DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 412

[CMS–1808–IFC]

RIN 0938–AV34

Medicare Program; Changes to the Fiscal Year 2025 Hospital Inpatient Prospective Payment System (IPPS) Rates Due to Court Decision

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Interim final action with comment period.

SUMMARY: This interim final action with comment period (IFC) implements revised Medicare wage index values for FY 2025, establishes a transitional payment exception for low wage hospitals significantly impacted by those revisions, and makes conforming changes to the hospital Inpatient Prospective Payment System (IPPS) payment rates for FY 2025. These changes reflect the removal of the low wage index hospital policy following the appellate court decision in *Bridgeport Hosp.* v. *Becerra.* This rule also makes conforming changes to IPPS rates and factors used to determine certain payments under the Long-Term Care Hospital Prospective Payment System (LTCH PPS).

DATES:

Effective date: This action is effective on September 30, 2024.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, by November 29, 2024.

ADDRESSES: In commenting, please refer to file code CMS–1808–IFC.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1808–IFC, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1808–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donald Thompson and Michele Hudson, (410) 786–4487 or *DAC@cms.hhs.gov.*

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

A. Scope and Authority

1. Acute Care Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. Section 1886(g) of the Act requires the Secretary to use a prospective payment system (PPS) to pay for the capital-related costs of inpatient hospital services for these ''subsection (d) hospitals.'' Under these PPSs, Medicare payment for hospital inpatient operating and capital-related costs is made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs).

The base payment rate is comprised of a standardized amount that is divided into a labor-related share and a nonlabor-related share. The labor-related share is adjusted by the wage index applicable to the area where the hospital is located. If the hospital is located in Alaska or Hawaii, the nonlabor-related share is adjusted by a cost-of-living adjustment factor. This base payment rate is multiplied by the DRG relative weight.

If the hospital treats a high percentage of certain low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate. This add-on payment, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payments to hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients. For qualifying hospitals, the amount of this adjustment varies based on the outcome of the statutory calculations. The Affordable Care Act revised the Medicare DSH payment methodology and provides for an additional Medicare payment beginning on October 1, 2013, that considers the amount of uncompensated care furnished by the hospital relative to all other qualifying hospitals.

If the hospital is training residents in an approved residency program(s), it receives a percentage add-on payment for each case paid under the IPPS, known as the indirect medical education (IME) adjustment. This percentage varies, depending on the ratio of residents to beds.

Additional payments may be made for cases that involve new technologies or medical services that have been approved for special add-on payments. In general, to qualify, a new technology or medical service must demonstrate that it is a substantial clinical improvement over technologies or services otherwise available, and that, absent an add-on payment, it would be inadequately paid under the regular DRG payment. In addition, certain transformative new devices and certain antimicrobial products may qualify under an alternative inpatient new technology add-on payment pathway by demonstrating that, absent an add-on payment, they would be inadequately paid under the regular DRG payment.

The costs incurred by the hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases. Any eligible outlier payment is added to the DRG-adjusted base payment rate, plus any DSH, IME, and new technology or medical service add-on adjustments and, beginning in FY 2023 for Indian Health Service (IHS) and Tribal

hospitals and hospitals located in Puerto Rico, the new supplemental payment.

Although payments to most hospitals under the IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate, which is determined from their costs in a base year. For example, sole community hospitals (SCHs) receive the higher of a hospital-specific rate based on their costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on the standardized amount. SCHs are the sole source of care in their areas. Specifically, section 1886(d)(5)(D)(iii) of the Act defines an SCH as a hospital that is located more than 35 road miles from another hospital or that, by reason of factors such as an isolated location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of hospital inpatient services reasonably available to Medicare beneficiaries. In addition, certain rural hospitals previously designated by the Secretary as essential access community hospitals are considered SCHs.

With the enactment of section 307 of the Consolidated Appropriations Act, 2024 (CAA, 2024) (Pub. L. 118–42), under current law, the Medicare-dependent, small rural hospital (MDH) program is effective through December 31, 2024. For discharges occurring on or after October 1, 2007, but before January 1, 2025, an MDH receives the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987, or FY 2002 hospital-specific rate. MDHs are a major source of care for Medicare beneficiaries in their areas. Section 1886(d)(5)(G)(iv) of the Act defines an MDH as a hospital that is located in a rural area (or, as amended by the Bipartisan Budget Act of 2018, a hospital located in a State with no rural area that meets certain statutory criteria), has not more than 100 beds, is not an SCH, and has a high percentage of Medicare discharges (not less than 60 percent of its inpatient days or discharges in its cost reporting year beginning in FY 1987 or in two of its three most recently settled Medicare cost reporting years). As section 307 of the CAA, 2024, extended the MDH program through the first quarter of FY 2025 only, beginning on January 1, 2025, the MDH program will no longer be in effect absent a change in law. Because the MDH program is not authorized by statute beyond December 31, 2024, beginning January 1, 2025, all hospitals that previously qualified for MDH status under section 1886(d)(5)(G) of the Act will no longer have MDH status and will be paid based on the IPPS Federal rate.

Section 1886(g) of the Act requires the Secretary to pay for the capital-related costs of inpatient hospital services in accordance with a prospective payment system established by the Secretary. The basic methodology for determining capital prospective payments is set forth in our regulations at 42 CFR 412.308 and 412.312. Under the capital IPPS, payments are adjusted by the same DRG for the case as they are under the operating IPPS. Capital IPPS payments are also adjusted for IME and DSH, similar to the adjustments made under the operating IPPS. In addition, hospitals may receive outlier payments for those cases that have unusually high costs.

The existing regulations governing payments to hospitals under the IPPS are located in 42 CFR part 412, subparts A through M.

2. Long-Term Care Hospital Prospective Payment System (LTCH PPS)

The Medicare prospective payment system (PPS) for LTCHs applies to hospitals described in section 1886(d)(1)(B)(iv) of the Act, effective for cost reporting periods beginning on or after October 1, 2002. The LTCH PPS was established under the authority of section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as codified under section 1886(m)(1) of the Act). Section 1206(a) of the Pathway for SGR Reform Act of 2013 (Pub. L. 113–67) established the site neutral payment rate under the LTCH PPS, which made the LTCH PPS a dual rate payment system. Under this statute, effective for LTCH cost reporting periods beginning in FY 2016, LTCHs are generally paid for discharges at the site neutral payment rate unless the discharge meets the patient criteria for payment at the LTCH PPS standard Federal payment rate. The existing regulations governing payment under the LTCH PPS are located in 42 CFR part 412, subpart O. Beginning October 1, 2009, we issue the annual updates to the LTCH PPS in the same documents that update the IPPS.

B. Wage Index for Acute Care Hospitals Paid Under the Hospital Inpatient Prospective Payment System (IPPS)

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary adjust the standardized amounts for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. We currently define hospital labor market areas based on the delineations of statistical areas established by the Office of Management and Budget (OMB). A discussion of the FY 2025 hospital wage index based on the statistical areas can be found in section III.B. of the preamble of the FY 2025 IPPS/LTCH PPS final rule (89 FR 69252).

Section 1886(d)(3)(E) of the Act requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. CMS collects these data on the Medicare cost report, CMS Form 2552–10, Worksheet S–3, Parts II, III, IV. The OMB control number for this information collection request is 0938–0050, which expires on September 30, 2025. Section 1886(d)(3)(E) of the Act also requires that any updates or adjustments to the wage index be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index.

We also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act when calculating IPPS payment amounts. Under section 1886(d)(8)(D) of the Act, the Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B), 1886(d)(8)(C), and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions.

II. Provisions of the Interim Final Action With Comment Period

A. General

In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42325 through 42339), we finalized a policy to address increasing of wage index disparities, based in part on comments we received in response to our request for information included in our FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20372 through 20377). In the FY 2020 IPPS/LTCH PPS final rule, based on those public comments and the growing disparities between wage index values for high- and low-wage-index hospitals, we explained that those growing disparities are likely caused, at least in part, by the use of historical

wage data to prospectively set hospitals' wage indexes. That lag between when hospitals increase wages and when those wage increases are reflected in the historical data creates barriers to hospitals with low wage index values being able to increase employee compensation, because those hospitals will not receive corresponding increases in their Medicare payment for several years (84 FR 42327). Accordingly, we finalized a policy that provided certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index (as they would expect to do if not for the lag).[1] We accomplished this by temporarily increasing the wage index values for certain hospitals with low wage index values and doing so in a budget neutral manner through an adjustment applied to the standardized amounts for all hospitals. We increased the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals (the low wage index hospital policy). As explained in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19396) and final rule (84 FR 42329), we indicated that the Secretary has authority to implement the low wage index hospital policy proposal under both section 1886(d)(3)(E) of the Act and section 1886(d)(5)(I) of the Act.

When we adopted the low wage index hospital policy in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42326 through 42328), we stated our intention that this policy would be effective for at least 4 years, beginning in FY 2020, to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation. We also stated we intended to revisit the issue of the duration of this policy in future rulemaking as we gained experience under the policy. For FY 2024, we continued to apply the low wage index hospital policy and the related budget neutrality adjustment (88 FR 58977 through 58980). In the FY 2025 IPPS/LTCH PPS final rule (89 FR 69301 through 69308), we adopted an extension of the low wage index hospital policy and the related budget neutrality adjustment effective for at least three more years, beginning in FY 2025, in order for sufficient wage data from after the end of the COVID–19 Public Health Emergency to become available.

In that same FY 2025 IPPS/LTCH PPS final rule (89 FR 69302), we also noted that the FY 2020 low wage index hospital policy and the related budget neutrality adjustment are the subject of pending litigation in multiple courts, and that on July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under section 1886(d)(3)(E) of the Act or under the ''adjustments'' language of section 1886(d)(5)(I)(i) of the Act to adopt the low wage index hospital policy for FY 2020, and that the policy and related budget neutrality adjustment must be vacated. *Bridgeport Hosp.* v. *Becerra,* 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024). We also stated that as of the date of that final rule's publication, the time to seek further review of the D.C. Circuit's decision in *Bridgeport Hospital* had not expired (see Fed. R. App. P. 40(a)(1)) and the government was evaluating the decision and considering options for next steps.

Although we respectfully disagree with the D.C. Circuit's decision in *Bridgeport Hosp.* v. *Becerra* and continue to believe that the low wage index hospital policy and the related budget neutrality adjustment should be effective for at least three more years for the reasons stated in the FY 2025 IPPS rulemaking, after considering the D.C. Circuit's decision in *Bridgeport Hosp.* v. *Becerra,* in this IFC we are recalculating the IPPS hospital wage index to remove the low wage index hospital policy for FY 2025. Because we are now no longer applying the low wage index hospital policy in FY 2025, we are also removing the low wage index budget neutrality factor from the FY 2025 standardized amounts.

In the past, we have established temporary transition policies when there have been significant changes to payment policies, and we have limited the duration of each transition in order to phase in the effects of those payment policy changes. In taking this temporary approach in the past, we have sought to mitigate short-term instability and payment fluctuations that can negatively impact hospitals. For example, CMS has recognized that hospitals in certain areas may experience a negative impact on their IPPS payment due to the adoption of revised OMB delineations for wage index purposes and has finalized transition policies to mitigate negative financial impacts and provide stability to year-to-year wage index variations. We refer readers to the FY 2015 IPPS/LTCH PPS final rule (79 FR 49956 through 49962) for a discussion of the transition period finalized when CMS adopted revised OMB delineations after the 2010 decennial census. For FY 2025, consistent with our past practice, we believe it is appropriate to establish a transition policy for hospitals significantly impacted by the removal of the FY 2025 low wage index hospital policy using our authority under section 1886(d)(5)(I) of the Act.

We currently have a wage index cap policy at 42 CFR 412.64(h)(7), under which we apply a 5-percent cap on any decrease to a hospital's wage index from its wage index in the prior FY in a budget neutral manner, regardless of the circumstances causing the decline, so that a hospital's final wage index for the upcoming fiscal year will not be less than 95 percent of its final wage index from the prior fiscal year. In accordance with 42 CFR 412.64(e)(1)(ii), CMS applies a budget neutrality adjustment to offset the increase in total payments resulting from the application of that cap.

Some hospitals that benefitted from the low wage index hospital policy previously will experience decreases of 5 percent or more from their FY 2024 wage index to the FY 2025 wage index established in this IFC. Similar to how 42 CFR 412.64(h)(7) would operate, we are applying a one-time, transitional adjustment to create a narrow transitional exception to the calculation of FY 2025 payments. The wage index cap policy at 42 CFR 412.64(h)(7) would have mitigated these FY 2025 decreases but would have done so in a budget neutral manner under our current regulations. Because section 1886(d)(5)(I) of the Act lacks any general budget neutrality requirement, we are not required by the statute to budget neutralize this transition policy. In some circumstances CMS has exercised discretion under section 1886(d)(5)(I) of the Act twice over—first to adopt an exception or adjustment, and then again to make that exception and adjustment budget neutral.[2] However, under the

[1] In the FY 2020 IPPS/LTCH PPS proposed rule, we agreed with respondents to a previous request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. We noted that this lag results from the fact that the wage index calculations rely on historical data. We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure (84 FR 19394 and 19395).

[2] For example, CMS has stated in the past that it would exercise its discretion under section

Continued

unique circumstances and due to the timing of the appellate court's decision so close to the beginning of FY 2025, we do not deem it appropriate to provide a second exception or adjustment that would budget neutralize the transition policy we are establishing in this IFC. Unlike most policies relevant to the calculation of the hospital wage index, the timing of the court's decision shortly before the beginning of the fiscal year necessitated swift action by the agency via an IFC, rather than providing for prior notice and opportunity for comment. The agency's action in this IFC is intended to promote certainty regarding FY 2025 IPPS payments in light of the reasoning of *Bridgeport* and its application to the low wage index hospital policy in FY 2025, which would create ongoing confusion for hospitals extending into FY 2025 about the amount of their IPPS payments and would constitute an inefficient use of agency resources. In this instance, the lack of an opportunity prior to the effective date for interested parties to comment on the transition policy weighs in favor of an approach that does not adversely affect the significant majority of hospitals. Because section 1886(d)(5)(I) lacks any general budget neutrality requirement, we are not required by the statute to budget neutralize this transition policy. For these reasons, we decline to budget neutralize the transition policy in this case.

Therefore, we are using our authority under section 1886(d)(5)(I)(i) of the Act to create a narrow transitional exception to the calculation of FY 2025 IPPS payments for low wage index hospitals significantly impacted by the removal of the low wage index hospital policy.[3] [4]

The transitional exception policy we are establishing in this IFC applies to hospitals that benefitted from the FY 2024 low wage index hospital policy. For those hospitals, we compare the hospital's FY 2025 wage index established in this IFC to the hospital's FY 2024 wage index. If the hospital is significantly impacted by the removal of the low wage index hospital policy, meaning the hospital's FY 2025 wage index established in this IFC is decreasing by more than 5 percent from the hospital's FY 2024 wage index, then the transitional payment exception for FY 2025 for that hospital is equal to the additional FY 2025 amount the hospital would be paid under the IPPS if its FY 2025 wage index were equal to 95 percent of its FY 2024 wage index.[5]

For example, assume the FY 2024 wage index for a hospital that benefitted from the low wage index hospital policy is 0.7600, and the hospital's FY 2025 wage index established in this IFC is 0.7100. The hospital's FY 2025 wage index established in this IFC is decreasing by more than 5 percent from the hospital's FY 2024 wage index [that is, 0.7100 < 0.7220 where 0.7220 = (0.95 times .7600)]. The transitional payment exception for FY 2025 for this hospital is equal to the additional amount the hospital would be paid under the IPPS if its FY 2025 wage index were equal to 0.7220, which is 95 percent of 0.7600, its FY 2024 wage index.

Because the need to provide for payment stability and promote predictability is satisfied by the transitional payment exception under this IFC, we are using our authority under section 1886(d)(5)(I)(i) of the Act to except hospitals that are eligible for this transition policy for the removal of the FY 2025 low wage index hospital policy for FY 2025 from the application of the wage index cap policy at 42 CFR 412.64(h)(7).

Under the capital IPPS, the adjustment for local cost variation is based on the hospital wage index value that is applicable to the hospital under the operating IPPS. We adjust the capital standard Federal rate so that the effects of the annual changes in the geographic adjustment factor (GAF) are budget neutral. The low wage index hospital policy has been reflected in the capital IPPS GAFs since FY 2020 (84 FR 42638). The removal of the low wage index hospital policy for FY 2025 also affects the FY 2025 GAFs. Because we are now no longer applying the low wage index hospital policy in FY 2025, we are also no longer making an adjustment to the FY 2025 capital standard Federal rate to ensure budget neutrality for the low wage index hospital policy.

As discussed previously, for FY 2025 we believe it is appropriate to establish a transition policy for low wage hospitals significantly impacted by the removal of the low wage index hospital policy. Since FY 2023, the GAFs reflect the wage index cap policy that limits any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the circumstances causing the decline, to 95 percent of its prior year value (87 FR 49435). As described previously, some low wage index hospitals would experience decreases of 5 percent or more in their FY 2025 wage index established in this IFC compared to their FY 2024 wage index. As such, we are establishing a transitional payment exception to the calculation of FY 2025 IPPS payments for low wage index hospitals impacted by the removal of the low wage index hospital policy. In this IFC, we are making a non-budget neutral equivalent exception under the capital IPPS.

B. Changes to Prospective Payment Rates for Hospital Inpatient Operating Costs for Acute Care Hospitals for FY 2025

1. Calculation of the Adjusted Standardized Amount for FY 2025

The FY 2025 IPPS/LTCH PPS final rule appeared in the August 28, 2024, **Federal Register** (89 FR 68986), as corrected in a document scheduled for publication in the **Federal Register** on October 2, 2024 (hereinafter referred to as the FY 2025 IPPS/LTCH PPS final rule correction). In section II. of the Addendum of the FY 2025 IPPS/LTCH PPS final rule (89 FR 69938) as corrected in FY 2025 IPPS/LTCH PPS final rule correction, we set forth a description of the methods and data we used to determine the prospective payment rates for Medicare hospital inpatient operating costs for FY 2025 for acute care hospitals.

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (for example, changes to MS–DRG classifications, recalibration of the MS–DRG relative weights, updates to the wage index, and different geographic reclassifications). We include outlier payments in the simulations because they may be affected by changes in these parameters. In the FY 2025 IPPS/LTCH PPS final rule, as corrected, the budget neutrality factors were calculated in the order in which they are discussed in the Addendum and shown in the table ''Summary of FY 2025 Budget Neutrality Factors'' (see 89 FR 69944 through 69948) with the FY 2025 IPPS/

1886(d)(5)(I) of the Act to make the low wage index hospital policy budget neutral even if budget neutrality were not required by statute (88 FR 58979).

[3] We note that the scope and magnitude of the transitional policy implemented in this IFC are much smaller than the low wage index hospital policy. As discussed in section VI. of this IFC, we estimate only 113 hospitals out of the over 3,000 hospitals paid under the IPPS would receive transitional exception payments, and the total payment impact of the transitional policy is approximately $41 million.

[4] We note that because creating an exception to the calculation of the FY 2025 payments is in this circumstance functionally equivalent to adjusting the FY 2025 payments, the transitional exception can be alternatively considered a transitional adjustment.

[5] We note that we are not changing the FY 2025 wage index values under section 1886(d)(3)(E) for hospitals eligible for the transitional exception policy on the basis of the exception; the change is applied as a separate step only for purposes of determining the hospitals' FY 2025 IPPS payments.

LTCH PPS final rule correction. Specifically, in determining the prospective payment rates for FY 2025 in that final rule, as corrected, the budget neutrality factors were calculated in the following order (after applying the applicable percentage increases):

- Reclassification and Recalibration of MS–DRG Relative Weights Before Cap (MS–DRG Reclassification and Recalibration Budget Neutrality Factor).
- Reclassification and Recalibration of MS DRG Relative Weights With Cap (Cap Policy MS–DRG Weights Budget Neutrality Factor).
- Updated Wage Index (Wage Index Budget Neutrality Factor).
- Reclassified Hospitals (Reclassification Budget Neutrality Factor).
- Rural Floor (Rural Floor Budget Neutrality Factor).
- Continuation of the Low Wage Index Hospital Policy (Low Wage Index Hospital Policy Budget Neutrality Factor).
- Cap Policy for Wage Index (Cap Policy for Wage Index Budget Neutrality Factor).
- Rural Community Hospital Demonstration Program (Rural Demonstration Budget Neutrality Factor).

We note 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.

Based on the order of our budget neutrality calculations, the removal of the low wage index hospital policy and application of the transitional exception policy do not impact the calculation of the first five budget neutrality factors (that is, MS–DRG Reclassification and Recalibration Budget Neutrality Factor, Cap Policy MS–DRG Weights Budget Neutrality Factor, Wage Index Budget Neutrality Factor, Reclassification Budget Neutrality Factor, and the Rural Floor Budget Neutrality Factor). Under the provisions of this IFC, we are no longer making a budget neutrality adjustment to the standardized amount for the low wage index hospital policy. Accordingly, in this IFC we recalculated the cap policy for wage index budget neutrality factor and rural demonstration budget neutrality factor used for determining the standardized amounts for FY 2025. We also calculated the FY 2025 outlier threshold to reflect the provisions of this IFC along with changes to these budget neutrality factors. In addition, as described in section IV. of this IFC, we made updates to the calculation of Factor 3 of the uncompensated care payment methodology for all DSH-eligible hospitals to reflect the updated information for the hospitals that are no longer projected to receive interim uncompensated care payments for FY 2025. We also revised the amount of the total uncompensated care payment calculated for each DSH-eligible hospital, and we updated the list that we published for the FY 2025 IPPS/LTCH PPS final rule, as corrected, of hospitals that we identified to be subsection (d) hospitals and subsection (d) Puerto Rico hospitals projected to be eligible to receive interim uncompensated care payments for FY 2025.

As discussed earlier, we are establishing a transitional exception policy for certain hospitals that benefitted from the low wage index hospital policy adjustment during FY 2024. Because we are applying this transitional exception in a non-budget neutral manner, we first determined which hospitals would be eligible for this transition policy (that is, identified those that had received a higher wage index under the low wage index hospital policy in FY 2024). We then applied the transitional payment exception for eligible hospitals as described in section II. A of this IFC. As discussed earlier, hospitals that are eligible for the new transitional exception policy are excepted from the wage index cap policy at 42 CFR 412.64(h)(7), which is budget neutral by design.

The FY 2025 budget neutrality factors that we recalculated in this IFC were calculated using data described in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69941 through 69948), with the FY 2025 IPPS/LTCH PPS final rule correction. The budget neutrality factor for the wage index cap policy at 42 CFR 412.64(h)(7) was calculated in accordance with the existing methodology. As noted earlier, hospitals that are eligible for the transitional exception policy are excepted from the wage index cap policy at 42 CFR 412.64(h)(7) in FY 2025. To calculate a wage index cap budget neutrality adjustment factor for FY 2025, we used FY 2023 discharge data to simulate payments and compared the following:

- Aggregate payments without the wage index cap policy at 42 CFR 412.64(h)(7) using the FY 2025 labor related share percentages, the new OMB labor market area delineations for FY 2025, the FY 2025 relative weights, and applied the proxy FY 2025 hospital readmissions payment adjustments and the proxy FY 2025 hospital value-based purchasing (VBP) payment adjustments.
- Aggregate payments with the wage index cap at 42 CFR 412.64(h)(7) using the FY 2025 labor related share percentages, the new OMB labor market area delineations for FY 2025, the FY 2025 relative weights, and applied the same proxy FY 2025 hospital readmissions payment adjustments and the proxy FY 2025 hospital VBP payment adjustments applied previously.

Cap Policy Wage Index Budget Neutrality Factor	0.999166

The budget neutrality factor for the rural community hospital demonstration program was calculated using the methodology described in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69947 through 69948). We note, as mentioned earlier, that we recalculated the rural demonstration budget neutrality factor; however, when rounded to the sixth decimal, the factor (0.999811) did not change from the corrected factor as set forth in the FY 2025 IPPS/LTCH PPS correction.

The standardized amounts set forth in Tables 1A, 1B, and 1C for FY 2025 that are listed and published in section IV. of this IFC (and available via the internet on the CMS website) reflect these factors.

2. Outlier Payments

In the Addendum of the FY 2025 IPPS/LTCH PPS final rule (89 FR 69948 through 66962), with the FY 2025 IPPS/LTCH PPS final rule correction, we discuss outlier payments for cases involving extraordinarily high costs and the methodology for determining the FY 2025 outlier threshold. To calculate the FY 2025 outlier fixed-loss amount that reflects the provisions of this IFC, we used the methodology (data, factors, etc.) as described in the FY 2025 IPPS/LTCH PPS final rule, as corrected, in conjunction with the wage index values, transitional payment exception policy for the removal of the low wage index hospital policy and other rates and factors established in this IFC (as described previously). For example, we used the following to calculate the FY 2025 outlier fixed-loss amount in this IFC:

- Targeted an outlier threshold at 5.14 percent [5.1 percent − (− 0.04 percent)] as reflected in the FY 2025 IPPS/LTCH PPS final rule.
- Applied the charge inflation factor of 4.1 percent (1.04118) (or 8.4 percent (1.08406) over 2 years) as reflected in the FY 2025 IPPS/LTCH PPS final rule.
- Applied the national average case-weighted operating and capital CCR adjustment factors of 1.015192 and

0.997234 respectively as reflected in the FY 2025 IPPS/LTCH PPS correction notice.

- Used the estimated per-discharge uncompensated care payment and estimated per-discharge supplemental payment updated in this IFC.
- Used the applicable standardized amounts in Tables 1A–1C of this IFC.
- Used the FY 2025 wage index values established in this IFC.
- Applied the transitional payment exception policy described in section II.A. of this IFC, where applicable.

For FY 2025, we determined a threshold of $46,217 and calculated total outlier payments of $4,354,709,696 and total operating Federal payments of $80,366,934,481. (We note that, if calculated without applying our methodology for incorporating an estimate of outlier reconciliation in the determination of the outlier threshold, the threshold would be $46,567.) For FY 2025, the outlier fixed-loss cost threshold is equal to the prospective payment rate for the MS–DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, estimated supplemental payment for eligible Indian Health Service (IHS)/Tribal hospitals and Puerto Rico hospitals, and any add on payments for new technology, plus $46,217. The outlier adjustment factor that is applied to the operating standardized amount based on the FY 2025 outlier threshold is 0.949 (as established in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69961)).

As discussed in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69961), we establish an outlier threshold that is applicable to both hospital inpatient operating costs and hospital inpatient capital-related costs. When we modeled the combined operating and capital outlier payments, we found that using a common threshold resulted in a higher percentage of outlier payments for capital-related costs than for operating costs. We project that the threshold for FY 2025 (which reflects our methodology to incorporate an estimate of operating outlier reconciliation (see 89 FR 69948 through 69953) would result in outlier payments that would equal 5.1 percent of operating DRG payments and we estimate that capital outlier payments would equal 4.23 percent of capital payments based on the capital Federal rate established in section II.C. of this IFC (and which reflects our methodology to incorporate an estimate of capital outlier reconciliation as discussed in the FY 2025 IPPS/LTCH PPS final rule (see 89 FR 69953 through 69955)).

In accordance with section 1886(d)(3)(B) of the Act, we reduce the FY 2025 standardized amount by 5.1 percent to account for the projected proportion of payments paid as outliers.

The outlier adjustment factors that would be applied to the operating standardized amount and capital Federal rate based on the FY 2025 outlier threshold are as follows:

	Operating standardized amounts	Capital federal rate *
National	0.949	0.957704

* The adjustment factor for the capital Federal rate includes an adjustment to the estimated percentage of FY 2025 capital outlier payments for capital outlier reconciliation, as discussed in the FY 2025 IPPS/LTCH final rule.

We are applying the outlier adjustment factors to the FY 2025 payment rates after removing the effects of the FY 2024 outlier adjustment factors on the standardized amount.

3. FY 2025 Standardized Amounts

The adjusted standardized amount is divided into labor-related and nonlabor-related portions. Tables 1A and 1B listed and published in section IV. of this IFC (and available via the internet on the CMS website) contain the national standardized amounts that we are applying to all hospitals, except hospitals located in Puerto Rico, for FY 2025. The standardized amount for hospitals in Puerto Rico is shown in Table 1C listed and published in section IV. of this IFC (and available via the internet on the CMS website).

The following table illustrates the changes from the FY 2024 national standardized amounts to the FY 2025 national standardized amounts. The second through fifth columns display the changes from the FY 2024 standardized amounts for each applicable FY 2025 standardized amount. The first row of the table shows the updated (through FY 2024) average standardized amount after restoring the FY 2024 offsets for outlier payments, geographic reclassification, rural demonstration, lowest quartile, and budget neutrality for the wage index cap policy at 42 CFR 412.64(h)(7). The MS–DRG reclassification and recalibration wage index, and stem cell acquisition budget neutrality factors are cumulative (that is, we have not restored the offsets). Accordingly, those FY 2024 adjustment factors have not been removed from the base rate in the following table.

CHANGES FROM FY 2024 STANDARDIZED AMOUNTS TO THE FY 2025 STANDARDIZED AMOUNTS

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is not a meaningful EHR user	Hospital did not submit quality data and is a meaningful EHR user	Hospital did not submit quality data and is not a meaningful EHR user
FY 2025 Base Rate after removing:.	If Wage Index is Greater Than 1.0000:.	If Wage Index is Greater Than 1.0000:.	If Wage Index is Greater Than 1.0000:.	If Wage Index is Greater Than 1.0000:
1. FY 2024 Geographic Reclassification Budget Neutrality (0.971295).	Labor (67.6%): $4,782.01 ..... Nonlabor (32.4%): $2,291.97 ..	Labor (67.6%): $4,782.01 ..... Nonlabor (32.4%): $2,291.97 ..	Labor (67.6%): $4,782.01 ..... Nonlabor (32.4%): $2,291.97 ..	Labor (67.6%): $4,782.01. Nonlabor (32.4%): $2,291.97.
2. FY 2024 Operating Outlier Offset (0.949).	If Wage Index is less Than or Equal to 1.0000:.	If Wage Index is less Than or Equal to 1.0000:.	If Wage Index is less Than or Equal to 1.0000:.	If Wage Index is less Than or Equal to 1.0000:
3. FY 2024 Rural Demonstration Budget Neutrality Factor (0.999463).	Labor (62%): $4,385.87 ..... Nonlabor (38%): $2,688.11	Labor (62%): $4,385.87 ..... Nonlabor (38%): $2,688.11	Labor (62%): $4,385.87 ..... Nonlabor (38%): $2,688.11	Labor (62%): $4,385.87. Nonlabor (38%): $2,688.11.
4. FY 2024 Lowest Quartile Budget Neutrality Factor (0.997402).				
5. FY 2024 Cap Policy Wage Index Budget Neutrality Factor (0.999645).				
* FY 2025 Update Factor	1.029	1.0035	1.0205	0.995.
* FY 2025 MS-DRG Reclassification and Recalibration Budget Neutrality Factor Before Cap.	0.997190	0.997190	0.997190	0.997190.

CHANGES FROM FY 2024 STANDARDIZED AMOUNTS TO THE FY 2025 STANDARDIZED AMOUNTS—Continued

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is not a meaningful EHR user	Hospital did not submit quality data and is a meaningful EHR user	Hospital did not submit quality data and is not a meaningful EHR user
* FY 2025 Cap Policy MS–DRG Weight Budget Neutrality Factor.	0.999874	0.999874	0.999874	0.999874.
* FY 2025 Wage Index Budget Neutrality Factor.	0.999981	0.999981	0.999981	0.999981.
* FY 2025 Reclassification Budget Neutrality Factor.	0.962786	0.962786	0.962786	0.962786.
FY 2025 Cap Policy Wage Index Budget Neutrality Factor.	0.999166	0.999166	0.999166	0.999166.
* FY 2025 RCH Demonstration Budget Neutrality Factor.	0.999811	0.999811	0.999811	0.999811.
* FY 2025 Operating Outlier Factor.	0.949	0.949	0.949	0.949.
National Standardized Amount for FY 2025 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (67.6/32.4).	Labor: $4,478.09 Nonlabor: $2,146.30	Labor: $4,367.12 Nonlabor: $2,093.11	Labor: $4,441.10 Nonlabor: $2,128.57	Labor: $4,330.13 Nonlabor: $2,075.38.
National Standardized Amount for FY 2025 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38).	Labor: $4,107.12 Nonlabor: $2,517.27	Labor: $4,005.34 Nonlabor: $2,454.89	Labor: $4,073.20 Nonlabor: $2,496.47	Labor: $3,971.42 Nonlabor: $2,434.09.

* This factor is not changing in this IFC.

C. Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2025

In section III. of the Addendum of the FY 2025 IPPS/LTCH PPS final rule (89 FR 69966 through 69971) as corrected in the FY 2025 IPPS/LTCH PPS final rule correction, we set forth a description of the methods and data we used to determine the prospective payment rates for Medicare hospital inpatient capital-related costs for FY 2025 for acute care hospitals. In that final rule (89 FR 69966 through 69970) the FY 2025 IPPS/LTCH PPS final rule correction, we discuss the factors we use for determining the capital Federal rate for FY 2025. Similar to the discussion of the operating IPPS payment rates previously, the removal of the low wage index hospital policy and the establishment of a transitional exception policy as discussed in section II.B. of this IFC impacts the calculation of certain budget neutrality adjustment factors used for determining the capital Federal rate for FY 2025. In addition, as discussed previously, we also calculated the FY 2025 outlier threshold to reflect the provisions of this IFC along with the corresponding changes to the IPPS payment rates. Accordingly, in this IFC we are establishing the following factors used for determining the capital Federal rate for FY 2025:

- The outlier payment adjustment factor.
- The portion of the budget neutrality adjustment factor for changes in the geographic adjustment factor (GAF) for the 5-percent cap on wage index decreases policy. (Under the provisions of this IFC, this factor would no longer reflect the low wage index hospital policy.)

As we discuss in this section, in general, these factors were calculated using the data and calculation methodology described in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69968 through 69971) with the FY 2025 IPPS/LTCH PPS final rule correction, except for the methodology for calculating the GAF budget neutrality factor which we are modifying to reflect the provisions of this IFC.

1. Outlier Payment Adjustment Factor

As discussed previously, a shared threshold is used to identify outlier cases for both inpatient operating and inpatient capital-related payments. Based on the threshold discussed in section II.B. of this IFC, we estimate that prior to taking into account projected capital outlier reconciliation payments, outlier payments for capital-related costs will equal 4.26 percent of inpatient capital-related payments based on the capital Federal rate in FY 2025. As discussed in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69968), we estimate that taking into account projected capital outlier reconciliation payments will decrease the estimated percentage of FY 2025 capital outlier payments by 0.03 percent. Therefore, accounting for estimated capital outlier reconciliation, the estimated outlier payments for capital-related PPS payments will equal 4.23 percent (4.26 percent − 0.03 percent) of inpatient capital-related payments based on the capital Federal rate in FY 2025. Accordingly, we applied an outlier adjustment factor of 0.9577 in determining the capital Federal rate for FY 2025. As we noted in the final rule, the capital Federal rate is calculated using unrounded budget neutrality and outlier adjustment factors. The unrounded FY 2025 outlier adjustment factor was revised because of the removal of the low wage index hospital policy and transitional payment exception. However, after rounding this factor to 4 decimal places (as displayed in the final rule and this IFC), the rounded factor was unchanged from the final rule.

2. Budget Neutrality Adjustment Factor for Changes in the GAF

The capital Federal rate is adjusted so that aggregate payments for the fiscal year based on the capital Federal rate, after any changes resulting from the annual DRG reclassification and recalibration and changes in the GAF, are projected to equal aggregate payments that would have been made on the basis of the capital Federal rate without such changes. As discussed in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69969 through 69970), for FY 2025 we use a 2-step methodology for computing the budget neutrality factor for changes in the GAFs in light of the effect of wage index changes on the GAFs. In the first step, we first calculate a factor to ensure budget neutrality for changes to the GAFs due to the update to the wage data, wage index

reclassifications and redesignations, and application of the rural floor policy, consistent with our historical GAF budget neutrality factor methodology. In the FY 2025 IPPS/LTCH PPS final rule (89 FR 69969) with the FY 2025 IPPS/LTCH PPS final rule correction, we calculated an incremental adjustment factor for changes in the GAFs for FY 2025 due to the update to the wage data, wage index reclassifications and redesignations, and application of the rural floor policy of 0.9884. The provisions of this IFC do not impact this budget neutrality factor. Also in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69969 through 69970), as corrected with the FY 2025 IPPS/LTCH PPS final rule correction, we calculated an incremental adjustment factor for the FY 2025 MS–DRG reclassification and recalibration and for changes in the FY 2025 GAFs due to the update to the wage data, wage index reclassifications and redesignations, and application of the rural floor policy of 0.9854 (0.9969 × 0.9884). This incremental adjustment factor is not impacted by the provisions of this IFC.

Due to the removal of the low wage index hospital policy (discussed previously in section II.B. of this IFC and also referred as the lowest quartile hospital wage index adjustment in the discussion of the 2-step methodology in the FY 2025 IPPS/LTCH PPS final rule), we are modifying the second step of our 2-step methodology for computing the budget neutrality factor for changes in the GAFs in light of the effect of wage index changes on the GAFs. In the FY 2025 IPPS/LTCH PPS final rule (89 FR 69968 through 69970) we calculated a factor in the second step of our methodology that ensured budget neutrality for changes to the GAFs due to the lowest quartile hospital wage index adjustment and the 5-percent cap on wage index decreases policy (our policy to place a 5 percent cap on any decrease in a hospital's wage index from the hospital's final wage index in the prior fiscal year under 42 CFR 412.64(h)(7)). In this IFC, we are modifying this budget neutrality factor to now ensure budget neutrality for changes to the GAFs due only to the 5-percent cap on wage index decreases policy. As discussed previously in section II.B. of this IFC, we are establishing a non-budget neutral transitional exception policy for hospitals that benefitted from the low wage index hospital policy during FY 2024. Hospitals that are eligible for the transitional exception policy are excepted from the wage index cap policy for FY 2025 under this IFC. Therefore, under the provisions of this IFC, the second step of our calculation of the budget neutrality factor for changes in the GAFs in light of the effect of wage index changes on the GAFs only accounts for the application of the 5-percent cap on wage index decreases for hospitals that did not receive the low wage index hospital policy adjustment in FY 2024. For this IFC, we compared estimated aggregate capital Federal rate payments based on the FY 2025 GAFs with and without the 5-percent cap on wage index decreases policy (which was applied only to hospitals that are not eligible for the transitional exception policy). For this calculation, estimated aggregate capital Federal rate payments were calculated using the FY 2025 MS–DRG classifications and relative weights (after application of the 10-percent cap) and the GAFs included the imputed floor, out-migration, and Frontier state adjustments. To achieve budget neutrality for the effects of the 5-percent cap on wage index decreases policy we calculated an incremental GAF budget neutrality adjustment factor of 0.9992.

3. Capital Federal Rate for FY 2025

As a result of factors established in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69971) with the FY 2025 IPPS/LTCH PPS final rule correction and the outlier adjustment factor and the budget neutrality factor for the effects of the 5-percent cap on wage index decreases established in this IFC (as discussed previously), we are establishing a national capital Federal rate of $512.14 for FY 2025. The national capital Federal rate for FY 2025 was calculated as shown in the following table. The combined effect of all the changes will increase the national capital Federal rate by approximately 1.65 percent, compared to the FY 2024 national capital Federal rate.

COMPARISON OF FACTORS AND ADJUSTMENTS: FY 2024 CAPITAL FEDERAL RATE AND THE FY 2025 CAPITAL FEDERAL RATE

	FY 2024	FY 2025	Change	Percent change
Update Factor [1]	1.0380	1.0310	1.0310	3.10
GAF/DRG Adjustment Factor [1]	0.9885	0.9854	0.9854	−1.46
Cap Adjustment Factor [2]	0.9964	0.9992	1.0028	0.28
Outlier Adjustment Factor [3]	0.9598	0.9577	0.9978	−0.22
Capital Federal Rate	$503.83	$512.14	1.0165	[4] 1.65

[1] The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rate. Thus, for example, the incremental change from FY 2024 to FY 2025 resulting from the application of the 0.9854 GAF/DRG budget neutrality adjustment factor for FY 2025 is a net change of 0.9854 (or −1.46 percent).

[2] The cap budget neutrality adjustment factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2025 cap budget neutrality adjustment factor is 0.9992/0.9964 or 1.0028 (or 0.28 percent).

[3] The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2025 outlier adjustment factor is 0.9577/0.9598 or 0.9978 (or −0.22 percent).

[4] Percent change may not sum due to rounding.

D. High-Cost Outlier (HCO) Threshold for Site Neutral Payment Rate Cases Under the LTCH PPS for FY 2025

In the FY 2025 IPPS/LTCH PPS final rule (89 FR 69987), we established that the applicable HCO threshold for site neutral payment rate cases for FY 2025 is the sum of the site neutral payment rate for the case and the IPPS fixed-loss amount. As discussed previously in section II.B.2. of this IFC, the provisions of this IFC result in the recalculation of the IPPS fixed-loss amount for FY 2025. Therefore, in this IFC, for FY 2025 we are establishing a fixed-loss amount for site neutral payment rate cases of $46,217, which is the same as the FY 2025 IPPS fixed-loss amount discussed in section II.B.2. of this IFC. Accordingly, under this policy, for FY 2025, we will calculate an HCO

payment for site neutral payment rate cases with costs that exceed the HCO threshold amount that is equal to 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the site neutral payment rate payment and the fixed-loss amount for site neutral payment rate cases of $46,217).

III. Waiver of Proposed Rulemaking and Delay in Effective Date

Under 5 U.S.C. 553(b) of the Administrative Procedure Act (APA), the agency is required to publish a notice of the proposed rulemaking in the **Federal Register** before the provisions of a rule take effect. Similarly, section 1871(b)(1) of the Act requires the Secretary to provide for notice of the proposed rulemaking in the **Federal Register** and provide a period of not less than 60 days for public comment. In addition, section 553(d) of the APA, and section 1871(e)(1)(B)(i) of the Act mandate a 30-day delay in effective date after issuance or publication of a rule. Sections 553(b)(B) and 553(d)(3) of the APA provide for exceptions from the notice and comment and delay in effective date APA requirements; in cases in which these exceptions apply, sections 1871(b)(2)(C) and 1871(e)(1)(B)(ii) of the Act provide exceptions from the notice and 60-day comment period and delay in effective date requirements of the Act as well. Section 553(b)(B) of the APA and section 1871(b)(2)(C) of the Act authorize an agency to dispense with normal rulemaking requirements for good cause if the agency makes a finding that the notice and comment process are impracticable, unnecessary, or contrary to the public interest. In addition, both section 553(d)(3) of the APA and section 1871(e)(1)(B)(ii) of the Act allow the agency to avoid the 30-day delay in effective date where such delay is contrary to the public interest and an agency includes a statement of support.

As discussed earlier, in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69302), we noted that the FY 2020 low wage index hospital policy and the related budget neutrality adjustment were the subject of pending litigation in multiple courts, and that on July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under section 1886(d)(3)(E) of the Act or under the ''adjustments'' language of section 1886(d)(5)(I)(i) of the Act to adopt the low wage index hospital policy for FY 2020, and that the policy and related budget neutrality adjustment must be vacated. *Bridgeport Hosp.* v. *Becerra,* 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024). We also stated that as of the date of that final rule's publication, the time to seek further review of the D.C. Circuit's decision in *Bridgeport Hospital* had not expired (see Fed. R. App. P. 40(a)(1)) and the government was evaluating the decision and considering options for next steps. There was a limited amount of time between July 23, 2024, and the beginning of FY 2025 on October 1, 2024, to consider options for the low wage index hospital policy for FY 2025 in the context of the D.C. Circuit's reasoning in *Bridgeport Hospital.* If the FY 2025 IPPS (and certain LTCH PPS) payment rates including the FY 2025 low wage index hospital policy were to go into effect on October 1, 2024, it is possible given the D.C. Circuit's decision regarding the FY 2020 low wage index hospital policy and potential further litigation developments that those FY 2025 payments would need to be revised, creating the potential need to reprocess significant numbers of FY 2025 claims and unnecessarily change FY 2025 payments retroactively for all IPPS and LTCH PPS hospitals. This would constitute an inefficient use of limited agency resources. It would also create legal uncertainty for the public and ongoing confusion for hospitals extending into FY 2025 about the amount of their IPPS and LTCH PPS payments, which runs counter to the prospective nature of these payment systems. Removing the FY 2025 low wage index hospital policy and associated budget neutrality adjustment through an IFC rather than through the notice and comment rulemaking cycle and waiving the delay of the effective date will allow these changes to be applied to FY 2025 IPPS payment rates (and certain LTCH PPS rates) at the beginning of the fiscal year on October 1, 2025, avoiding these issues. Therefore, we find good cause to waive the notice of proposed rulemaking requirements as well as the delay of the effective date and to issue this final rule on an interim basis. Even though we are waiving notice of proposed rulemaking requirements and are issuing these provisions on an interim final basis, we are providing a 60-day public comment period.

IV. Tables Referenced in This Interim Final Rule With Comment Period

This section lists the tables referred to throughout this IFC. As stated in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69989), for the FY 2025 rulemaking cycle, the IPPS and LTCH PPS tables will not be published in the **Federal Register** in the annual IPPS/LTCH PPS proposed and final rules and will be on the CMS website. Specifically, all IPPS tables listed in this IFC, with the exception of IPPS Tables 1A, 1B, 1C, and 1D, will generally be available on the CMS website. IPPS Tables 1A, 1B, 1C, and 1D are displayed at the end of this section.

Readers who experience any problems accessing any of the tables that are posted on the CMS websites identified in this IFC should contact Michael Treitel at (410) 786–4552.

The following IPPS tables for this IFC are generally available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.* Click on the link on the left side of the screen titled ''FY 2025 IPPS Final Rule Home Page'' or ''Acute Inpatient-Files-for Download.''

Table 2.—Final Case-Mix Index and Wage Index Table by CCN—FY 2025 Interim Final Rule With Comment Period

Table 3.—Final Wage Index Table by CBSA—FY 2025 Interim Final Rule With Comment Period

Table 18.—FY 2025 Interim Final Rule with Comment Period Medicare DSH Uncompensated Care Payment Factor 3. We note that we made updates to the calculation of Factor 3 of the uncompensated care payment methodology for all DSH-eligible hospitals to reflect the updated information for the hospitals that are no longer projected to receive interim uncompensated care payments for FY 2025. More specifically, because the Factor 3 calculated for each hospital reflects that hospital's uncompensated care amount relative to the uncompensated care amount for all subsection (d) hospitals that receive a DSH payment for the fiscal year, we recalculated Factor 3 for all DSH-eligible hospitals. The hospital-specific Factor 3 determines the total amount of the uncompensated care payment a hospital is eligible to receive for the fiscal year. Accordingly, we also recalculated the total uncompensated care amount for all DSH-eligible hospitals to reflect these updates. Each hospital's total uncompensated care payment amount is then used to calculate the amount of the interim uncompensated care payments a hospital receives per discharge. Given the very narrowly targeted update to the information used in the calculation of Factor 3, the change to the previously calculated Factor 3 is of limited magnitude for the majority of hospitals.

For the FY 2025 IPPS/LTCH PPS final rule, as corrected, we published a list of hospitals that we identified to be subsection (d) hospitals and subsection (d) Puerto Rico hospitals projected to be eligible to receive interim uncompensated care payments for FY 2025. We are updating this list and the calculations of Factor 3 of the uncompensated care payment methodology to reflect our updated interim uncompensated care eligibility projections. As noted earlier in this section, we are revising Factor 3 for all DSH-eligible hospitals to reflect these updates, and we are revising the amount of the total uncompensated care payment calculated for each DSH-eligible hospital.

TABLE 1A—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (67.6 PERCENT LABOR SHARE/32.4 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)—FY 2025

Hospital submitted quality data and is a meaningful EHR user (update = 2.9 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = 0.35 percent)		Hospital did not submit quality data and is a meaningful EHR user (update = 2.05 percent)		Hospital did not submit quality data and is not a meaningful EHR user (update = −0.5 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,478.09	$2,146.30	$4,367.12	$2,093.11	$4,441.10	$2,128.57	$4,330.13	$2,075.38

TABLE 1B—NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2025

Hospital submitted quality data and is a meaningful EHR user (update = 2.9 percent)		Hospital submitted quality data and is not a meaningful EHR user (update = 0.35 percent)		Hospital did not submit quality data and is a meaningful EHR user (update = 2.05 percent)		Hospital did not submit quality data and is not a meaningful EHR user (update = −0.5 percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,107.12	$2,517.27	$4,005.34	$2,454.89	$4,073.20	$2,496.47	$3,971.42	$2,434.09

TABLE 1C—ADJUSTED OPERATING STANDARDIZED AMOUNTS FOR HOSPITALS IN PUERTO RICO, LABOR/NONLABOR (NATIONAL: 62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE BECAUSE WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2025

	Rates if wage index greater than 1		Hospital is a meaningful EHR user and wage index less than or equal to 1 (update = 2.9)		Hospital is not a meaningful EHR user and wage index less than or equal to 1 (update = 0.35)	
	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
National [1]	Not Applicable	Not Applicable	$4,107.12	$2,517.27	$4,005.34	$2,454.89

[1] For FY 2025, there are no CBSAs in Puerto Rico with a national wage index greater than 1.

TABLE 1D—CAPITAL STANDARD FEDERAL PAYMENT RATE—FY 2025

	Rate
National	$512.14

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Analysis

We have examined the impacts of this IFC as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), Executive Order 14094 on Modernizing Regulatory Review (April 6, 2023), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (CRA) (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 14094 amends section 3(f) of Executive Order 12866 to define a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $200 million or more in any 1 year, or adversely affect in a material way the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, territorial, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise legal or policy issues for which centralized review would meaningfully further the President's priorities or the principles set forth in this Executive Order.

A regulatory impact analysis (RIA) is prepared for a regulatory action to document the economic impact and determine if a regulatory action is significant under section 3(f)(1). Based on our estimates, OMB'S Office of Information and Regulatory Affairs (OIRA) has determined this rulemaking is not significant under section 3(f)(1) of E.O. 12866. Accordingly, we have prepared a regulatory impact analysis that to the best of our ability presents the costs and benefits of the rulemaking. Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has also determined that this rule meets the

criteria set forth in 5 U.S.C. OMB has reviewed this IFC, and the Departments have provided the following assessment of their impact. The analysis in this section, in conjunction with the remainder of this document, demonstrates that this IFC is consistent with the regulatory philosophy and principles identified in Executive Orders 12866 and 13563, the RFA, and section 1102(b) of the Act. This IFC would affect payments to a substantial number of small rural hospitals, as well as other classes of hospitals, and the effects on some hospitals may be significant. Finally, in accordance with the provisions of Executive Order 12866, the Office of Management and Budget has reviewed this IFC.

The following quantitative analysis presents the projected effects of the policy changes established in this IFC, as well as changes effective for FY 2025 established in the FY 2025 IPPS/LTCH PPS final rule and correction notice, on various hospital groups.

To illustrate the effects of the provisions of this IFC on hospitals' FY 2025 payments, this impact analysis was developed by comparing the total estimated change in payments under this FY 2025 IPPS/LTCH PPS IFC and the total estimated change in payments from the FY 2025 IPPS/LTCH PPS final rule (89 FR 69991) as corrected in the FY 2025 IPPS/LTCH PPS final rule correction. Specifically, our analysis shows the effects of the removal of the low wage index hospital policy and the application of the transition policy (discussed in sections II.A. and B. of this IFC) by comparing the following:

- The total estimated change in payments based on FY 2025 policies relative to payments based on FY 2024 policies as calculated in our impact analysis in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69991) as corrected in FY 2025 IPPS/LTCH PPS final rule correction, which included the low wage index hospital policy.
- The total estimated change in payments based on FY 2025 policies after removing the low wage index hospital policy and applying the transitional exception policy (discussed in sections II.A. and II.B. of this IFC) relative to payments based on FY 2024 policies.

A comparison of these two isolates the estimated impact of removing the low wage index hospital policy and the application of the transition policy on FY 2025 payments as discussed later in this section.

Other than removing the low wage index hospital policy and applying the transitional exception policy, this impact analysis was developed using the same data and methodology described in the FY 2025 IPPS/LTCH PPS final rule and correction notice in conjunction with the rates and factors (for example, outlier threshold, interim uncompensated care per discharge payments amounts) established in this IFC, as discussed in sections II.A. and II.B. of this IFC. For ease of discussion, references to the removal of the low wage index hospital policy and the application of the transitional exception policy also include the conforming changes to the rates and factors established in this IFC (for example, outlier threshold, interim uncompensated care per discharge payments amounts).

A. Analysis of Table I

Table I displays the results of our analysis of the changes for FY 2025 before and after the removal of the low wage index hospital policy and the application of the transitional exception policy, and then uses this information to isolate the impact of the provisions of this IFC. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals, which are described in the FY 2025 IPPS/LTCH PPS final rule (89 FR 69996).

TABLE 1—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2025

	Number of hospitals	All FY 2025 changes—final rule as corrected [1] (A)	All FY 2025 changes—IFC [1] (B)	Overall impact of removing low wage index hospital policy with the transitional exception policy applied for FY 2025 [2] (C)
All Hospitals	3,083	2.8	2.8	0.0
By Geographic Location:				
Urban hospitals	2,392	2.8	2.9	0.1
Rural hospitals	691	2.6	2.2	−0.4
Bed Size (Urban):				
Q10–99 beds	645	1.1	1.1	0.0
100–199 beds	682	2.6	2.6	0.0
200–299 beds	421	2.8	2.8	0.0
300–499 beds	394	2.7	2.8	0.1
500 or more beds	248	3.2	3.2	0.0
Bed Size (Rural):				
0–49 beds	341	1.6	1.2	−0.4
50–99 beds	183	1.4	1.3	−0.1
100–149 beds	91	2.8	2.6	−0.2
150–199 beds	44	3.5	2.7	−0.8
200 or more beds	32	3.8	3.7	−0.1
Urban by Region:				
New England	106	4.2	4.4	0.2
Middle Atlantic	280	1.1	1.3	0.2
East North Central	367	4.6	4.8	0.2
West North Central	156	2.7	2.6	−0.1
South Atlantic	396	4.4	4.4	0.0
East South Central	142	4.7	3.3	−1.4
West South Central	358	3.7	3.6	−0.1
Mountain	179	2.4	2.6	0.2

TABLE 1—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2025—Continued

	Number of hospitals	All FY 2025 changes—final rule as corrected [1] (A)	All FY 2025 changes—IFC [1] (B)	Overall impact of removing low wage index hospital policy with the transitional exception policy applied for FY 2025 [2] (C)
Pacific	356	0.1	0.3	0.2
Rural by Region:				
New England	21	2.2	2.4	0.2
Middle Atlantic	52	4.4	4.6	0.2
East North Central	110	2.1	2.1	0.0
West North Central	78	2.0	1.9	−0.1
South Atlantic	112	1.6	1.3	−0.3
East South Central	132	3.6	1.8	−1.8
West South Central	120	3.1	2.5	−0.6
Mountain	42	2.5	2.5	0.0
Pacific	24	1.5	1.6	0.1
Puerto Rico:				
Puerto Rico Hospitals	52	2.3	−0.5	−2.8
By Payment Classification:				
Urban hospitals	1,714	2.4	2.4	0.0
Rural areas	1,369	3.1	3.1	0.0
Teaching Status:				
Nonteaching	1,833	2.3	2.3	0.0
Fewer than 100 residents	958	2.9	2.9	0.0
100 or more residents	292	3.0	3.1	0.1
Urban DSH:		0.0		
Non-DSH	331	2.6	2.6	0.0
100 or more beds	1,015	2.4	2.4	0.0
Less than 100 beds	368	2.4	2.4	0.0
Rural DSH:				
Non-DSH	83	2.0	2.1	0.1
SCH	243	2.9	2.8	−0.1
RRC	791	3.2	3.2	0.0
100 or more beds	39	4.0	4.1	0.1
Less than 100 beds	213	−1.8	−2.6	−0.8
Urban teaching and DSH:				
Both teaching and DSH	581	2.4	2.4	0.0
Teaching and no DSH	52	2.1	2.2	0.1
No teaching and DSH	802	2.4	2.4	0.0
No teaching and no DSH	279	2.9	2.9	0.0
Special Hospital Types:				
RRC	155	3.0	2.8	−0.2
RRC with Section 401 Reclassification	579	3.3	3.3	0.0
SCH	245	2.6	2.5	−0.1
SCH with Section 401 Reclassification	34	3.1	3.1	0.0
SCH and RRC	119	2.8	2.6	−0.2
SCH and RRC with Section 401 Reclassification	46	2.7	2.7	0.0
Type of Ownership:				
Voluntary	1,907	2.7	2.8	0.1
Proprietary	755	3.2	3.3	0.1
Government	420	2.6	2.4	−0.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	1,362	2.9	3.0	0.1
25–50	1,616	2.7	2.7	0.0
50–65	65	1.1	1.2	0.1
Over 65	16	0.0	−1.0	−1.0
Medicaid Utilization as a Percent of Inpatient Days:				
0–25	1,911	2.8	2.9	0.1
25–50	1,044	2.8	2.9	0.1
50–65	99	1.1	1.3	0.2
Over 65	29	0.8	0.9	0.1
FY 2025 Reclassifications:				
All Reclassified Hospitals	1,061	3.1	3.1	0.0
Non-Reclassified Hospitals	2,022	2.5	2.5	0.0
Urban Hospitals Reclassified	902	3.1	3.1	0.0
Urban Nonreclassified Hospitals	1,501	2.4	2.5	0.1
Rural Hospitals Reclassified Full Year	281	2.9	2.6	−0.3
Rural Nonreclassified Hospitals Full Year	399	2.1	1.8	−0.3
All Section 401 Reclassified Hospitals:	729	3.2	3.2	0.0

TABLE 1—IMPACT ANALYSIS OF CHANGES TO THE IPPS FOR OPERATING COSTS FOR FY 2025—Continued

	Number of hospitals	All FY 2025 changes—final rule as corrected [1] (A)	All FY 2025 changes—IFC [1] (B)	Overall impact of removing low wage index hospital policy with the transitional exception policy applied for FY 2025 [2] (C)
Other Reclassified Hospitals (Section 1886(d)(8)(B))	51	1.9	1.8	−0.1

[1] Percent change in estimated payments from FY 2024 to FY 2025.
[2] Calculated as (1 plus (the Column B value/100)) divided by (1 plus the (Column A value/100)), minus 1, multiplied by 100.

- Effects of All FY 2025 Changes—Final Rule, as Corrected (Column A)

Column A shows our estimate of the change in payments per discharge from FY 2024 to FY 2025 resulting from all changes reflected in the FY 2025 IPPS/LTCH PPS final rule, as corrected, including the estimated effects of the continuation of the low wage index hospital policy in FY 2025. For complete details refer to the FY 2025 IPPS/LTCH PPS final rule (89 FR 69994 through 70002) and FY 2025 IPPS/LTCH PPS final rule correction.

- Effects of All FY 2025 IFC Changes (Column B)

As in Column A, Column B also shows our estimate of the change in payments per discharge from FY 2024 to FY 2025 resulting from all changes reflected in the FY 2025 IPPS/LTCH PPS final rule, as corrected, except instead of including the estimated effects of the continuation of the low wage index hospital policy in FY 2025, it includes the estimated effects in FY 2025 of removing the low wage index hospital policy and applying the transitional exception policy.

- Overall Impact of Removing the Low Wage Index Hospital Policy with the Transitional Exception Policy Applied for FY 2025 (Column C)

This column compares Column B, reflecting the removal of the low wage index hospital policy and the application of the transition policy in FY 2025, to Column A, reflecting the continuation of the low wage index hospital policy in FY 2025, to isolate the impact of removing the low wage index hospital policy and applying the transition policy. Specifically, it shows the changes in FY 2025 payments from the FY 2025 final rule, as corrected, to the FY 2025 payments under this IFC. These changes are entirely attributable to the effects of (1) the removal of the low wage index hospital policy and (2) the application of the transitional exception policy (as described in section II.B. of this IFC), because those are the only policy differences between the FY 2025 IPPS/LTCH PPS final rule as corrected, and this IFC. As noted earlier, other than those policy changes, this impact analysis was developed using the same data and methodology described in the FY 2025 IPPS/LTCH PPS final rule and the FY 2025 IPPS/LTCH PPS final rule correction.

The average change in FY 2025 payments under the IPPS for all hospitals due to the provisions of this IFC is approximately 0.0 percent to the nearest tenth of a percent. Although the non-budget neutral transition policy is estimated to increase IPPS operating payments by approximately $37 million, this amount represents less than a tenth of a percent of IPPS payments.

As a result of the provisions of this IFC, overall 768 hospitals will receive a lower wage index in FY 2025 than their FY 2025 wage index in the FY 2025 IPPS/LTCH PPS final rule, as corrected, and 2,315 hospitals will experience no change in their FY 2025 wage index. Hospitals in urban areas will experience a 0.1 percent increase in their FY 2025 estimated payments relative to the FY 2025 estimated payments in the FY 2025 IPPS/LTCH PPS final rule, as corrected. We estimate that 445 urban hospitals will receive a lower FY 2025 wage index than their FY 2025 wage index in the FY 2025 IPPS/LTCH PPS final rule, as corrected, while 1,947 urban hospitals will experience no change to their FY 2025 wage index. Hospitals in rural areas will experience a −0.4 percent decrease in their FY 2025 estimated payments relative to the FY 2025 estimated payments in the FY 2025 IPPS/LTCH PPS final rule, as corrected. We estimate that 323 rural hospitals will receive a lower FY 2025 wage index than their FY 2025 wage index in the FY 2025 IPPS/LTCH PPS final rule, as corrected, while 368 rural hospitals will experience no change to their FY 2025 wage index. We estimate that 113 hospitals (85 urban and 28 rural) will receive the transitional exception policy.

The comparisons by region show that the change in payments for urban areas range from a 1.4 percent decrease for the East South Central urban region to a 0.2 percent increase for New England, Middle Atlantic, East North Central, Mountain, and Pacific urban regions. Meanwhile, the change in payments for rural areas range from a 1.8 percent decrease for the East South Central rural region to increases of 0.2 percent for the New England and Middle Atlantic rural regions. IPPS payments to hospitals located in Puerto Rico are projected to decrease by 2.8 percent. These changes reflect the fact that different regions have different proportions of low wage hospitals, with the highest relative concentrations of low wage hospitals in Puerto Rico and the East South Central region. Regions that have relatively few low wage hospitals compared to non-low wage hospitals are projected to experience payment increases due to the removal of the low wage index hospital budget neutrality adjustment.

B. Effects of Changes on the Capital IPPS

The approach for estimating the effect of the provisions of this IFC on capital IPPS payments parallels the approach taken for IPPS operating payments. Table II displays the results of our analysis of the changes for FY 2025 before and after the removal of the low wage index hospital policy and the application of the transition policy, and then uses this information to isolate the impact of the provisions of this IFC.

The average change in FY 2025 capital IPPS payments per case for all hospitals due to the provisions of this IFC is approximately 0.1 percent to the nearest tenth of a percent. The non-budget neutral transitional exception policy is estimated to increase capital IPPS payments by approximately $3 million. (We note that the difference in the average change for all hospitals between operating and capital is primarily due to rounding.) Capital IPPS payments per case will increase by an

estimated 0.1 percent for hospitals in urban areas compared to the FY 2025 IPPS/LTCH PPS final rule as corrected while payments to hospitals in rural areas will decrease by 0.5 percent.

The comparisons by region show that the change in capital payments per case for urban areas range from a 1.7 percent decrease for the East South Central urban region to a 0.3 percent increase for the New England, Middle Atlantic, and Pacific urban regions. Meanwhile, the change in capital payments per case for rural areas range from a 2.6 percent decrease for the East South Central rural region to a 0.4 percent increase for the New England, Middle Atlantic, and Pacific rural regions. Capital payments per case for hospitals located in Puerto Rico are projected to decrease by an estimated 3.6 percent. As with operating payments, these regional changes reflect the fact that different regions have different proportions of low wage hospitals, with the highest relative concentrations of low wage hospitals in Puerto Rico and the East South Central region. Regions that have relatively few low wage hospitals compared to non-low wage hospitals are projected to experience payment increases due to the removal of the low wage index hospital budget neutrality adjustment.

TABLE II—COMPARISON OF TOTAL CAPITAL PAYMENTS PER CASE

	Number of hospitals	All FY 2025 changes—final rule as corrected (A) *	All FY 2025 changes—IFC (B) *	Overall impact of removing low wage index hospital policy with the transitional exception policy applied for FY 2025 (C) **
All Hospitals	3,083	2.8	2.9	0.1
By Geographic Location:				
Urban hospitals	2,392	2.7	2.8	0.1
Rural hospitals	691	3.8	3.3	−0.5
Bed Size (Urban):				
0–99 beds	645	2.3	2.3	0.0
100–199 beds	682	2.6	2.7	0.1
200–299 beds	421	2.6	2.6	0.1
300–499 beds	394	2.5	2.6	0.1
500 or more beds	248	2.8	2.9	0.1
Bed Size (Rural):				
0–49 beds	341	3.6	2.7	−0.9
50–99 beds	183	3.6	3.3	−0.3
100–149 beds	91	3.5	3.0	−0.5
150–199 beds	44	4.2	3.1	−1.0
200 or more beds	32	4.0	3.7	−0.3
Urban by Region:				
New England	106	3.9	4.2	0.3
Middle Atlantic	280	0.8	1.1	0.3
East North Central	367	5.0	5.1	0.1
West North Central	156	2.1	2.1	0.0
South Atlantic	396	4.4	4.4	0.0
East South Central	142	5.0	3.2	−1.7
West South Central	358	3.6	3.6	0.0
Mountain	179	2.2	2.4	0.2
Pacific	356	−0.1	0.2	0.3
Rural by Region:				
New England	21	3.5	3.9	0.4
Middle Atlantic	52	5.0	5.5	0.4
East North Central	110	6.0	6.0	0.0
West North Central	78	2.4	1.9	−0.5
South Atlantic	112	2.4	1.9	−0.5
East South Central	132	5.0	2.2	−2.6
West South Central	120	4.1	3.4	−0.7
Mountain	42	1.7	2.1	0.3
Pacific	24	−0.4	0.0	0.4
Puerto Rico:				
Puerto Rico Hospitals	52	2.1	−1.6	−3.6
By Payment Classification:				
Urban hospitals	1,714	2.3	2.4	0.1
Rural areas	1,369	3.2	3.2	0.0
Teaching Status:				
Nonteaching	1,833	2.6	2.6	0.0
Fewer than 100 residents	958	2.9	2.9	0.0
100 or more residents	292	2.6	2.7	0.1
Urban DSH:				
Non-DSH	331	2.5	2.5	0.0
100 or more beds	1,015	2.3	2.4	0.1
Less than 100 beds	368	2.3	2.3	0.0
Rural DSH:				
Non-DSH	83	3.5	3.8	0.3
SCH	243	2.9	2.7	−0.2

TABLE II—COMPARISON OF TOTAL CAPITAL PAYMENTS PER CASE—Continued

	Number of hospitals	All FY 2025 changes—final rule as corrected (A)*	All FY 2025 changes—IFC (B)*	Overall impact of removing low wage index hospital policy with the transitional exception policy applied for FY 2025 (C)**
RRC	791	3.1	3.1	0.0
100 or more beds	39	4.3	4.3	0.1
Less than 100 beds	213	4.2	3.2	−1.0
Urban teaching and DSH:				
Both teaching and DSH	581	2.2	2.3	0.1
Teaching and no DSH	52	2.1	2.2	0.1
No teaching and DSH	802	2.3	2.3	0.0
No teaching and no DSH	279	2.7	2.7	0.0
Special Hospital Types:				
RRC	155	4.9	4.6	−0.3
RRC with Section 401 Rural Reclassification	579	3.0	3.1	0.1
SCH	245	3.4	3.0	−0.4
SCH with Section 401 Rural Reclassification	34	2.6	2.9	0.3
SCH and RRC	119	4.2	3.7	−0.4
SCH and RRC with Section 401 Rural Reclassification	46	2.5	2.6	0.1
Type of Ownership:				
Voluntary	1,907	2.7	2.8	0.2
Proprietary	755	3.2	3.2	0.0
Government	420	2.3	2.1	−0.2
Medicare Utilization as a Percent of Inpatient Days:				
0–25	1,362	2.7	2.7	0.0
25–50	1,616	2.8	2.9	0.1
50–65	65	1.2	1.3	0.1
Over 65	16	0.8	−0.7	−1.5
Medicaid Utilization as a Percent of Inpatient Days:				
0–25	1,911	2.9	3.0	0.1
25–50	1,044	2.6	2.6	0.0
50–65	99	0.9	1.1	0.3
Over 65	29	0.4	0.5	0.1
FY 2025 Reclassifications:				
All Reclassified Hospitals	1,061	3.1	3.1	0.0
Non-Reclassified Hospitals	2,022	2.4	2.5	0.1
Urban Hospitals Reclassified	902	3.0	3.1	0.1
Urban Non-Reclassified Hospitals	1,501	2.3	2.3	0.1
Rural Hospitals Reclassified Full Year	281	4.1	3.6	−0.5
Rural Non-Reclassified Hospitals Full Year	399	3.3	2.6	−0.6
All Section 401 Rural Reclassified Hospitals	729	3.0	3.1	0.1
Other Reclassified Hospitals (Section 1886(d)(8)(B))	51	4.2	4.2	0.0

* Percent change in estimated payments from FY 2024 to FY 2025.
** Calculated as (1 plus (the Column B value/100)) divided by (1 plus the (Column A value/100)), minus 1, multiplied by 100.

C. Overall Conclusion

Acute care hospitals are estimated to experience an increase of approximately $41 million in FY 2025 due to the provisions of this IFC. This change is primarily due to the application of the non-budget neutral transitional payment exception policy. The estimated change in operating payments is approximately $37 million (discussed in section VI.A. of this IFC). The estimated change in capital payments is approximately $3 million (discussed in section VI.B. of this IFC). The total differs from the sum of the components due to rounding.

Table I of section VI.A. of this IFC and Table II of section VI.B. of this IFC demonstrate the estimated redistributional impacts of the provisions of this IFC. Discussions presented in the previous pages, in combination with the remainder of this IFC, constitute the regulatory impact analysis.

D. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table V. of this IFC, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this IFC as they relate to acute care hospitals. This table provides our best estimate of the change in Medicare payments to providers as a result of the changes to the IPPS presented in this IFC relative to the FY 2025 IPPS/LTCH PPS final rule as corrected in the FY 2025 IPPS/LTCH PPS final rule correction. All expenditures are classified as transfers to Medicare providers.

As shown in Table V., the net costs to the Federal Government associated with the policies in this IFC are estimated at $41 million.

TABLE V—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES UNDER THE IPPS

Category	Transfers
Annualized Monetized Transfers	$41 million.
From Whom to Whom	Federal Government to IPPS Medicare Providers.

E. Regulatory Flexibility Act (RFA) Analysis

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. We estimate that most hospitals and most other providers and suppliers are small entities as that term is used in the RFA. The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the SBA definition of a small business (having revenues of less than $8.0 million to $41.5 million in any 1 year). (For details on the latest standards for health care providers, we refer readers to page 38 of the Table of Small Business Size Standards for NAIC 622 found on the SBA website at *https://www.sba.gov/sites/default/files/files/Size_Standards_Table.pdf*.)

For purposes of the RFA, all hospitals and other providers and suppliers are considered to be small entities. Because all hospitals are considered to be small entities for purposes of the RFA, the hospital impacts described in this IFC are impacts on small entities. Individuals and States are not included in the definition of a small entity. MACs are not considered to be small entities because they do not meet the SBA definition of a small business. HHS's practice in interpreting the RFA is to consider effects economically ''significant'' if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. Although less than 5 percent of providers are estimated to reach a threshold of 3 to 5 percent of total revenue or total costs, the provisions of this IFC relating to IPPS hospitals would have an economically significant impact on many small entities as explained in this IFC. For example, as discussed in section VI.A. of this IFC, we estimate 113 hospitals will receive the transitional exception policy due to being significantly impacted by the removal of the low wage index hospital policy.

This IFC provides descriptions of the provisions that are addressed, identifies the finalized policies, and presents rationales for our decisions. The analyses discussed in this IFC constitutes our regulatory flexibility analysis. We solicit public comments on our estimates and analysis of the impact of our policies on small entities.

F. Impact on Small Rural Hospitals

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed or final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of an urban area and has fewer than 100 beds. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent urban area. Thus, for purposes of the IPPS, we continue to classify these hospitals as urban hospitals.

As shown in Table I. in section VI.A. of this IFC, rural IPPS hospitals with 0–49 beds (341 hospitals) are expected to experience a decrease in payments of −0.4 percent, and rural IPPS hospitals with 50–99 beds (182 hospitals) are expected to experience a decrease in payments of −0.1 percent relative to the FY 2025 IPPS/LTCH PPS final rule as corrected by the FY 2025 IPPS/LTCH PPS final rule correction. These changes are due to the removal of the low wage index hospital policy in conjunction with the application of the transition policy. We refer readers to Table I. in section VI.A. of this IFC for additional information on the quantitative effects of the policy changes under the IPPS for operating costs.

G. Unfunded Mandates Reform Act Analysis

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2024, that threshold level is approximately $183 million. This IFC would not mandate any requirements that meet the threshold for State, local, or tribal governments, nor would it affect private sector costs.

H. Executive Order 13132

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a rule that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has federalism implications. This IFC would not have a substantial direct effect on state or local governments, preempt states, or otherwise have a federalism implication.

I. Executive Order 13175

Executive Order 13175 directs agencies to consult with Tribal officials prior to the formal promulgation of regulations having tribal implications. Section 1880(a) of the Act states that a hospital of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization, is eligible for Medicare payments so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals. Consistent with section 1880(a) of the Act, this IFC contains general provisions also applicable to hospitals and facilities operated by the Indian Health Service or Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act. We continue to engage in consultations with Tribal officials on IPPS issues of interest. We use input received from these consultations, as well as the comments on this IFC, to inform our rulemaking.

J. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this IFC was reviewed by the Office of Management and Budget.

VII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Chiquita Brooks-LaSure, Administrator of the Centers for Medicare & Medicaid Services, approved this document on September 26, 2024

Xavier Becerra,

Secretary, Department of Health and Human Services.

[FR Doc. 2024–22765 Filed 9–30–24; 4:15 pm]

BILLING CODE 4120–01–P