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Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2025 Changes

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Implementation Date: October 7, 2024
Related CR Transmittal Number: R12805CP
Related CR Title: Fiscal Year (FY) 2025 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

Affected Providers

- Hospitals
- LTCHs

Action Needed

Make sure your billing staff knows about these changes:

- FY 2025 IPPS updates
- FY 2025 LTCH PPS updates
- Updates to certain hospitals that CMS excludes from the IPPS

Background

The following policy changes for FY 2025 went on display on August 1, 2024, and appeared in the **Federal Register** on August 28, 2024. All items covered in this Article are effective for hospital discharges occurring on or after October 1, 2024 - September 30, 2025, unless otherwise noted.

CMS is releasing new IPPS and LTCH PPS Pricer software packages that include the updated rates, factors, and policies for FY 2025.

The FY 2025 Final Rule webpage has the FY 2025 Final Rule Data Files, FY 2025 Final Rule Tables, and FY 2025 MAC Implementation Files referenced in this Article. Medicare Administrative Contractors (MACs) will use these files, unless otherwise specified.

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IPPS FY 2025 Update

A. FY 2025 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, see Tables 1A-D. For other IPPS factors, including applicable percentage increase, budget neutrality factors, high cost outlier (HCO) threshold, and cost-of-living adjustment (COLA) factors, see MAC Implementation File 1.

B. FY 2025 Puerto Rico Hospital Update Under the IPPS

Section 1886(n)(6)(B) of the Social Security Act (the Act) specifies that the adjustments to the applicable percentage increase under Section 1886(b)(3)(B)(ix) of the Act apply to subsection (d) Puerto Rico hospitals that aren't meaningful electronic health record (EHR) users, effective starting FY 2022. Accordingly, for FY 2022 and subsequent fiscal years, any subsection (d) Puerto Rico hospital that isn't a meaningful EHR user as defined in Section 1886(n)(3) of the Act and not subject to an exception under section 1886(b)(3)(B)(ix) of the Act will have a reduction applied to the applicable percentage increase.

For the applicable operating standardized amount and corresponding update factor for hospitals in Puerto Rico, see to Table 1C of the FY 2025 IPPS/LTCH PPS Final Rule.

C. Medicare Severity - Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The GROUPER assigns each case into an MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 42.0 uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2024.

For discharges occurring on or after October 1, 2024, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date.

For discharges occurring on or after October 1, 2024, the MCE selects the proper internal code edit tables based on discharge date

CMS deleted 3 MS-DRGs and increased the number of MS-DRGs by 12, for a total of 775 for FY 2025.

The ICD-10 MS-DRG V42.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V42 manual located on the MS-DRG Classifications and Software webpage shows the complete documentation of the GROUPER logic for the FY 2025 ICD-10 MS-DRGs and Medicare Code Edits. See MAC Implementation File 6 for the complete list of new MS-DRGs for FY 2025.

D. Replaced Devices Offered without Cost or with a Credit

We reduce a hospital's IPPS payment for specified MS-DRGs when the implantation of a device is replaced without cost or with a credit equal to 50% or more of the cost of the replacement device. We add new MS-DRGs to the list subject to this policy for payment under the IPPS for replaced devices offered without cost or with a credit when they are formed from procedures previously assigned to MS-DRGs already on the list. See MAC Implementation File 7 for the complete list of MS-DRGs covered under the Replaced Devices Offered without Cost or with a Credit in FY 2025.

E. Post-acute Transfer and Special Payment Policy

We evaluated the changes to MS-DRGs for FY 2025 against the general post-acute care transfer policy criteria using the FY 2022 MedPAR data per 42 CFR 412.4 (c). As a result, we added new MS–DRGs 426, 427, 428, 447 and 448 to the list of MS-DRGs subject to the post-acute care transfer policy and the special payment policy. We're deleting MS-DRGs 459 and 460, currently subject to the post-acute care transfer policy, and renumbering them as MS-DRGs 450 and 451. As a result of this review, MS-DRGs 450 and 451 won't be subject to the post-acute care transfer policy. See Table 5 of the FY 2025 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2025 Final Rule Tables webpage.

F. New Technology Add-On Payment Policy

For FY 2025, 24 technologies continue to be eligible for new technology add-on payments, and 15 new applications are eligible for new technology add-on payments. For more information on FY 2025 new technology add-on payments, specifically regarding the technologies either continuing to receive payments or starting to receive payments, see MAC Implementation File 8 available. MAC Implementation File 8 also includes information regarding technologies no longer eligible to get new technology add-on payments.

G. FY 2025 Labor Related Share Percentage

There are no changes to the labor-related share percentages under the IPPS for FY 2025.

H. Cost of Living Adjustment (COLA) for Hospitals Paid Under the IPPS

There are no changes to the COLA factors for FY 2025.

I. Updating MAC Provider Specific Files (PSF) for Wage Index, Reclassifications and Redesignations and Wage Index Changes and Issues

Your MAC will update its the PSF to include changes dues to the FY 2025 final rule.

Effective October 1, 2024, CMS is revising the labor market areas used under the IPPS,

including for the wage index, based on the most recent labor market area delineations issued by the Office of Management and Budget (OMB) to reflect the changes made in the July 15, 2023, OMB Bulletin 23–01. The MACs will make sure that the Core Based Statistical Area (CBSA) are assigned properly for all IPPS hospitals.

For hospitals located in rural counties that are deemed Lugar counties on Table 4B (that is, counties redesignated under section 1886(d)(8)(B) of the Act), the MACs will make sure that a hospital's Lugar status is applied appropriately.

For FY 2025, the following policies will apply to the wage index:

- Increase the wage index values for hospitals with a wage index value below the 25th percentile wage index value for FY 2025 across all hospitals. See MAC Implementation File 1 for the 25th percentile wage index value for FY 2025.
- Apply a 5% cap for FY 2025 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2024.
- Effective starting FY 2024, wage data from hospitals with dual 42 CFR 412.103 rural reclassifications and Medicare Geographic Classification Review Board (MGCRB) reclassifications will be included in rural wage index calculations.

J. Multicampus Hospitals

We allocate the wages and hours to the CBSA in which a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. We base Medicare payment to a hospital on the geographic location of the hospital facility at which the discharge occurred. If a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CCN of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers.

K. Treatment of Hospitals Redesignated Under Section 1886(d)(8)(B) of the Act (Lugar Hospitals) Other Than for Wage Index Purposes

Effective October 1, 2024, we're revising the labor market areas used for the wage index based on the most recent labor market area delineations in OMB Bulletin 23–01. These changes include revisions to the list of counties deemed urban under Section 1886(d)(8)(B) of the Act. The following changes to the current "Lugar" county list are adopted effective October 1, 2024:

- 17 urban counties will become rural under the adoption of the revised OMB delineations, and both newly created rural Connecticut planning region county-equivalents will qualify as "Lugar" counties.
- 33 rural counties will lose "Lugar" status, as the county no longer meets the commuting thresholds or adjacency criteria specified in Section 1886(d)(8)(B) of the Act.

- 22 rural counties will change to urban, under the revised OMB delineations and will no longer qualify as “Lugar” counties. Hospitals located within these counties will be considered geographically urban under the revised OMB delineations.

Table 4B of MAC Implementation File 4 lists all “Lugar” counties for FY 2025. MAC Implementation File 4 also lists the counties no longer be deemed urban under Section 1886(d)(8)(B) of the Act effective October 1, 2024.

“Lugar” counties that are deemed urban are listed on Table 4B of each fiscal year’s IPPS final rule (or correcting document, as applicable). Hospitals located in a “Lugar” county with active 412.103 reclassifications are considered rural for IPPS payment purposes that are dependent on urban/rural status. Also, hospitals that waive “Lugar” status to receive the out-migration adjustment are considered rural for IPPS payment purposes that are dependent on urban/rural status. For a list of hospitals that waived “Lugar” status for FY 2025, see MAC Implementation File 5. (Note, the list of hospitals that waived “Lugar” status can change each Fiscal Year.)

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2025

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through December 31, 2024.

For FY 2025, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2024, in order for the applicable low-volume payment adjustment to be applied to payments for its discharges occurring on or after October 1 - December 31, 2024.

If a hospital’s written request for low-volume hospital status for the portion of FY 2025 starting October 1, 2024 - December 31, 2024 is received after September 1, 2024, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC would apply the low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2025 discharges starting October 1, 2024 - December 31, 2024, effective prospectively within 30 days of the date of the MAC’s low-volume hospital status determination.

Also, a hospital must also submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital continues to meet the applicable mileage and discharge criteria for the portion of FY 2025 starting on January 1, 2025 - September 30, 2025 (as described earlier). Specifically, for the portion of FY 2025 starting on January 1, 2025, a hospital must make a written request for low-volume hospital status that’s received by its MAC no later than December 1, 2024, in order for the 25%, low-volume, add-on payment adjustment to be applied to payments for its discharges starting on or after January 1, 2025. If a hospital’s written request for low-volume hospital status for the portion of FY 2025 starting on January 1, 2025 is received after December 1, 2024, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC would apply the low-volume hospital payment adjustment to determine the payment for the hospital’s FY 2025

discharges on or after January 1, 2025, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

A hospital may choose to make a single written request for low-volume hospital status to its MAC for both the portion of FY 2025 starting on October 1, 2024 and ending December 31, 2024 and the portion of FY 2025 starting on January 1, 2025 - September 30, 2024 by the September 1, 2024 deadline discussed previously. Alternatively, a hospital may choose to submit separate written requests, one for the portion of FY 2025 starting on October 1, 2024 and ending on December 31, 2024 (by the September 1, 2024 deadline discussed previously), and another for the portion of FY 2025 starting on January 1, 2025 - September 30, 2025 (by the December 1, 2024 deadline discussed previously).

M. Medicare-Dependent, Small Rural Hospital (MDH) Program Expiration

The special payment provisions provided to a Medicare dependent small rural hospital (MDH) aren't authorized by statute beyond CY 2024. Starting January 1, 2025, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate.

N. Medicare Advantage (MA) Nursing and Allied Health (NAH) Education Payments – Rates for CYs 2020, 2021 and 2022

Under 42 CFR 413.87, hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs and treat Medicare Advantage enrollees receive additional payments. Determining a hospital's NAH MA payment essentially involves applying a ratio of the hospital-specific NAH Part A payments, total inpatient days, and MA inpatient days, to national totals of those same amounts, from cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year. The formula is as follows:

((Hospital NAH pass-through payment / Hospital Part A Inpatient Days) * Hospital MA Inpatient Days) / ((National NAH pass-through payment / National Part A Inpatient Days) * National MA Inpatient Days)) * Current Year Payment Pool.

In the FY 2025 IPPS/LTCH PPS final rule, we published the final national rates and percentages, and their data sources for CY 2023.

O. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed on the CMS QualityNet.

P. Hospital-Acquired Condition (HAC) Reduction Program

We expect to issue the final list of hospitals that are subject to the HAC Reduction Program for FY 2025 to MACs in mid-September 2024.

Q. Hospital Value-Based Purchasing (VBP) Program

For FY 2025, we're implementing the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2025. We expect to post the final value-based incentive payment adjustment factors for FY 2025 in the near future in Table 16B of the FY 2025 IPPS/LTCH PPS final rule.

R. Hospital Readmissions Reduction Program (HRRP)

We expect to post the HRRP payment adjustment factors for FY 2025 in mid-September 2024 in Table 15 of the FY 2025 IPPS/LTCH PPS final rule.

S. Medicare Disproportionate Share Hospitals (DSH) Program

1. Medicare DSH Payment Adjustment Implementation of New OMB Labor Market Delineations

The hospitals located in urban counties that are becoming rural under our adoption of the new OMB delineations are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural, it would be subject to a DSH payment adjustment cap of 12%. Under the transition, per the regulations at 42 CFR 412.102, for the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one-third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. This adjustment will be determined at cost report settlement. In determining the claim payment, the PRICER will only apply the DSH payment adjustment based on its urban/rural status according to the redesignation.

2. Uncompensated Care Payments

In the FY 2025 IPPS/LTCH PPS Final Rule, we finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. Interim uncompensated care payments will continue to be paid on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2025. The estimate Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2025, which is available via the Internet on the FY 2025 Final Rule Data Files webpage.

3. Hospitals without prospective FY 2025 Factor 3 calculation (New Hospitals, Uncompensated Care Trim and Newly Merged Hospitals)

For FY 2025, new hospitals for uncompensated care payment purposes, that is, hospitals with CCNs established after October 1, 2021, determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2025 cost report, as reported on Line 30 of Worksheet S-10 (annualized, if needed) as the numerator. The denominator used for this calculation is in the FY 2025 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, Factor 3 is multiplied by a scaling factor and multiplied by the total uncompensated care payment amount finalized in the FY 2025 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement.

For new hospitals, newly merged hospitals, and hospitals subject to the Uncompensated Care Data Trim, the MAC shall apply a scaling factor for the Factor 3 calculation, if the hospital is determined DSH eligible at cost report settlement. The scaling factor used for the calculation is in the FY 2025 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description or in the MAC Implementation File 1 available on the FY 2025 MAC Implementation Files webpage.

In the FY 2025 final rule, we continued an additional Uncompensated Care Data Trim for hospitals that weren't projected DSH eligible for purposes of interim uncompensated care payments. Similar to new hospitals, the hospitals impacted by this new trim, don't have a Factor 3 listed in the FY 2025 Medicare DSH Supplemental File.

For FY 2025, newly merged hospitals, for example, hospitals that have a merger during FY 2025 or mergers not known at the time of development of the final rule, will have their interim uncompensated care payments reconciled at cost report settlement by the MAC.

4. Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

For FY 2025, CMS used a 2-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount, is divided by the hospital's historical 2-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that is used to make interim uncompensated care payments to each projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

Under this policy, if a hospital submits a request to its MAC, for a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the starting of the Federal fiscal year and/or once during the Federal fiscal year, then the MAC will review the

request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10% or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if the per discharge amount were not lowered. Examples include, but are not limited to, the following:

1. A request showing a large projected increase in discharges during the fiscal year to support reduction of its per discharge uncompensated care payment amount
2. A request that its per discharge uncompensated care payment amount be reduced to 0 midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital

Your MAC will evaluate the request for strictly reducing the per discharge uncompensated payment amount and the supporting documentation before the starting of the Federal fiscal year and/or with midyear request when the 3-year average of discharges is lower than hospital's projected FY 2025 discharges. If following review of the request and the supporting documentation, the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to lower the per discharge amount either to the amount requested by the hospital or another amount the MAC determines appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request doesn't change how the total uncompensated care payment amount shall be reconciled at cost report settlement. The interim uncompensated care payments made to the hospital during the fiscal year are still reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal fiscal year.

T. Supplemental Payment for Indian Health Service and Tribal hospitals and hospitals located in Puerto Rico

For the supplemental payment for IHS and Tribal hospitals and hospitals located in Puerto Rico, we based eligibility to receive interim supplemental payments on a projection of DSH eligibility for the applicable fiscal year. The DSH Supplemental Data File includes the combined interim uncompensated care payment and interim supplemental payment.

Your MAC will make a final determination with respect to a hospital's eligibility to receive the supplemental payment for a fiscal year, in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that fiscal year. If a hospital is determined not to be DSH eligible for a fiscal year, then the hospital wouldn't be eligible to receive a supplemental payment for that fiscal year.

The MAC will reconcile the interim supplemental payments at cost report settlement to ensure that the DSH eligible hospital receives the full amount of the supplemental payment that was determined prior to the start of the fiscal year. Projected DSH eligible hospitals have a total supplemental payment available in the Medicare DSH Supplemental Data File.

Consistent with the process used for uncompensated care payments cost reporting periods that span multiple Federal fiscal years, a pro rata supplemental payment calculation must be made if the hospital's cost reporting period differs from the Federal fiscal year. Thus, the final supplemental payment amounts to be included on a cost report spanning 2 Federal fiscal years are the pro rata share of the supplemental payment associated with each Federal fiscal year. This pro rata share is determined based on the proportion of the applicable Federal fiscal year that is included in that cost reporting period.

U. Outlier Payments

1. IPPS Statewide Average CCRs

Tables 8A and 8B contain the FY 2025 Statewide average operating and capital Cost-to-Charge ratios (CCRs) for urban and rural hospitals. Tables 8A and 8B are available on the FY 2025 Final Rule Tables webpage. Per the regulations in 42 CFR 412.84(i)(3)(iv)(C), for FY 2025, statewide average CCRs are used in the following instances:

- New hospitals that haven't yet submitted their first Medicare cost report.
- Hospitals whose operating or capital cost-to-charge ratio is in excess of 3 standard deviations above the corresponding national geometric mean. We recalculate this mean annually and publish it in the annual notice of prospective payment rates. For FY 2025 operating CCR and capital CCR trim values, see MAC Implementation File 1 available on the FY 2025 MAC Implementation Files webpage.
- Hospitals for whom accurate data with which to calculate either an operating or capital cost-to-charge ratio, or both, aren't available.

V. Payment Adjustment for Clinical Trial and Expanded Access Use Immunotherapy Cases in MS-DRG 018

CMS makes an adjustment to the payment amount for clinical trial and expanded access use immunotherapy cases that group to MS-DRG 018. See MAC Implementation File 1 for the FY 2025 MS-DRG weighting factor used for such discharges.

Under this policy, a payment adjustment will be applied to claims that group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there's expanded access use of immunotherapy. However, when the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, the payment adjustment won't be applied in calculating the payment for the case.

In a case where there was expanded access use of CAR T-cell therapy or other immunotherapy products, you may submit condition code "90" on the claim so that the Pricer will apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product (and ICD-10-CM diagnosis code Z00.6 on the claim), the provider may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim, and MACs shall add payer-only

condition code “ZC” so that the Pricer won’t apply the payment adjustment in calculating the payment for the case.

W. IPPS Add-on Payment for Certain End-Stage Renal Disease (ESRD) Discharges

We provide an additional payment to a hospital for inpatient services provided to certain Medicare patients with ESRD who receive a dialysis treatment during a hospital stay, if the hospital’s ESRD Medicare patient discharges, excluding discharges classified into the MS-DRGs listed at 42 CFR 412.104(a), where the patient received dialysis services during the inpatient stay, are 10% or more of its total Medicare discharges.

Starting with FY 2025, the annual CY ESRD PPS base rate multiplied by 3 is used to calculate the ESRD add-on payment for hospital cost reporting periods that start during the FY for the same year. Specifically, the CY 2025 ESRD PPS base rate will be used for all cost reports starting during FY 2025.

The applicable ESRD base rate effective for cost reporting periods starting on or after October 1, 2024, is in the MAC Implementation File 3 after the issuance of the CY 2025 ESRD PPS final rule, which is expected by early November 2024.

LTCH PPS FY 2025 Update

A. FY 2025 LTCH PPS Rates and Factors

The FY 2025 LTCH PPS Standard Federal Rates are in Table 1E. Other FY 2025 LTCH PPS Factors are in MAC Implementation File 2.

The LTCH PPS Pricer has been updated with the Version 42 MS-LTC-DRG table, weights and factors, effective for discharges occurring October 1, 2024 - September 30, 2025.

B. Discharge Payment Percentage

Starting with LTCHs’ FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their “Discharge Payment Percentage” (DPP), which is the ratio (expressed as a percentage) of the LTCHs’ FFS discharges which received LTCH PPS standard federal rate payment to the LTCHs’ total number of LTCH PPS discharges. MACs will continue to provide notification to the LTCH of its DPP upon settlement of the cost report.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods starting on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50% be informed of such a fact; and Section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH’s discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH’s compliance with the process for reinstatement provided for by Section 1886(m)(6)(C)(iii) of the Act.

C. LTCH Quality Reporting (LTCHQR) Program

Under the LTCHQR Program, for FY 2025, the annual update to a standard Federal rate will continue to be reduced by 2% if a LTCH doesn't submit quality-reporting data in accordance with the LTCHQR Program for that year.

D. PSF

1. LTCH Statewide Average CCRs

Table 8C of the FY 2025 final rule contains the FY 2025 Statewide average LTCH total Cost-to-Charge ratios (CCRs) for urban and rural LTCHs.

Statewide average CCRs are used for new hospitals that haven't yet submitted their first Medicare cost report and are also used for:

- LTCHs with a total CCR in excess of the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR). For the FY 2025 LTCH total CCR ceiling, refer to MAC Implementation File 2.
- Any hospital for which data to calculate a CCR isn't available.

2. LTCH Labor Market Areas and Wage Indexes

Effective October 1, 2024, we're revising the labor market areas used under the LTCH PPS based on the most recent labor market area as reflected in OMB Bulletin 23–01.

For FY 2025, we'll apply a 5% cap to any decrease in an LTCH's wage index from its FY 2024 wage index. A list of LTCHs whose FY 2025 LTCH PPS wage index decreased by more than 5% along with their capped FY 2025 LTCH PPS wage index value is in the FY 2025 MAC Implementation Files webpage. We note that hospitals newly classified as an LTCH during FY 2025 aren't eligible for the 5% cap.

For FY 2025, a 5% cap will also be applied to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2024 applicable IPPS comparable wage index. A list of LTCHs whose FY 2025 applicable IPPS comparable wage index decreased by more than 5% along with their capped FY 2025 applicable IPPS comparable wage index value in on the FY 2025 MAC Implementation Files webpage.

E. Cost of Living Adjustment (COLA) under the LTCH PPS

There are no updates to the COLAs for FY 2025.

F. Codification of LTCH Qualifying Period Policy

Prior to a hospital being classified as an LTCH, the hospital must first participate in Medicare as a hospital (typically a hospital paid under the IPPS) during which time average length of stay (ALOS) data is gathered. This data is used to determine whether the hospital has an ALOS of greater than 25 days, which is required to be classified as an LTCH. We generally refer to the period during which a hospital seeks to establish the required ALOS as a "qualifying period." The qualifying period is the 6-month period immediately preceding the hospital's conversion to an LTCH, and it has been our policy that the requisite ALOS must be demonstrated based on patient data from at least 5 consecutive months of this period. For example, for a hospital seeking to become an LTCH effective January 1, 2025, the qualifying period would be July 1, 2024, - December 31, 2024 (that's the 6 months immediately preceding the conversion to an LTCH). For the hospital to convert to an LTCH, the ALOS must be demonstrated for a period of at least 5 consecutive months (for example, July 1, 2024 - November 30, 2024, or July 15, 2024- December 14, 2024) of the 6-month qualifying period. We note that, in accordance with our existing policy, the ALOS is calculated for the entire period, not for each individual month within the period. This policy is codified in the regulations at 42 CFR 412.23(e)(3).

G. Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of increase percentage specified in 42 CFR 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2025 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2025 of 3.4%.

More Information

We issued CR 13734 to your MAC as the official instruction for this change.

For more information, find your MACs' website.

Document History

Date of Change	Description
August 29, 2024	Initial article released.