National Rural Health Association

Fiscal Year (FY) 2025 Inpatient Prospective Payment System final rule

The Centers for Medicare and Medicaid Services (CMS) recently released its FY 2025 Inpatient Prospective Payment System (IPPS) final rule. Please find CMS' fact sheet here and NRHA's summary of major rural relevant provisions below. For reference, please find our comments on the proposed rule here.

If you have any questions or concerns, contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Key provisions include:

Payment update. CMS finalized a **2.9% payment increase** over FY 2024 for all hospitals. Rural hospitals will see a payment increase closer to 2.6%. Additionally, rural hospitals will see about **$331 million in uncompensated care payments** which is $4 million less than in FY 2024.

Low wage index. In the FY 2020 IPPS rule, CMS finalized the low wage index policy that increases wage index values for hospitals below the 25th percentile wage index value for a fiscal year. These hospitals receive an increase of half the difference between the otherwise applicable final wage index for the year and the 25th percentile wage index value for the year across all hospitals.

CMS proposed to continue this policy for at least 3 more years and is finalizing this policy as proposed. However, on July 23, the D.C. Court of Appeals issued a decision in the *Bridgeport Hospital v. Becerra* case, vacating the low wage index policy by reasoning that CMS lacked the authority to implement it. CMS notes in the final rule that the window for appealing this decision is still open and is evaluating next steps.

For FY 2025, the 25th percentile wage index value across all hospitals is 0.9007.

Extension of MDH designation and LVH adjustment. The Consolidated Appropriations Act (CAA), 2024, passed in March, extended the Medicare-Dependent Hospital (MDH) and Low Volume Hospital (LVH) adjustment through December 31, 2024. As such, CMS is implementing this extension.

Without a congressional extension, the MDH program and LVH payment adjustment will expire. Note that MDHs can apply for sole community hospital (SCH) status but must do so **by December 2, 2024,** in order to gain SCH status by January 1, 2025.

GME.

Section 4122 slots. Section 4122 of the CAA, 2023 created 200 new Medicare Graduate Medical Education (GME) slots ("Section 4122 slots") that will be effective July 1, 2026. In this rule, CMS is finalizing its distribution policy for these slots. CMS is required by statute to distribute half of the slots to psychiatry or psychiatry subspecialty programs and ensure that at least 10% of slots go to the following categories: rural hospitals (including those reclassified as rural); hospitals training over their Medicare GME cap; hospitals in a state with a new medical school or branch campus as of 2000; and hospitals serving a geographic health professional shortage area (HPSA). The statute also requires that CMS take into account the hospital's demonstrated likelihood of filling the new slots. CMS interpreted this requirement to mean that the hospital (1) is training over its current FTE cap, is not a rural hospital eligible for a cap increase, and plans to use additional slots as part of a new residency program OR (2) is training over its FTE cap and intends to use new slots to expand an existing residency program within 5 years.

Section 4122 also requires that CMS distribute slots on a pro rata basis. CMS interpreted the pro rata distribution to mean that every qualifying hospital that applies for slots will receive up to 1 slot, or at least a fraction of a slot. Each hospital will receive the same amount. If any slots are left over (i.e., less than 200 hospitals apply), CMS will prioritize allocating the remaining slots to hospitals based upon their HPSA score.

The deadline to apply for new slots will be March 31, 2025. CMS noted in the final rule that they will engage in outreach to rural hospitals to ensure geographically rural hospitals apply and receive slots. The format and information required in an application can be found in the final rule.

Section 126 slots. Section 126 of the CAA, 2021 created 1,000 new GME slots. CMS has allocated 400 slots through two rounds of distribution so far. Section 126 mandated that 10% of slots go to the same four categories as above and CMS chose to prioritize applications based on HPSA scores. CMS stated in the proposed rule that it is not on track to distribute 10% to the HPSA category. Now CMS is finalizing a revised distribution method to ensure hospitals in HPSAs get at least 10% of Section 126 slots. For the fourth and fifth rounds of distribution, CMS will prioritize hospitals in a HPSA, regardless of the HPSA score.

New residency program reuqirements. CMS proposed a new standard for defining whether residents are considered "new" for purposes of determining whether a new residency program is new. CMS is not finalizing this proposal. CMS also issued requests for information around other elements of residency program "newness" and states that it will take them into consideration for future rulemaking.

TEAM model. The Transforming Episode Accountability Model (TEAM) is a mandatory episode-based alternate payment model that CMS finalized in the rule. The model will run from January 1, 2026, to December 31, 2030. Certain core-based statistical areas (CBSAs), which include metropolitan and micropolitan statistical areas, were chosen and all hospitals in the CBSAs paid under IPPS are required to participate. CMS is using stratified random sampling to select CBSAs and ensure a variety of geographic and hospital characteristics are represented in the model. **Table X.A.-07 in the proposed rule lists the mandatory CBSAs selected for participation in TEAM.**

TEAM is an episode-based payment model that would make hospitals accountable for care coordination following certain episodes. The five general surgical episodes CMS chose are Coronary Artery Bypass Grafting (CABG), Lower Extremity Joint Replacement (LEJR), Surgical Hip and Femur Fracture Treatment (SHFFT), Spinal Fusion and Major Bowel Procedure. Each episode is triggered by an "anchor" acute care hospital stay or outpatient procedure and continues for 30 days after discharge from anchor hospitalization or procedure.

CMS finalized a three-track glide path to financial risk for participant hospitals:

TRACK	Eligible hospitals	Risk
Track 1	All hospitals in performance year (PY) 1 Safety net hospitals during PYs 1-3	Upside only (up to 10% of the target price)
Track 2	Rural hospitals, MDHs, SCHs, and safety net hospitals during PYs 2-5	Two-sided risk (up to 5% stop-gain/stop-loss limits until PY 4, up to 10% in PY 5)

Track 3	All hospitals in PYs 1-5	Two-sided risk (up to 20% stop-gain/stop-loss limits)

CMS is defining safety net hospitals as those that exceed the 75th percentile of dually eligible beneficiaries across all acute care hospitals in the baseline period **OR** exceed the 75th percentile of beneficiaries partially or fully eligible for Part D Low-Income Subsidy across all acute care hospitals in baseline period.

Find more information on the model on the TEAM webpage.