Medicare IPPS Final Rule Impact Analysis

Federal Fiscal Year 2025 | Version 1

Analysis Description

The federal fiscal year (FFY) 2025 Medicare inpatient prospective payment system (IPPS) final rule analysis is intended to show providers how Medicare inpatient fee-for-service (FFS) payments may change from FFY 2024 to FFY 2025, based on the policies set forth in the FFY 2025 IPPS final rule.

The analysis compares the final year-over-year change in operating, capital, and uncompensated care IPPS payments and includes breakout sections that provide detailed insight into specific policies that influence IPPS payment changes, including:

- impact of changes to index, including hospitals eligible for receiving the rural floor, the rural floor budget neutrality that is applied to wage indexes, and changes due to the adopted Core-Based Statistical Area (CBSA) delineation updates;
- impact of CMS' adjustment to the wage index of hospitals in bottom quartile of wage index values nationally to reduce wage disparities;
- year-over-year impact of CMS' 5% cap on wage index decreases from FFY 2024;
- quality-based payment adjustments;
- potential payment penalties under the Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) Incentive Programs; and
- Disproportionate Share Hospital (DSH) uncompensated care (UCC) payments.

Dollar impacts in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage (MA) patients (including Indirect Medical Education (IME) payments for MA patients), electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

FFY 2025 IPPS Final Rule Changes Modeled in This Analysis:

- Provider Type Changes: Changes to inpatient payments resulting from a change in provider type. This includes adjustments to both hospital specific rate (HSR) (if received) and changes to the traditional, rate-based DSH payment calculation for hospitals that change special status. A breakout for the transitional traditional DSH payment is provided for providers who's geographic CBSA changed from urban to rural and who are eligible.
- Change in Hospital Specific Rate Payment Status: Reflects the impact to special status hospitals (sole community hospitals (SCH), Medicare dependent hospitals (MDH), or essential access community hospitals (EACH)) where there is a change in payment status (hospital-specific vs federal).
- Market Basket Updates (Includes Budget Neutrality): 3.4% operating market basket increase and 2.6% capital input price index increase. Budget neutrality factors decrease the federal operating update by 1.11% and decrease the capital update by 1.65%. Impacts of the following budget neutrality adjustments are broken out separately: the 10% cap on reductions to Medicare Severity Diagnosis Related Group (MS-DRG) weights, the bottom quartile wage index policy, and the 5% cap on wage index decreases.
- Affordable Care Act (ACA) Mandated Market Basket Adjustment: -0.50 percentage point (PPT) productivity adjustment to the operating market basket authorized by the ACA of 2010.
- Forecast Error Adjustment: +0.5 PPT adjustment to the inpatient capital rate in order to address unanticipated price fluctuations that may result in differences between actual price increases and those forecasted to calculate the capital update factor.
- MS-DRG Weight 10% Reduction Cap Budget Neutrality: Budget neutrality adjustments of 0.999874 for operating rates and 0.9999 for capital rates due to the 10% cap on decreases of MS-DRG weights.
- Wage Index/Geographic Adjustment Factor (GAF) (Wage Data and Reclassifications): Updated wage index and capital GAF values, including any impact due to new wage data, reclassifications, other adjustments to the wage indexes, and changes in labor share. Impacts due to the changes in the rural floor budget neutrality factor and a provider's payment wage index are broken out for each hospital and includes:
    - removal of the FFY 2024 rural floor wage index budget neutrality adjustment of 0.978138 from the wage index of the hospital;
    - removal of the FFY 2024 rural floor adjusted wage index (if the hospital is eligible); change in the pre-rural floor wage index from FFY 2024 to FFY 2025;
    - the incorporation of the FFY 2025 rural floor adjusted wage index (if the hospital is eligible); and
    - applying the FFY 2025 rural floor wage index budget neutrality factor of 0.977499 to the rural floor-adjusted wage index of the hospital.

  Hospitals with a rural reclassification will see the impact of their wage index changing on the line "Change due to Wage Index and Labor Share (Prior to Rural Floor)".
- Wage Index/GAF (Other Changes): All other changes to the calculation of the wage index values of hospitals finalized for FFY 2025. These changes are broken out below the overall impact and include those impacts due to:

- the removal of the FFY 2024 5% stop loss cap for eligible hospitals whose FFY 2024 wage index that was less than 95% of what it was for FFY 2023 and the associated budget neutrality adjustments of 0.999645 for operating payments and 0.999567 for capital payments;
- the inclusion of the FFY 2025 5% stop loss and the associated budget neutrality adjustments of 0.997173 for operating payments and 0.997905 for capital payments;
- the removal of the FFY 2024 adjustment to the wage index for hospitals in the bottom quartile of the wage index nationally and associated budget neutrality adjustments of 0.997402 for operating payments and 0.996833 for capital payments; and
- the inclusion of the FFY 2025 updates to the wage index for hospitals in the bottom quartile of wage index values nationally and the associated budget neutrality adjustments of 0997157 for operating payments and 0.997894 for capital payments.

- DSH–UCC Payment Changes: Changes to UCC payments under the ACA-mandated DSH payment formula. In this analysis, DSH and UCC payment eligibility are held constant at the eligibility status predicted by CMS in its FFY 2025 final rule DSH supplemental file. Changes in hospital UCC payments that result from changes in the national UCC pool dollars are isolated to the list of DSH-eligible hospitals in the FFY 2025 final rule DSH supplemental file. These impacts also include year-to-year changes in hospital-specific UCC payment factors (Factor 3) for these hospitals, the impact of which is displayed separately.
- Change in Hospital Specific Rate: Reflects the impact where the value of the hospital-specific/federal blend for MDHs is changed due to a variation in uncompensated care payments. MDH status was extended through December 31, 2024 by the Consolidated Appropriations Act (CAA) of 2024, after which these providers would be paid based solely on the federal standard rate. To estimate the impact to MDH providers for FFY 2025, the add-on rate is divided by four before being added to the federal operating rate.
- MS-DRG Updates: Changes due to updates to the DRG groupings and weights.
- Quality-Based Payment Adjustments: Year-to-year change in hospital-specific quality performance and subsequent adjustments under the Value-Based Purchasing (VBP), Readmissions Reduction, and Hospital-Acquired Conditions (HAC) programs.
- Low Volume Hospital (LVH) Adjustment Changes: Reflects the change in overall payments made as a result of the LVH adjustment policy. The CAA of 2024 extended the LVH program through December 31, 2024, after which these providers would only receive a 25% adjustment if they have less than 200 total discharges (all payer) and are located more than 25 miles from another subsection (d) hospital. FFY 2024 factors are from the FFY 2024 IPPS final rule impact file and FFY 2025 factors are from the FFY 2025 IPPS final rule impact file. To estimate the impact to providers with a low volume adjustment rate for FFY 2025, the published adjustment is divided by four before being applied to the total operating and capital revenues.

The values shown in the impact table do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress through FFY 2032. The estimated sequestration reduction applicable to IPPS-specific payment for FFY 2025 has been calculated separately and is provided below the impact table.

Data Sources

Estimated FFYs 2024 and 2025 IPPS payments are calculated using individual hospital characteristics provided by CMS in its FFY 2025 IPPS final rule Impact File and DSH Supplemental files. These files are available on CMS' website at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page.

The inpatient federal operating and capital rates are from the FFY 2024 final rule correction notice and FFY 2025 final rule, as published in the *Federal Register*.

Medicare cases and case-mix indices are from the CMS FFY 2025 final rule Impact File. CMS used FFY 2023 claims data for FFY 2025 rate-setting. Thus, cases, case-mix indices, and transfer-adjusted cases utilized in the impact file result from running the FFY 2023 Medicare claims data through the DRG Grouper software program (Grouper Version 42 for FFY 2025) and assigning the respective MS-DRG weight.

Wage indexes are based upon information about hospitals' permanent and reclassified wage areas from CMS' FFY 2024 final (corrected) and FFY 2025 final rule impact files and the wage index tables released by CMS with the final rules.

For providers that have a published HSR in the FFY 2025 final rule Impact File but do not have an HSR in the FFY 2024 final rule Impact File, it is assumed an HSR determination was made after the publication of the final rule and is equal to their FFY 2025 HSR adjusted by 0.9740214 (removing the final FFY 2025 net HSR rate update of 2.60%).

DSH impact estimates are based on the Impact and DSH Supplemental files published with the final FFY 2024 (corrected) and final FFY 2025 IPPS rules. The DSH Supplemental file includes an indicator of DSH-eligible hospitals for FFY 2025, the national UCC pool dollars, and hospital-specific UCC factors/payment amounts.

The impacts of the quality-based payment adjustments are determined as follows:

- The FFY 2025 Readmission Reduction Program adjustment factors are from the FFY 2025 IPPS final rule impact file, which are proxies based on the FFY 2024 adjustment factors.

- The list of hospitals that could potentially be subject to the FFY 2025 HAC Reduction Program penalty is derived from hospital quality data available with the 1st quarter 2024 update of Care Compare (CMS does not provide this list with the rule).

- The FFY 2025 VBP adjustment factors are estimated based on hospital quality data available with the 1st quarter 2024 update of Care Compare (CMS' published FFY 2025 VBP proxy adjustment factors are based on a prior program year).

- For FFY 2024, VBP and RRP adjustment factors are from the FFY 2024 IPPS final rule and HAC flags are from the 4th quarter 2023 update of Care Compare.

This analysis measures the impact of IPPS policy changes only. Hospitals' provider types, volume, patient mix, factors used to calculate the traditional DSH and IME adjustments, and other factors used to estimate IPPS payments are held constant at the status/value published in the FFY 2025 final rule Impact and DSH Supplemental Files. For example, this analysis will not measure the impact to IME payments for a hospital that has increased the number of interns and residents from the previous year.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated by first estimating FFY 2024 payments. Estimated FFY 2024 payments reflect the wage index, labor-share, DSH, IME, and quality-adjusted federal payment amount (or hospital-specific for SCHs or blended payment amount for MDHs) multiplied by each hospital's appropriate cases, case-mix index, and low volume adjustment. Using estimated FFY 2024 payments, the adopted policy changes to the IPPS payment rates are applied. Then, the effect of the updated wage index values, MS-DRG groupings and weights, performance under the quality-based payment policies, and DSH policy changes are calculated by substituting FFY 2024 values with FFY 2025 values and calculating the incremental differences in payments. Percent changes by each component change are derived from the resulting changes in payment.

Each component change is applied sequentially in order to capture the compounded dollar impacts. For example, the change due to the market basket update is applied to estimated FFY 2024 payments. Then, the change to the ACA-mandated market basket reduction is applied to the dollar result of the first change. This method continues for the remaining changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. Due to the influence of the DSH uncompensated care pool, which is not tied to the inpatient rate, percentage impacts may not tie to the values listed for component updates (i.e. market basket, ACA, etc.).

Individual percentages and dollars shown in this analysis may not add to total, due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros, due to rounding.

Hospitals with Special Status

MDH/SCH status and federal/hospital-specific payment determinations for MDH/SCHs are based on the status predicted by CMS in its corrected FFY 2024 final and FFY 2025 final rule Impact and DSH Supplemental files. If the hospital-specific payment rate is more beneficial than the adjusted federal rate (after wage index, DSH, IME, and transfer adjustments), payments based on the hospital-specific rate are used in this analysis.

This analysis does not factor in the impact of outlier payments (facilities paid at the hospital-specific rate are not eligible for outlier payments). In some cases, the inclusion of outlier payments may make the difference as to whether the federal or the hospital-specific rate is more beneficial.

For SCHs, if the hospital-specific rate is more beneficial, these hospitals are paid at 100% of the hospital-specific rate. For MDHs, if the hospital-specific rate is more beneficial, these hospitals are paid at a blend of 75% of the hospital-specific rate and 25% of the federal rate. MDH status was extended through December 31, 2024 by the CAA of 2023, after which these providers will be paid based solely on the federal standard rate. Revenue shown in this analysis for FFY 2025 accounts for only one quarter of the additional revenue the hospital will receive if the policy were to be in effect for the whole year.