

Centers for Medicare & Medicaid Services
Hospital Open Door Forum
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Webinar recording:

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Jill Darling: Hi, everyone. Good morning and good afternoon. My name is Jill Darling, and I am in the CMS Office of Communications. Welcome to today's Hospital Open Door Forum (ODF). Thank you for your patience as we were letting more folks into the webinar today. Before we begin with our agenda, I do have a few announcements. For those who need closed captioning, I provided a link in the chat, and I will provide it again for you. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum transcript webpage. That link was on the agenda, and I can provide it for you again in the chat. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry.

For today's webinar, I have the agenda slide presented to you today. We will be taking questions at the end of the agenda today. We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's webinar. If you have any questions unrelated to these topics, we may not have the appropriate person on the call to answer your questions. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the Open Door Forum resource mailbox that I will provide, and we'll get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for Q&A. Please introduce yourself with the organization or business you're calling from. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we'll do our best to get to all of your questions today. And now I'll turn the call over to our Chair, Joe Brooks.

Joseph Brooks: [inaudible]. OPPOS (Outpatient Prospective Payment System) and ASC (Ambulatory Surgical Center) Payment System final rule, which was issued on November 1. We'll also be discussing the FY 25 IPPS (Inpatient Prospective Payment System) IFC (Interim Final Action with Comment) with comment, which was issued on September 30. And to be assured, consideration comments and response to the IFC should be received no later than 11:59 p.m. Eastern Time on November 29. And finally, we'll be discussing payment adjustments for domestic NIOSH (The National Institute for Occupational Safety and Health) approved surgical N95 respirators. We have several topics to work through today. So, to save some time for Q&A,

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I'm going to let us get right to it. I'll turn it over to David Rice, who will begin with updates to the OPSS and ASC payment rates. David.

David Rice: Thanks Joe. So, in accordance with Medicare law, CMS is finalizing an update to OPSS payment rates for hospitals by 2.9%. This update is based on the projected hospital market basket percentage increase of 3.4%, reduced by 0.5 percentage points for the productivity adjustment. In the 2019 OPSS ASC final rule, CMS finalized a proposal to apply the productivity adjusted hospital market basket update to ASC payment rates for an interim period of five years, which was 2019 through 2023. The 2024 final rule extended this for an additional two years through 2025. Accordingly, using the hospital market basket update, CMS has finalized an update factor for the ASC rates for 2025 of 2.9%. Now, I'll pass it over to Cory Duke.

Cory Duke: Thanks, Dave. All right, just testing if the echo is gone. All right, I think we might be good.

Jill Darling: You're good now.

Cory Duke: All right, so I'll start with the access to non-opioid treatments for pain relief. So, for this item, CMS is finalizing the implementation of Section 4135 of the Consolidated Appropriations Act of 2023, which provides temporary additional payments for certain non-opioid treatments for pain relief in the hospital outpatient department and ASC settings from January 1, 2025, through December 31, 2027. This policy is implementing several statutory provisions, including evidence requirements for medical devices and the requirements for FDA approved indications for drugs. To implement the statutory payment limitation under which the separate payment must not exceed the estimated average of 18% of the OPSS payment for a service or group of services with which the non-opioid treatment for pain relief is furnished, CMS is finalizing our proposal to utilize the top five primary OPSS procedures by volume for each non-opioid drug or device in order to calculate the payment limitation. CMS is finalizing the policy to include drugs and devices that qualify as nonopioid treatments for pain relief, and these products will be paid separately in both the HOPD (Hospital Outpatient Department) and ASC setting starting in 2025. The qualifying drugs have FDA approved indications to reduce postoperative pain or produce post-surgical analgesia, and the qualifying medical devices have the appropriate FDA approval and have demonstrated through evidence that they reduce opioid usage when used in the postoperative setting. A total of six drugs and five medical devices were designated as qualifying non-opioid treatments for pain relief, and they will receive separate payment in both the HOPD and ASC setting starting in calendar year 2025. New product-specific C codes were created for the five medical devices, and additionally, payment for the non-opioid treatments for pain relief will also be excluded from OPSS packaging, such as from comprehensive APC (Ambulatory Payment Classifications) packaging.

I'll move on to the next item on the agenda: Payment for diagnostic radiopharmaceuticals. Currently, under the OPSS, the payment for diagnostic radiopharmaceuticals is packaged into the payment for the nuclear medicine tests with which they are used. This follows the policy in the

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calendar 2008 OPPS ASC final rule comment where we finalize the packaging status of diagnostic radiopharmaceuticals as part of our overall packaging approach for the calendar year 2008 OPPS and subsequent years. We believe diagnostic radiopharmaceuticals are always intended to be used with a diagnostic nuclear medicine procedure and function as supplies when used in a diagnostic test or procedure—generally making it appropriate to package the payment for the item with the payment for the related nuclear medicine procedure. While we continue to believe that this should be the policy for most diagnostic radiopharmaceuticals, we understand there are certain situations in which the package payment amount attributed to the diagnostic rate of pharmaceutical used in an imaging procedure which is assigned to a nuclear medicine APC may not adequately account for the cost of a diagnostic radiopharmaceutical that has a significantly higher cost relative to other diagnostic radiopharmaceuticals that may be used with that same procedure.

To ensure Medicare payment policy does not provide a financial disincentive to using a high-cost diagnostic radiopharmaceuticals, especially when those agents may be the most clinically appropriate and to ensure appropriate individual access, we believe a subset of diagnostic radiopharmaceuticals with higher per-day costs should be paid separately and not packaged into the diagnostic procedure in which they are used. Consequently, we proposed and finalized refinements to our existing package and policy to improve the accuracy of the overall payment amounts by paying separately for non pass-through diagnostic radiopharmaceuticals with a per-day cost greater than \$630 and subsequently removing their costs from the payment amounts for the nuclear medicine APCs. \$630 is approximately two times the volume-weighted average cost associated with diagnostic radiopharmaceuticals assigned to nuclear medicine APCs. We multiply the volume weighted average amount of the offset by two to establish the threshold triggering separate payment because this amount would ensure that separate payment would apply only to diagnostic radiopharmaceuticals whose cost significantly exceeded the appropriate amount of payment already attributed to the product in the nuclear medicine APC. Starting in the calendar year 2026 and for subsequent years, we will update the threshold amount of \$630 by the PPI (Producer Price Index) for pharmaceuticals for human use. For calendar year 2025, all qualifying diagnostic radiopharmaceuticals will be paid separately at their mean unit cost or MUC, which is a payment rate derived from hospital claims data. Any diagnostic radiopharmaceutical with a per-day cost equal to or below that threshold will continue to be policy-packaged into the payment for the nuclear medicine tests. This policy will provide separate payments for 26 diagnostic radiopharmaceuticals during the calendar year 2025.

Next, I'll move on to the next topic on the agenda. The gene and cell therapy exclusion from C-APCs (comprehensive APCs) and comprehensive APCs or C-APCS in the OPPS create payment bundles for common surgeries and procedures performed in the hospital outpatient department. A single payment is made for the C-APC, which includes ancillary items and services used to support the primary service, including drugs, regardless of their cost. The intent has been to make a single prospective payment based on the cost of all individually reported codes that appear on a claim with the primary C-APC service, which we believe represents the provision of a primary service and all adjunctive services provided to support the delivery of that primary

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service. In rare instances, the payment for very high-cost drugs, namely chimeric antigen receptor T-cell therapies or CAR T therapies and gene therapies, is inadvertently packaged into comprehensive APCs even though the cell or gene therapy is not functioning as integral, ancillary supportive dependent or adjunctive to the primary C-APC service. Therefore, we are finalizing a policy to exclude payment for cell and gene therapies from being packaged when furnished with primary C-APC services for calendar year 2025 and subsequent years. For new cell and gene therapy products that are not integral, ancillary, supportive, dependent, or adjunctive to any C-APC primary service, we'll continue to add their product-specific HCPCS (Healthcare Common Procedure Coding System) codes, when created, to the C-APC exclusion lists. Currently for calendar year 2025, we are excluding payment from being packaged into primary C-APC services for 10 cell or gene therapies. I will now hand it over to my colleague, Nicole Marcos, for the next topic in the agenda. Thank you.

Nicole Marcos: Thanks so much, Cory. I will be talking about our final policies for Category B IDE (Investigational Device Exemption) and CED (Coverage with Evidence Development) trials. In the CY 2023 OPSS final rule, we finalized a policy to make a single blended payment for devices and services in Category B investigational device exemptions for IDE studies in order to preserve the scientific validity of these studies by avoiding differences in Medicare payment methods that would otherwise reveal the group, either the treatment or the control, to which patient had been assigned. For CY 2025, we made two proposals regarding OPSS payments for clinical trials. First, we proposed to clarify that our policy to make a single, blended payment to preserve the scientific integrity of Category B IDE clinical trials only applies to Category B IDE trials with a control arm. We did not receive any comments on this proposal, and we are finalizing as proposed. Second, we proposed to extend our coding and payment policy to trials with treatment and control arms for drugs and devices that are covered under an NCD with a coverage and evidence development, or CED, designation. We received several comments expressing concerns regarding applying this payment methodology to CED drugs and devices. For example, commenters were concerned about the implications of requiring a co-insurance payment for beneficiaries participating in trials for CED drugs and devices, as well as the potential payment reduction as a result of making one single blended payment. Given those concerns, we are not finalizing our CED proposal at this time. We'll take this feedback and use this additional time to further consider the broader policy implications prior to finalizing a payment policy for CED drugs and devices in the future. With that, I will pass it to Dave Rice for the next few items. Thank you.

David Rice: Thanks, Nicole. So, moving to the OPSS wage index, since the establishment of the OPSS, we have adopted the IPPS wage index on a calendar year basis in the OPSS. However, on July 23, 2024, the court of appeals for the DC circuit held that the secretary lacked authority under Section 1886D of the Act to adopt the low wage index hospital policy for fiscal year 2020 for the IPPS and that the policy and related budget neutrality adjustment in the IPPS must be vacated. In consideration of the court decision, CMS subsequently removed the low wage index hospital policy for the fiscal year 2025 IPPS purposes. We note that we propose to include the low wage index hospital policy as part of the 2025 OPSS wage index and believe that the

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statutory authority provided under Section 1833T2D of the Act allows us to finalize a similar policy for calendar year 2025 OPPS, as we have each year since beginning calendar year 2020. In light of the unique circumstances presented by the timing of the DC Circuit Court's decision, application of the low wage index hospital policy under the OPPS for calendar year 2025 avoids unexpected payment consequences for hospitals that were not plaintiffs in the Bridgeport case and so falls within our equitable adjustment authority. We believe that this appropriate approach for 2025 OPPS and given the unusual circumstances wherein an appellate court ruled that CMS lacked authority under the IPPS statute for a policy that the OPPS proposed rule had already proposed to include in the OPPS wage index. CMS will explore options for realigning the IPPS wage index values through future rulemaking.

Moving to the ASC covered procedures list, the ASC covered procedures list specifies the list of procedures that can be safely performed in an ASC. CMS evaluates the ASC covered procedures list each year to determine whether procedures should be added or removed from the list. In the final rule for the calendar year 2025, CMS has added 21 medical and dental procedures to the ASC covered procedures list for the calendar year 2025. Moving to the add-on payment for domestically produced Technetium-99m. Technetium-99 is the radioisotope used in most diagnostic imaging services, and this is historically derived from legacy reactors outside of the United States using highly enriched uranium (HEU). Beginning in 2013, we finalized a policy to provide an additional payment of \$10 for the marginal cost of Tc-99m produced by non-HEU sources. 2025 is the final year of the add-on payment for Tc-99m when the Tc-99m is produced without the use of highly enriched uranium. As the Secretaries of Energy and Health and Human Services have issued a certification, there's sufficient global supply of Tc-99m without the use of HEU available to meet the needs of patients in the United States. However, the Department of Energy and other interested parties have identified another issue affecting the domestic supply chain for Mo-99, the source material for Tc-99m, that could cause payment inequity among outpatient hospital providers. For an Mo-99, production has historically been subsidized, resulting in prices below the true cost of production. We propose to address this payment inequity in this rule by establishing a new add-on payment of \$10 per dose for radiopharmaceuticals that use Tc-99m derived from domestically produced Mo-99 starting January 1, 2026. We believe the \$10 add-on payment for domestically produced Tc-99m would ensure equitable payments by providing pain providers who use domestically produced Tc-99 radiopharmaceuticals an amount that reflects the anticipated higher cost of these products. And at this point, I will pass it over to Nate Vercauteren.

Nate Vercauteren: Hello, I'm going to talk about remote services in the calendar year 2025 final OPPS rule. To maintain alignment across payment systems, we clarified that for OPPS payment for services furnished remotely by hospital staff to individuals in their homes, including remotely furnished outpatient therapy services, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT) services, and mental health services. We anticipated aligning our requirements with those associated with Medicare telehealth and billed under the PFS. We noted that while the amendments made by Section 4113 of the 2023 Consolidated Appropriations Act expanded the range of practitioners eligible to furnish telehealth services through calendar year

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2024 without subsequent legislation, these practitioners will no longer be able to bill for Medicare telehealth services beginning January 1, 2025. Consequently, beginning January 1, 2025, CMS likewise will no longer pay for outpatient therapy DSMT and MNT services when furnished remotely by hospital staff to beneficiaries in their homes. We also clarified that the delay of the application of the in-person requirements for mental health services that individuals receiving remotely furnished mental health services are required to have an in-person visit in the six months prior to initiation of services and once annually thereafter would absent subsequent legislation end of January 1, 2025, under the OPSS since they are ending as of that date under the PFS. I think I have an outdated agenda. Am I the next person as well, or is someone else the next person?

David Rice: You're next, Nate.

Nate Vercauteren: OK, thank you. So, I'll cover next IHS (Indian Health Service) and tribal hospitals. Under current regulations, IHS and tribal hospitals are excluded from payment under the OPSS. Instead, IHS and tribal outpatient departments are paid the Medicare outpatient hospital all-inclusive rate, or AIR, for each encounter that provides hospital outpatient services. On an annual basis, based on a review of yearly cost reports, IHS calculates and publishes in the Federal Register the AIR payment rates. For calendar year 2024, the outpatient AIR is \$667 in the lower 48 states. As IHS and tribal hospitals have continued to expand the breadth of services that they provide to their communities, increasingly, this has meant providing higher-cost drugs along with more complex and expensive services, such as cancer-related services. As the cost of many of these specialty drugs exceeds the AIR by significant amounts, we were concerned about the beneficiary equity and access since IHS, and tribal hospitals would always receive payment for those drugs that is far below what is paid to acquire them.

Consequently, effective January 1, 2025, we are establishing an add-on payment to the AIR for all drugs furnished in hospital outpatient departments of Indian Health Service and tribal hospitals with a per day cost of more than two times the Medicare outpatient per visit rate for the lower 48 states' AIR, which is \$1,334 in the calendar year 2024. Drugs exceeding this threshold will be paid for separately in addition to the \$667 AIR payment. The amount of payment for these drugs will be the average sales price. We believe this policy will increase access to high-cost drugs like certain chemotherapies in IHS and tribal hospital settings and will help improve disparities in access to cancer-related care consistent with the goals of the Cancer Moonshot. And I believe I'm turning this over to Molly next.

Molly Anderson: Yes, thank you, Nate. Today, I'll be discussing the health and safety standards for obstetrical services in hospitals and critical access hospitals, or CAHs. These requirements, which were informed by public input, build on CMS' comprehensive maternity care action plan, drive improvements in access, and aim to make pregnancy childbirth and postpartum care safer. These new standards ensure that all Medicare and Medicaid participating hospitals and CAHs offering obstetrical services are held to a consistent standard of high-quality maternity care that protects the health and safety of pregnant birthing and postpartum patients. As a part of this final

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rule, we have established new requirements for maternal quality assessment and performance improvement, or QAPI, baseline standards for the organization, staffing, and delivery of obstetrical care, and staff training on evidence-based maternal health practices. For organization staffing and delivery of services, hospitals and CAHs that provide obstetrical services outside of the emergency department will be required to provide such services in a well-organized manner in accordance with nationally recognized acceptable standards of practice.

Hospitals and CAHs will also be required to make specified equipment readily available for treating obstetrical cases in accordance with the scope, volume, and complexity of services offered. For staff training, hospitals and CAHs with obstetrical services will be required to develop policies and procedures to ensure that relevant staff, as identified by the governing body, are trained biannually on evidence-based best practices aimed at improving the delivery of maternal health care services within the facility. Staff identified by the governing body will also be required to complete an initial training, and new staff will be required to complete an initial training and then would be required to complete subsequent training every two years. For QAPI hospitals or CAHs with OB services must use their QAPI programs to assess and improve health outcomes and disparities among OB patients on an ongoing basis. They must analyze data and quality indicators for OB patients by diverse subpopulations; measure, analyze, and track quality indicators on patient outcomes and disparities and processes of care services and operations and outcomes among obstetrical patients; develop and implement actions to address these disparities and subsequent results; and conduct at least one performance improvement activity focused on reducing maternal health disparities annually. The obstetrical services leadership must also be engaged in the facility's QAPI program. Lastly, if a maternal mortality review committee, or MMRC, is available at the state, local, or tribal level, the facility must have a process for incorporating MMRC data and recommendations into the facility's QAPI program.

Additionally, we have established emergency services readiness and transfer protocol requirements for all patients, which will better prepare hospitals and critical access hospitals to respond to obstetric emergencies. For obstetric services readiness, hospitals and CAHs are required to have adequate provisions and protocols to meet the emergency needs of patients. Under this requirement, hospitals specifically must have equipment, supplies, and medication used in treating emergency cases that must be kept at the hospital and are readily available for treating emergency cases. For transfer protocols, hospitals must have written policies and procedures for transferring patients under their care, which would be inclusive of hospital and patients to the appropriate level of care as needed to the patient's needs. The staff must also be trained on transfer protocols annually.

Lastly, we will also have a phased in implementation to balance the need for improved maternal health outcomes with reducing potential burden and mitigating against any unintended consequences. The implementation will be conducted in three phases, with each phase starting from the effective date of the final rule. So, phase one will begin in six months and include emergency services readiness for hospitals and CAHs and transfer protocols for hospitals. Phase two will begin in one year and include organization staffing and delivery of services. Phase three

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will begin in two years and include obstetrical staff training and QAPI requirements for both hospitals and CAHs. Next, I'll be passing it off to David Pope to review the PHP (partial hospitalization programs) and IOP (intensive outpatient programs) rate updates. Thank you.

David Pope: Thank you, Molly. The calendar year 2025 OPSS ASC final rule updates Medicare payment rates for intensive outpatient programs and partial hospitalization program services furnished in hospital outpatient departments and community mental health centers. CMS is maintaining the existing rate structure. Consistent with the OPSS, with the calendar year 2025 rate setting, CMS is using the calendar year 2023 claims data and the latest available cost information from cost reports. Finally, CMS is maintaining the calculation of both hospital outpatient and CMHC (community mental health centers) IOP and PHP payment rates for three services per day and four or more services per day based on cost per day using OPSS data that includes PHP and non PHP days. CMS believes continuing to use the OPSS dataset will allow CMS to capture data from hospital claims that are not identified as PHP but that include the service codes and intensity required for an IOP and PHP day. And with that, I'll turn it over to Michael Treitel for our next topic.

Michael Treitel: Thank you. So, as mentioned earlier by David concerning the OPSS wage, the DC Court of Appeals for the DC circuit held that the Secretary lacked authority under the Inpatient Statute 1880 63 of the Act as well as 1880 65 of the Act to adopt the low wage index policy, which we adopted in the fiscal year 2020. And also, that the policy and the budget related budget trial adjustment must be vacated. So, things are a little different on the inpatient side compared to the outpatient side. So, I think we'll just go through that just to make sure everybody's aware of what's going on the inpatient side. So, in the final rule, actually for FY 2025, on the inpatient side, we adopted the extension of the low wage index hospital policy and the related budget neutrality adjustment in the final rule, and we adopted that for an extension of three more years. We also mentioned in the final rule that due to the court's decision, that we would, as of the date of the publication of the final rule, take the time to seek further review of the DC circuit's decision in the Bridgeport Hospital case had not expired and the government was evaluating the decision and considering options for next steps. So, on the inpatient side, after considering the DC court's decision in the Bridgeport case, we issued an interim final rule with comment on October 3, 2024, and we recalculated the IPPS hospital wage index to remove the low wage index hospital policy for fiscal year 2025. And because we are no longer applying the low wage index hospital policy in the fiscal year 2025, we also removed the low wage index budget neutrality factor from the fiscal year 2025 standardized amounts. In addition to that, we made some conforming changes to other budget neutrality factors into the outlier threshold as well for fiscal year 2025.

In the past, we've established temporary transition policies when there have been significant changes to payment policies, and we've limited the duration of each transition or to facing the effects of the transition policies. So, we already have a cap policy on the wage index. When a hospital's wage index decreases 5% from the prior year, we cap it at 95% of the wage index from the prior year. And that policy, that cap wage index policy, is budget neutral. Now, some

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hospitals that benefited from the low wage index hospital policy previously will experience decreases of 5% or more from their fiscal year 2024 wage index compared to their 2025 wage index established in the IFC (interim final rule). Similar to how that cap policy would operate, in the interim final action with comment, we applied a one-time transitional adjustment to create a narrow transitional exception to the calculation of fiscal year 2025 payments, and the wage index cap policy would've mitigated these 2025 decreases but would've done so in a budget neutral manner under our current regulations.

So therefore, we are using our authority under 1886(d)(5)(I) to create a narrow transitional exception to the calculation of the fiscal year 2025 IPPS payments for low wage hospitals significantly impacted by the removal of the low wage index hospital policy. The transitional policy established is for hospitals that would've benefited from the FFY 2024 low wage index hospital policy. And it's basically similar to the cap policy we have already on the books for those hospitals. We compare the hospital's FY 2025 wage index established in the IFC to the hospital's FY 2024 wage index. And if the hospital is significantly impacted by the removal of the low wage index hospital policy, then we would cap at 95% of the wage index from 2024. Also, we're applying this transition under the capital PPS because the geographic adjustment factor is also, which is based on the wage index. So that is also going to be transitioned at 95% for these eligible hospitals as well. The common period for the IFC, which was issued on October 3, closes on November 29, 2024. And all the wage index values based on the IFC are posted, like always, on our FY 2025 wage index IPPS final rule homepage. And you can take a look there at the wage index that will be applied for all hospitals, including the ones eligible for the transition. With that, I think I will turn it over to Jim Mildenberger to discuss the next topic.

Jim Mildenberger: Good afternoon. So, to help maintain the domestic production capacity of PPE (personal protective equipment) and ensure that PPE is available to health care personnel when needed, in the 2023 OPSS final rule, CMS established a policy under the IPPS and OPSS that reimburses hospitals for the additional costs they incur when purchasing domestically made NIOSH approved surgical N95 respirators over less expensive non-domestic respirators. To determine payments under this policy, a hospital currently must report on its cost report the aggregate cost and quantity of surgical N95 respirators it purchased that were domestically made and those the hospital purchased that were not domestically made. Based on the Berry Amendment, this policy defines a respirator as domestic if the respirator and all of its components were produced in the United States. In the 2025 OPSS proposed rule, CMS sought information from commenters on potential improvements to this payment adjustment and potential expansion of the adjustment to other types of PPE in the future.

We received many informative and thoughtful comments. Several commenters provided suggestions on ways CMS could reduce the reporting burden associated with the current policy. So, in response to these comments in 2026 rulemaking, we intend to propose a revised payment methodology that would no longer rely exclusively on hospital specific reported data. Furthermore, to help hospitals identify surgical respirators eligible for the payment adjustment, we also are planning to explore the feasibility of creating and making available a list of domestic

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surgical N95 respirators that qualify for the payment adjustment. Several commenters also urge CMS to expand this payment adjustment to include other PPE and medical devices. Therefore, in the 2026 rulemaking, we also intend to propose to expand the payment adjustments to include domestic non-surgical N95 respirators and domestic nitro gloves. We continue to believe payment modifications that account for the higher cost of domestically produced PPE will help to safeguard hospital personnel and beneficiary safety over the long term by sustaining domestic production and availability of these PPE. So, this was the last item on the agenda, so I'll turn it back over to Jill and Joe. Thank you.

Jill Darling: Great. Thank you, Jim. And thank you to all of our speakers for today. We will have our Q&A now, so if you do have a question or comment, please use the raise hand feature at the bottom of your screen and then we will wait until we see any hands raised. Chuck Brewster, you're able to ask a question. Can you unmute from your end?

Chuck Brewster: Can you hear me now?

Jill Darling: Yes.

Chuck Brewster: OK. Just want to clarify the wage index issue that was discussed by several of the speakers today. Inpatient uses Table 2 wage indexes, and column F would have the 5% cap applied, and column G would have the transition amount that the IFC is covering, correct?

Michael Treitel: Correct.

Chuck Brewster: OK. So, for outpatient, they've always matched up, they've always aligned. Now I'm hearing that they will not, in the cases of the facilities that would be in that transitional category.

Michael Treitel: Correct. I can't speak for outpatient tables, but on the inpatient side, anybody, the difference between the two policies is that one is getting 95% of the wage index in the prior year, and that's if you're not a low wage hospital, and your wage index decreases by 5% or more, that goes into the cap budget neutrality. And if you're a low wage hospital, then you get that 95% of the prior year. But we're not budget neutralizing that increase of payment. So not speaking for outpatient, but it seems the wage index that we're applying in either of those columns probably would be used in outpatient. Just it's a different way of getting there.

Chuck Brewster: OK. So, the transition amount that was added on the inpatient in column G, would it still be up, so inpatient and outpatient are going to have the same values for any given facility, or are we saying they could be—

Michael Treitel: I think the values would probably be the same, but again, the definition of what that value is different on each side of the payment system. On the inpatient side, it's a transitional payment. On the outpatient side, it is still the low wage policy.

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Chuck Brewster: Got it. OK. Thank you.

Jill Darling: Yeah, I currently do not see any more hands raised, but we'll just give it another moment. And I'm going to send out the Hospital ODF email in the chat for everyone. OK, so I do not see any more raised hands. So, I will turn the call back to our Chair, Joe Brooks, for closing the remarks.

Joseph Brooks: OK, sounds good. Jill, thank you very much. I appreciate it. And thank you to your staff for helping provide this Open Door Forum. Thank you to all the presenters as well for the information they shared with us today. We really appreciate that. And once again, if you didn't get a chance to ask your question, please go ahead and get that to us via email, which is shared on your screen. If, for some reason, you can't see the screen or you're dialed in, I'm not sure if anybody's dialed in, but I'll just say the email address out loud, hospital_odf@cms.hhs.gov. We'd be happy to take a look and get you an answer to your question. So, thanks again to everyone for joining, and have a great rest of your afternoon and week. Thank you.

Jill Darling: Thanks, everyone. This concludes today's webinar. Have a great one.