Annual Regulatory Update

FFY 2025 IPPS and CY 2025 OPPS Final Rule

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forvis mazars

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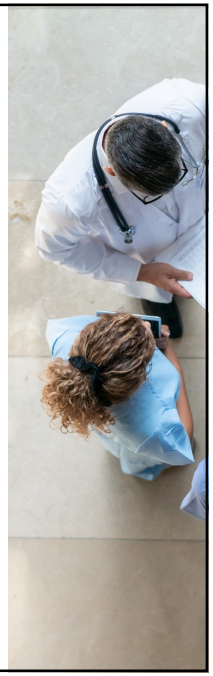
Payment Update Agenda

- FY 2025 Inpatient Prospective Payment System (IPPS)
- CY 2025 Outpatient Prospective Payment System (OPPS)



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Inadequate Inpatient Medicare Payment Update

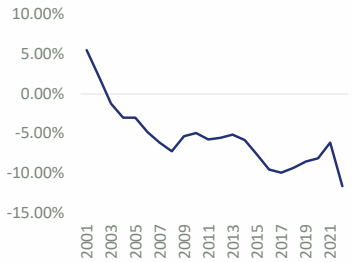
The 2025 IPPS payment update was less than hospitals' anticipated input price inflation, further exacerbating margin pressure.

Medicare IPPS Operating and Capital Rates
2024 Compared to 2025

	Final FFY 2024	Final FFY 2025	Percent* Change
Operating Rate	$6,498	$6,624	1.94%
Capital Rate	$504	$512	1.59%

*Percentage changes calculated net of productivity and budget neutrality adjustments.

MedPAC Average IPPS Hospital
Medicare Margin 2001 to 2022



Sources:
1) Comparison of 2025 IPPS Final Rule Tables 1A/B (operating) to 2024 IPPS Final Rule Tables 1A/B for hospitals that received the full market basket update.
2) Comparison of 2025 IPPS Final Rule Table 1D (capital) to 2024 IPPS Final Rule Table 1D.
3) IPPS Proposed Rule Comment Letter, California Hospital Association, June 10, 2024, page 5.

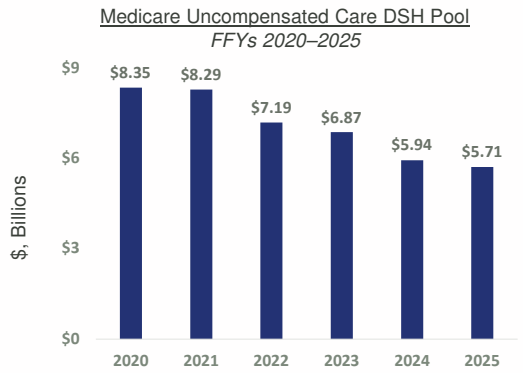
Outlier Payments for High-Cost Inpatient Cases

CMS makes outlier payments to hospitals as a stop-loss for high-cost cases.

- CMS targets outlier payments at 5.11%
- Current FFY 2024 threshold is **$42,750**
- Final fixed loss outlier threshold of **$46,217** for FFY 2025
- An increase in the threshold results in reduced outlier payments relative to FY 2024

Deep Uncompensated Care DSH Cuts

CMS has reduced Medicare uncompensated care DSH payments by 32% since 2020.



CMS' under-projection of uninsured rates has reduced payments to safety-net hospitals by **$2.6 billion** in 2025 compared to 2020.

Sources:
1) Analysis of FFY 2020–2025 IPPS Final Rules

Medicare Wage Index

CMS uses compensation data collected from hospitals to create an index that adjusts hospital payments for geographic differences in wages.

- **"Bottom Quartile" Policy**: Increases the wage index (and therefore payments) for hospitals in the bottom quartile of the wage index, at the expense of all PPS hospitals.
  - CMS extended the policy for another three years.
  - Policy subject to ongoing litigation.
- **Rural Floor**: Hospitals' wage index value may not be lower than a state's rural area value. In 2024, CMS included urban hospitals reclassified as rural in the rural floor calculation, which benefited some states at the expense of others.
  - CMS estimates 771 hospitals will receive their state's rural floor wage index value in FY 2025.
- **Update CBSAs**: CMS implemented updated definitions of labor markets which shifted some hospitals from urban to rural areas and vice versa.
  - Affected hospitals need to review certain add-on payments and/or special statuses to understand and mitigate the impact.
- **Downside Cap**: CMS continues the 5% cap on reductions to a hospital wage index for any reason.

Medicare Wage Index: "Bottom Quartile" Lawsuit

Hospitals negatively impacted by the bottom quartile policy have successfully challenged its legality in court.

Appeals court eliminates Medicare supplemental payments for low-wage hospitals

Plaintiff hospitals won litigation last week at the federal appellate level that will adversely affect Medicare payment for some rural hospitals.

The U.S. Court of Appeals for the D.C. Circuit backed a district court's decision that HHS acted unlawfully in 2019 when it issued regulations to increase payments for hospitals in the bottom quartile of the Medicare area wage index. Due to budget-neutrality requirements, the supplemental payment was funded by an across-the-board reduction in Medicare inpatient payments.

The appeals court went a step further than the district court, finding that the…

Source: https://www.hfma.org/accounting-and-financial-reporting/wage-index/appeals-court-eliminates-medicare-supplemental-payments-for-low-wage-hospitals/

Medicare Dependent Hospital (MDH): Status Expiring

MDH status expires for discharges occurring on or after January 1, 2025.

- **Eligible Hospitals**: MDHs are rural hospitals with 100 or fewer beds with Medicare patients responsible for at least 60% of admissions or patient days.
- **MDH Payment Adjustment**: Qualifying hospitals receive the IPPS payment rate plus 75% of the difference between the IPPS rate and their inflation adjusted cost from one of three base years.
- **Post-MDH Payment Rate**: MDHs would be paid the IPPS rate (unless qualifying for Sole Community Hospital (SCH) status).
- **Other Alternatives**: Qualifying MDHs may apply to receive payment as an SCH.
  - To receive SCH status effective January 1, 2025, the MDH must apply at least 30 days (by Dec. 2, 2024) before the expiration of the MDH program.

Low Volume Adjustment: Qualifying Criteria Changing

Qualifying criteria for the Low-Volume Adjustment becomes more stringent on January 1, 2025.

Low Volume Adjustment Qualifying Criteria & Payment Methodology

2019 –Current

Fiscal Year	Distance Criteria	Discharge Criteria	Payment Methodology
2019 through 2024 and 2025	> 15 miles	< = 500	25%
		> 500 < 3,800	0.25 - [0.25/3300] x (number of total discharges - 500) = (95/330) - (number of total discharges/13,200)
2025 discharges beginning 1/1/25 and subsequent years	>25 miles	< 200	25%

Source: 2025 IPPS Final Rule, display copy pg. 923

Graduate Medical Education – Additional Slots

CMS finalized distribution criteria for 200 new residency slots created by Congress.

- **Residency Program Requirements**: At least half of the residency slots must be allocated to psychiatry or psychiatric subspeciality training programs.
- **Allocation Criteria**: At least 10% of the slots must be allocated to:
  - Hospitals located in rural areas
  - Hospitals operating above residency caps
  - Hospitals in states with new medical schools
  - Hospitals that serve health professional shortage areas (HPSAs)
- **Key Dates**: Applications are due March 31, 2025; slots are effective July 1, 2026.

Establishing & Maintaining Access to Essential Medicines

Certain hospitals are eligible for separate payment for the cost of maintaining a stockpile of essential medicines.

- **Qualifying Hospitals**: Independent hospitals with 100 or fewer beds.
- **What's Covered**: Additional costs necessary to establish/maintain a six-month buffer stock of one or more of 86 essential medicines.
- **Payment Amount**: The Medicare "inpatient share" of the cost associated with establishing/maintaining the buffer stock.
- **When**: Available for cost reporting periods on or after October 1, 2024.

New Condition of Participation – Respiratory Infections

CMS establishes a new hospital condition of participation requiring hospitals and CAHs to report data on respiratory illnesses.

- **What**: Report a snapshot of:
  - Staffed bed capacity and occupancy (one day a week)
  - Hospitalization prevalence by respiratory illness and bed type (one day a week)
  - Total new hospital admissions by age range (weekly total)
- **When**: Beginning November 1, 2024
- **Where**: To CDC's NHSN or other CDC-owned or CDC-supported system, as determined by the Secretary.

Quality Program Changes

The final rule modifies the Inpatient Quality Reporting and Hospital Value Based Purchasing Programs.

Hospital Inpatient Quality Reporting Program Changes

- Adds seven new measures, removes five measures, modifies two measures.
- Modifies submission requirements for electronic clinical quality measures (eCQMs) and progressively increases the reporting requirements from 6 in CY 2025 to 11 in CY 2028.

Hospital Value-Based Purchasing Program

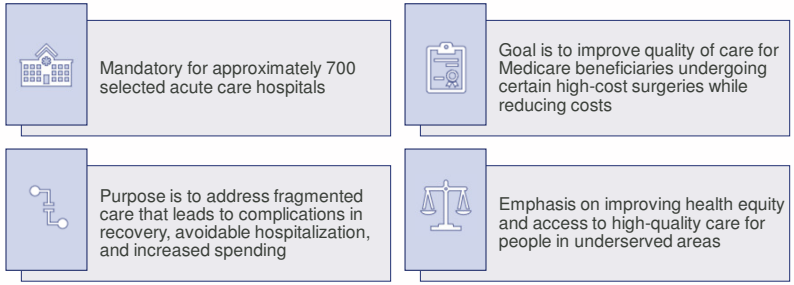
- Modifies scoring of HCAHPS measure to accommodate changes in instrument.

Hospital Readmissions Reduction & Hospital Acquired Conditions Programs

- No changes

Transforming Episode Accountability Model (TEAM)

Beginning in 2026 approximately 700 selected hospitals are required to participate in a mandatory bundled payment model with downside risk.



Transforming Episode Accountability Model (cont.)

The model is complex and places new regulatory requirements on participants.

Traditional Medicare FFS Duration: 1/1/2026 – 12/31/2030	Hospitals required to participate were selected based on geographic regions	Current BPCI-A & CJR participants can opt in to participation if their region was not selected	Inpatient stay + 30-day total cost of care episodes, incl. Parts A & B; revenue cycle undisrupted
Graduated risk through three participation tracks, with 0% downside risk moving up to 5% or 20% in subsequent years*	5 surgical episode groups (inpatient & outpatient settings)	Target prices will be set at the regional level for each DRG/HCPCS with additional adjustments	Patients attributed to a Medicare ACO are still included in TEAM
Quality measures will be linked to financial gains and losses	One financial reconciliation per model year	Participants are required to screen patients for health-related social needs (HRSN) and include referral to primary care in discharge planning	Gainsharing is allowed

Transforming Episode Accountability Model (cont.)

Selected rural hospitals are eligible to participate in a lower financial "risk track" of the model for its duration.

TEAM Risk Tracks by Performance Year

Risk Track	Performance Year (PY)	TEAM Participant Eligibility	Financial Risk
Track 1	PY 1	• All participants	• Upside only (10% stop-gain limit)
Track 1	PYs 1-3	• Safety net hospitals	• Upside only (10% stop-gain limit)
Track 2	PYs 2-5	• Safety net hospital • Rural hospital • Medicare Dependent Hospital • Sole Community Hospital • Essential Access Community Hospital	• Upside/downside risk (5% stop-gain/stop-loss limits)
Track 3	PYs 1-5	• All participants	• Upside/downside risk (20% stop-gain/stop-loss limits)

Source: 2025 IPPS Final Rule, display copy pg. 1822

FY 2025 IPPS

Transforming Episode Accountability Model (cont.)

While hospitals have approximately 16 months before the model starts, they should begin preparing now.

Fall 2024

Current State Assessment

Purpose: Determine your organization's current state in TEAM episodes and areas for improvement to develop an outlook of performance in the model.

TEAM Outlook

- Financial Projections
- Risk Adjustment/Stratification
- Care Setting Optimization
- Provider Alignment/Intelligence
- Discharge Planning
- Coordination of Care
- Outcomes Management
- Quality Measure Results
- Model Requirement Readiness

2025

Playbook Development

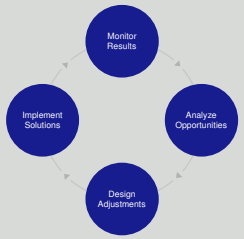
Purpose: Implement strategies to improve performance in areas identified in current state assessment and comply with model requirements.

- Financial Performance
- Model Requirements
- Clinical Transformation
- Optional Strategies

2026

Ongoing Monitoring

Purpose: Track performance and identify areas for improvement across the care continuum.



CY 2025 OPPS

OPPS Conversion Factor

The proposed OPPS conversion factor increases 2.29% over the prior year.

CY 2024 Final vs. CY 2025 Proposed
Outpatient Prospective Payment System Conversion Factor

Final CY 2024	Proposed CY 2025	Percent Change
$87.382	$89.379	+2.29%

*Percentage changes calculated net of productivity and budget neutrality adjustments.

Source: 2025 OPPS Proposed Rule, pg. 59224

Payment for Off-Campus Provider-Based Department Clinic Visits

CMS proposes continuing to pay 40% of the OPPS rate for basic clinic services in CY 2025.

- CMS' "site-neutral" clinic visit policy has the following exceptions:
  - Excepted off-campus PBDs belonging to rural sole community hospitals (SCHs)
  - Application of the Community Mental Health Center (CMHC) per diem rates for hospital partial hospitalization program (PHP) and intensive outpatient (IOP) services provided at an off-campus PBD, instead of the Medicare PFS rate for that service
  - Payment made for intensive cardiac rehabilitation (ICR) services

Sole Community Hospital Adjustment

CMS proposes to continue applying a 7.1% payment adjustment to all SCHs.

- Includes services and procedures paid under the OPPS, excluding:
  - Separately payable drugs and biologicals
  - Devices paid under the pass-through payment policy
  - Items paid at charges reduced to costs.
- Adjustment is budget-neutral and is applied before calculating outliers and copayments.
- CMS proposes to maintain this for future years until data supports a change to the adjustment.

Remote Services

CMS proposes a number of telehealth policies in response to the expiration of additional flexibilities legislated by Congress that expire at the end of the year.

- **Remote Mental Health Services**: In-person visit requirements will be reinstated after Dec. 31, 2024, unless Congress extends COVID public health emergency (PHE) waivers.
  - In-person visits are required six months prior to the administration of remote mental health services and annually thereafter.
- **Outpatient Therapy, Diabetes Self-Management Training (DSMT), & Medical Nutrition Therapy (MNT):** Waivers allowing institutional providers to continue to deliver remote outpatient physical therapy, occupational therapy, speech-language pathology, DSMT, and MNT in patients' homes via telehealth expire after Dec. 31, 2024.
- CMS intends to align its policies should Congress extend telehealth flexibilities in the year-end legislative package.

Virtual Direct Supervision

CMS proposes extending virtual direct supervision for CR, ICR, PR services, and diagnostic services through Dec. 31, 2025.

- Under current OPPS policy, cardiac, intensive cardiac, and pulmonary rehabilitation services (CR, ICR, and PR) must be provided under the direct supervision of a physician.
- During the COVID PHE, CMS allowed for direct supervision requirements to be met with the virtual presence (audio/video real-time communications technology) of the supervising physician, PA, NP, or CNS.
- CMS proposes extending the availability of virtual direct supervision for CR, ICR, PR services, and diagnostic services through Dec. 31, 2025, to align with policies proposed under the CY 2025 Physician Fee Schedule.

OPPS Outlier Threshold

CMS calculates a proposed CY 2025 outlier fixed-dollar threshold of $8,000

- This is an increase of approximately 3.2% compared to the current threshold of $7,750.
- CMS proposes to continue paying outpatient outlier cases at 50% of the amount by which the hospital's cost exceeds 1.75 times the APC payment amount when both the 1.75 multiplier threshold and the fixed-dollar threshold are met.
- Like prior years, CMS is targeting outlier payments to equal 1% of total OPPS payments.

Wage Index

Like prior years, CMS proposes using the final FFY 2025 IPPS post-reclassified wage index for the CY 2025 OPPS.

- Labor-related share remains at 60%.
- Proposes continuing the 5% cap on reductions to a hospital wage index for any reason to OPPS payments.
- For non-IPPS hospitals paid under the OPPS for 2025, CMS proposes continuing its past policies of assigning the wage index that would be applicable if the hospital were paid under the IPPS and allowing the hospital to qualify for the out-migration adjustment.
- Proposes to continue its "bottom quartile" wage index policy in a budget-neutral manner.

Payment for Drugs, Biologicals & Radiopharmaceuticals

Drugs, biologicals, and radiopharmaceuticals above the packaging threshold will continue to be paid at average sales price (ASP) plus 6%.

- Proposes a "standard drug" packaging threshold of $140.
- Proposes to pay separately for diagnostic radiopharmaceuticals and sets a packaging threshold of $630.
- Pass-through status will expire by December 31, 2024, for 25 drugs and biologicals by December 31, 2025, for 28 drugs and biologicals and is proposing to continue/establish pass-through status in CY 2025 for 57 drugs and biologicals.

Non-Opioid Treatment Alternatives

The CAA of 2023 directs CMS to provide separate payment beginning January 1, 2025 for non-opioid treatments for pain relief.

Proposed Products Qualifying for Separate Payment as Non-Opioid Pain Relief Products

Brand Name	HCPCS Code	Long Descriptor
Exparel	C9290	Injection, bupivacaine liposome, 1mg
Omidria	J1097	Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml
Dextenza	J1096	Dexamethasone, lacrimal ophthalmic insert, 0.1 mg
Xaracoll	C9089	Bupivacaine, collagen-matrix implant, 1 mg
Zynrelef	C9088	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg
Ketorolac tromethamine Injection	J1885	Injection, ketorolac tromethamine, per 15 mg
ON-Q Pump	C98X4	Elastomeric infusion pump, non-opioid pain management delivery system, including catheter and other system component(s)

Areas With No Significant Changes

The proposed rule does make significant changes to the following areas for CY 2025:

- Blood & Blood Products
- Composite APCs
- Adjustment to OPPS Payment for No Cost/Full Credit and Partial Credit Devices
- Device Intensive Procedures
- Brachytherapy Sources
- Universal Low-Volume Policy
- High-Cost/Low-Cost Skin Substitutes

Outpatient Quality Reporting Program

CMS proposes several changes to the Outpatient Quality Reporting Program.

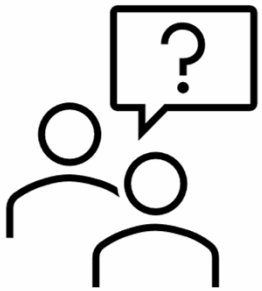
- Three health equity measures proposed across program settings
- OQR Proposals include:
  - Four new measures
  - Two measure removals
  - Public reporting of Median Time from ED Arrival to ED Departure for Discharged ED Patients (Psychiatric/Mental Health Patients Strata)
  - EHR certification for electronic clinical quality measures (eCQMs)
- Inpatient Quality Reporting Program
  - Modification of the Hybrid Hospital-Wide All-Cause Readmission and Mortality Measures

New Obstetrical Conditions of Participation

CMS proposes new and revised Medicare CoPs for hospitals and CAHs intended to improve maternal health outcomes.

Hospitals & CAHs That Offer OB Services	Hospitals & CAHs That Offer Emergency Services	All Hospitals
• New Obstetrical Services CoPs • Update to quality assessment & performance improvement (QAPI) CoPs to include OB-related activities	• Update to emergency services CoPs to include protocols, provisions, & training	• Update to discharge planning CoP to include transfer protocols

Questions



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