoid any lapse in its special status
  - No two-year grace period like CAH

Urban hospitals may have moved from one urban CBSA to another based on the new OMB delineations that could be positive or negative

529 CBSAs in FFY 2025 vs. 522 CBSA in 2024 (Excluding Rural CBSA)

Impact of Update to 2020 Census: Reclassifications

- Urban Counties becoming Rural or Rural Counties becoming urban:
  - Will not terminate an existing MGCRB reclass of a hospital to its home CBSA.
  - If a hospital had a reclassification to an urban area that become rural, the reclassification would be terminated
- For hospitals that reclassified to a CBSA where one or more counties move to a different Urban CBSA
  - CMS determined the best alternate location for the remaining 3 –years of existing reclassification.
  - Uses the most proximate county that: (1) is located outside of the hospital's proposed FY 2025 geographic labor market area, and (2) is part of the original FY 2024 CBSA to which the hospital is reclassified.
  - Hospitals had options to submit alternatives to CMS

Impact of Update to 2020 Census: Reclassifications

- Hospitals that previously had multiple campuses in CBSA and are now located in the same CBSA of its main campus can no longer qualify for a sperate reclassification for its remote campus location
- Critical to review proposed rule wage index data annually even if your hospital has an approved MGCRB reclass to determine if withdrawing from a prior reclassification yielded a higher wage index
  - Hospitals have 45 days from when the display copy of proposed rule is released

OMB Impacts to Pennsylvania

- Urban Counties and CBSA that became rural
  - 14100 Bloomsburg-Berwick
  - Hospitals lost MGCRB wage reclass if there were reclassified to one of these two areas:
    - Evangelical Community Hospital
    - UPMC Williamsport
  - Multi-campus hospitals could also have been impacted
- Rural Counties that became urban
  - Lawerence County: Moved to Pittsburgh CBSA
  - Hospitals located in this county need to apply for urban to rural reclassification to maintain RRC, SCH, or MDH

Wage Index Case Study 2025

- Urban Hospital that is reclassified from urban to rural
- Hospital was previously reclassified to Columbus OH CBSA for FFY 2023-2025 period to avoid rural wage index.
  - In many cases, urban reclassified hospitals should be placing an annual reclassification application back to its home CBSA if it has another MGCRB application in place as a contingency plan.
    - It is critical to estimate the wage index upon the publishing of the Public Use Files (PUF) to determine future reclassification applications.
    - The hospital has 45 days from the proposed rule to withdraw a reclassification and reinstate the previously approved reclassification.
  - By failing to submitting an annual reclassification back to its geographic CBSA in 2025 and cancelling its reclass to Columbus, OH the hospital forfeited $3.7M of additional Inpatient Medicare reimbursement in 2025

	Reclassified Columbus, OH CBSA	Geographic CBSA
FFY 2025	0.9213	0.9935
FFY 2024	0.8894	0.8793
FFY 2023	0.9077	0.8970

- All hospitals should be reviewing annual reclassification applications, and not waiting for the next 3-year period

Wage Index Reduction Cap

- In the FFY 2023, CMS finalized its reduction cap permanently
- Caps reduction to wage index to 5% decrease from prior year final wage index regardless of circumstance
- No additional transition period for these hospitals negative impacted by the update to the 2020 census data
- 117 hospitals are capped at a 5% reduction in FFY 2025 that were not subject to the cap in FFY 2024

Low Wage Index Hospital Policy

- CMS finalized the low wage index hospital policy and the related budget neutrality adjustment would be effective for at least **three** more years, beginning in FFY 2025 through FFY 2027
  - CMS extended the previously adopted policy to increase the wage index values for certain hospitals with low wage index values

- The Court of Appeals for the D.C. Circuit ruled on July 23, 2024 that the Secretary lacked the authority to adopt the low wage index hospital policy for FY 2020. The court ruled that the policy and related budget neutrality adjustment must be vacated.
  - CMS has 90 days from the date of the decision to seek a review by the Supreme Court

Low wage index policy

In the FY 2020 IPPS final rule CMS adopted a low wage index disparity adjustment.

The adjustment increases hospitals wage index with values below the 25th percentile wage index. The increase is ½ the difference between a hospitals wage index and the 25th percentile wage index

CMS lost litigation on this issue in the Bridgeport Hospital v. Becerra in the US District Courts decision. A decision is still pending if CMS will further appeal

The 25th percentile wage index value for FY 2025 is finalized to be 0.9007 compared to .8667 of the prior year

Lugar Counties and Hospitals

- "Lugar" counties are rural areas that have a high number of residents that commute to the adjacent to an urban area for work
  - Lugar county hospitals are deemed to be located in an urban area
  - "Lugar" counties are assigned to the adjacent Urban CBSA for which their residents commute

- Outmigration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index.
  - A hospital can either be reclassified or receive the outmigration adjustment but not both
  - Hospitals need to analyze whether their wage index would be higher with the outmigration adjustment or paid as a Lugar hospital

- Waiving deemed urban status results in the Lugar hospital being treated as rural for all IPPS purposes.
  - Waiving deemed urban status can be done once for the 3-year period that the outmigration adjustment is effective
  - If a Lugar hospital waives its reclassification for 3 years, it must notify CMS to reinstate its Lugar status within 45 days of the IPPS proposed rule publication for the following fiscal year.

Wage index – rural floor

CMS counts 771 hospitals to receive the rural floor in FY 2025

- This increase requires an offsetting budget neutrality adjustment factor of 0.977499 (-2.25%) applied to hospital wage indexes. This compares to an adjustment 0.981185 (-1.88%) in FY 2024.
- New rural hospitals due to the update of the OMB Delineations are included in the rural floor calculation.

2024 IPPS Rule changed how urban to rural reclassified hospitals are treated in calculations

- Urban to rural reclassified hospitals § 412.103 are treated like a hospital that is physically located in the rural area.
  - Rather than being included in the group that reclassifies into the rural area when determining how to apply the regulatory hold harmless provision
- Urban to rural reclassified hospital with an MGCRB reclassification will be included in the group of hospitals reclassifying out of the rural area to determine whether the hold harmless policy applies
- Hospitals that reclassify across state lines to use the rural wage index in a different state would receive the combined wage index that includes the wage data for geographically rural hospitals and all hospitals reclassified into the rural area

Occupational Mix Updates

- CMS is using the calendar year 2022 Occupational Mix data to adjust the wage index starting in FFY 2025

National Category	2022 Survey	2019 Survey	Change ($)	Change (%)
RN	$60.40	$44.42	$15.98	35.97%
LPN & Surgical Technician	$35.02	$26.85	$8.16	30.39%
Nurse Aide	$23.58	$18.53	$5.00	26.98%
Medical Assistant	$23.12	$19.51	$3.60	18.45%
Nurse Category	$50.14	$37.35	$12.82	34.32%
Percent of Employees in Nursing Category	45%	42%	4%	9.52%


Medical
education
payment
changes

Impact of OMB Changes

New Program FTE Resident Cap Adjustments for Rural Hospitals redesignated as Urban

- If the hospital started training residents in a new program(s) prior to redesignation and is in its cap-building period for that program(s), the hospital can continue to build the program(s) and receive the permanent FTE cap adjustment until the end of its original 5-year period
  - Must have received a letter of accreditation for the new program(s) prior to being redesignated as urban.
- Once the cap building period is over for the new program(s) and while the hospital is determined to be urban it cannot longer receive additional cap adjustments.
- Will not lose the 30% cap increase to its base 1996 cap year

Urban Hospitals redesignated as Rural from new OMB Delineations

- Will be granted the ability to adjust its permanent FTE cap for both IME and DGME purposes
- Receive 30% increase in 1996 base year cap amount
  - Note: if the hospital previously, received the 30% increase (through reclassification), it is not increased further

Criteria for New Residency Programs

- CMS did **not** finalize the proposal: “for a program to be considered "new" and eligible for additional direct GME and/or Independent Medical Education (IME) cap slots, at least 90% of the individual resident trainees (not FTEs) within the program must lack previous training in the same specialty.”“
- CMS is initiating another request for information (RFI) particularly focused on GME topics
  - Defining “newness of residents”
  - Defining “newness of program directors and faculty”
  - Cap adjustments for providers that are urban-to-rural reclassified hospitals

Graduate medical education updates (GME)

Distribution of Slots Under Section 4122 of the Consolidated Appropriations Act of 2024 (CAA), 2023:

- Similar to the Section 126 expansion of 1,000 resident positions
  - Consistent with policies and regulations of Section 126, but must attest to meeting National Culturally and Linguistically Appropriate Services (CLAS) Standards in application
- 200 additional Medicare-funded Graduate Medical Education (GME) positions. Four categories of qualifying hospitals are eligible for awards:
  - rural hospitals or hospitals treated as rural,
  - hospitals that are over the GME cap,
  - hospitals in states with new medical schools or branch campuses,
  - hospitals that serve geographic Health Professional Shortage Areas (HPSAs)

Graduate medical education updates (GME)

At least half of the positions must go to psychiatry or psychiatry subspecialty programs

No hospital may receive more than 10 positions

CMS has a distribution methodology that would award all qualifying hospitals that submit timely applications to receive an award of up to one full-time employee (FTE) before any hospital is awarded two FTE

If slots remain, CMS will use the same HPSA distribution methodology that it finalized for the Section 126 distribution, meaning hospitals with the highest HPSA scores would receive prioritization. Awards through Section 4122 will be **effective July 1, 2026.**

Applications due March 31, 2025. Applications will open in the fall of 2025

Any awarded slots cannot be included in an affiliation agreement for 5-years


Proposed
Medicare
Outpatient
Prospective
Payment
System (OPPS)

Proposed CY 2025 Increase

- Proposed CY 2025 update
  - Commonly publicized rate increase by CMS beginning January 1, 2025 is a 3.0% increase less: (0.4%) adjustment for productivity with an increase of 2.6%
    - Update will align with the IPPS market basket increase of 2.9% at the final rule.
  - However, when you factor all the budget neutrality factors published in the final rule, the actual increase between Calendar Year 2025 and Calendar Year 2024 is: **2.3%**
    - Calendar Year 2025 Conversion Factor (Base Rate): $89.38
    - Calendar Year 2025 Conversion Factor (Base Rate): $87.38

Steps	Value applied	CF
2024 OPPS CF		87.382
Return PT and outliers (/)	(1-.01-.0027)	88.506
Wage Index (x)	1.0026	88.736
Wage Index cap (x)	0.9982	85.576
Cancer Hospital (x)	1.0006	88.630
Rural Hospital (x)	1.0000	88.630
Hospital Outpatient Update (x)	1.026	90.934
Remove PT and outliers (x)	(1-.01-.0071)	89.379
2025 OPPS CF		89.379

    - Hospitals and ASCs failing to meet the Hospital Outpatient Quality Reporting (OQR) Program reporting requirements will face an additional 2% reduction from the increase factor adjustment

Other OPPS Proposed Updates

- CMS proposed to update the ASC covered procedures list (CPL) by adding 20 medical and dental surgical procedures to the list
- CMS proposed no procedure removals from the inpatient only (IPO) list for CY 202
- CMS proposed to revise its current bundling policy for diagnostic radiopharmaceuticals to separately pay for high-cost radiopharmaceuticals with a per-day cost over a specific threshold.
- CMS proposed updates to the payment rates, coding and billing requirements for Partial Hospitalization Programs (PHPs) and Intensive Outpatient Programs (IOPs) furnished in HOPDs

Other Proposed Changes

- Payment policy for outpatient clinic visits in an excepted off-campus provider based department
  - HOPD services in excepted off-campus departments continues to be paid at 40% of the OPPS payment amount

- Invoice Drug pricing proposal for CY 2026
  - Increasing number of Drugs without ASP, wholesale acquisition cost, average wholesale price and MUC information available.
  - CMS would require providers to track and report a specific invoice amount for a drug in order to calculate payment based on provider invoices.
    - Tracking this information would be very burdensome due to frequent price changes
    - CMS would require rebates and reductions to be netted against the invoice cost
  - This exercise would require providers to essentially disclose their 340B acquisition costs

Rural Emergency Hospital Quality

- Rural Emergency Hospital (REH)
  - There are currently 19 REH facilities across the country
  - REH facilities must submit Quality Reporting measures

    (1) the Hospital Commitment to Health Equity (HCHE) measure beginning with the CY 2025 reporting period/CY 2027 program determination

    (2) the Screening for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination;

    (3) the Screen Positive Rate for Social Drivers of Health (SDOH) measure beginning with voluntary reporting in the CY 2025 reporting period followed by mandatory reporting beginning with the CY 2026 reporting period/CY 2028 program determination.

- REH's will be required to report on the first day of the quarter following the date that a hospital has been designated as converted to an REH.

Thank you

Keith Hutcheson, CPA,
Partner

M: +1 (817) 307 2087
E: keith.hutcheson@bakertilly.com

Brian Restivo, MBA, CHFP
Director

P: +1 (703) 923 8397
E: brian.restivo@bakertilly.com

Questions?

Appendix: Tables

BRO

4-Year IPPS increases Trend

FY	Market Basket Percentage	Productivity Adjustment	Documentation and Coding	Total Update Percentage
2022	2.7	-0.7	0.5	2.5
2023	4.1	-0.3	0.5	4.3
2024	3.3	-0.2	0	3.1
2025	3.4	-0.5	0	2.9

Note: All figures in this table are the final inpatinet updates for the applicable fiscal year.

Slide 60

BR0 Move to Appendix?
Restivo, Brian, 2024-09-11T16:05:44.148

BR0

Final rule – Labor and nonlabor rates

FY 2025

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)		
Labor-related	Nonlabor-related	Total
$ 4,466.00	$ 2,140.51	$ 6,606.51

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)		
Labor-related	Nonlabor-related	Total
$ 4,096.04	$ 2,510.47	$ 6,606.51

TABLE 1D. - CAPITAL STANDARD FEDERAL PAYMENT RATE

		Rate
National		510.51

FY 2024

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)		
Labor-related	Nonlabor-related	Total
$ 4,392.49	$ 2,105.28	$ 6,497.77

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)		
Labor-related	Nonlabor-related	Total
$ 4,028.62	$ 2,469.15	$ 6,497.77

TABLE 1D. - CAPITAL STANDARD FEDERAL PAYMENT RATE

		Rate
National		503.83

Slide 61

BR0 Move to appendix
Restivo, Brian, 2024-09-11T16:17:55.916

BR0 0 Updated 2024
Restivo, Brian, 2024-09-11T16:18:02.199