VIRGINIA-DC HFMA 2025 FALL CONFERENCE

MEDICARE HOSPITAL REIMBURSEMENT UPDATE

Zachary Bell

Vince Gurioli

David Hall

Medicare Hospital Reimbursement Update

Disclaimer

All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Additionally, a majority if the information contained herein is proposed and should be further examined once final rules have been published. Although we endeavor to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation.

Medicare Hospital Reimbursement Update

FY 2026 IPPS Final Rule

- Display date July 31, 2025
- Published in Federal Register August 4, 2025
- 2.6% increase in operating payment rates (3.3% market basket increase less .7% productivity adjustment from Affordable Care Act)
- Overall hospital payments expected to increase by $5.0 billion from FY 25

https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page

Medicare Hospital Reimbursement Update

Wage Index

- Low quartile adjustment
- Geographic reclassification
- Section 401
- Rural Floor
- FY 2026 Wage Index

Medicare Hospital Reimbursement Update

Wage Index - Low quartile adjustment

- Implemented by CMS beginning in FY 2020 “to address wage index disparities affecting low wage index hospitals”
- Courts struck down July 23, 2024
- CMS originally extended in FY 2025 IPPS Final Rule but reversed course with Interim Final Rule September 30, 2024
- Transition exception policy for FY 26 – for hospitals that benefitted from the policy in FY 24, their FY 26 wage index can be no lower than 90.25% of their FY 24 wage index

Medicare Hospital Reimbursement Update

Wage Index - Geographic reclassification

- Allows providers meeting specific requirements to reclass to another geographic area for purposes of receiving higher wage index
- Application is submitted to Medicare Geographic Classification Review Board (MGCRB) and is due 13 months prior to when reclassification would go into effect (deadline for FY 2026 was September 2, 2025)
- Reclassifications are in effect for three years, but provider can elect to withdraw reclassification during the three-year period, and also elect to reinstate reclassification the following year if still within the three-year window
- Election to withdraw must be submitted to MGCRB within 45 days of publication of Proposed Rule

Medicare Hospital Reimbursement Update

Wage Index – Section 401

- Section 401 of the Balanced Budget Refinement Act of 1999 allows urban hospitals meeting specific conditions to elect to be redesignated as rural for Medicare payment purposes
- Most common reason is to qualify as SCH, RRC or CAH
- Prior to 2016 regulations prevented Section 401 hospitals from also receiving a wage index geographic reclassification so hospitals had to accept rural wage index
- In April 2016 CMS withdrew prohibition of 401 hospitals also having a geo reclass after two separate courts ruled that Congress never gave CMS that authority

Medicare Hospital Reimbursement Update

Wage Index – Section 401

- Potential benefits:
  - Ability to increase cap for Indirect Medical Education (IME)
  - Benefits from RRC and/or SCH status
    - Reduced requirements for geographic reclassification
    - Reduced requirements for 340B eligibility
  - Considered rural for Rural Health Transformation Program?

Medicare Hospital Reimbursement Update

Wage Index – Section 401

Number of Section 401 hospitals at time of Final Rule:

FY 2016	64
FY 2017	72
FY 2018	166
FY 2019	266
FY 2020	346
FY 2021	467
FY 2022	532
FY 2023	615
FY 2024	659
FY 2025	729
FY 2026	811 (~34% of all geographically urban PPS hospitals)

Medicare Hospital Reimbursement Update

Wage Index – Section 401

Virginia Section 401 Hospitals per FY 2026 IPPS Impact File - Final Rule (August 2025)

Sentara Rmh Medical Center
Winchester Medical Center
Sentara Norfolk General Hospital
Uva Health Sciences Center
Bon Secours Maryview Medical Center
Augusta Health
Centra Health, Inc
Carilion Roanoke Memorial Hospital
Medical College Of Virginia Hospitals
Carilion New River Valley Medical Center
Sentara Obici Hospital
Sentara Leigh Hospital
Riverside Regional Medical Center
Sentara Virginia Beach General Hospital
Bon Secours St Marys Hospital
Sentara Williamsburg Regional Medical Center
Bon Secours Memorial Regional Medical Center
Sentara Martha Jefferson Hospital
Bon Secours Southampton Memorial Hospital
Sentara Careplex Hospital
Cjw Medical Center
Sentara Northern Virginia Medical Center
Lewisgale Hospital Pulaski
Henrico Doctors' Hospital
Sentara Princess Anne Hospital
Chesapeake General Hospital, Chesapeake Reg Mc
Bon Secours St Francis Medical Center

Medicare Hospital Reimbursement Update

Wage Index – Section 401

HEALTH AFFAIRS AUGUST 2025

By Yang Wang, Jared Perkins, Christopher M. Whaley, and Ge Bai

Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23

"Congress should consider ensuring that all federal programs intended to improve rural health are directed to geographically rural hospitals, not to dually classified geographically urban hospitals."

Medicare Hospital Reimbursement Update

Wage Index – Rural Floor

- Section 4410(a) of the Balanced Budget Act of 1997 requires that the wage index for any urban CBSA cannot be lower than that state's rural wage index
- For FY 2026 there are 961 hospitals receiving a rural floor wage index, compared to 771 in FY 025
- Calculation is budget neutral
- CMS has changed how the Rural Floor is calculated relative to Section 401 hospitals several times in recent years
  - Beginning in FY 2024 CMS adopted a method of using the highest result of three calculations for each state

Medicare Hospital Reimbursement Update

Wage Index – FY 2026

Highest Nationally	**San Jose-Sunnyvale-Santa Clara, CA**	**1.7328**

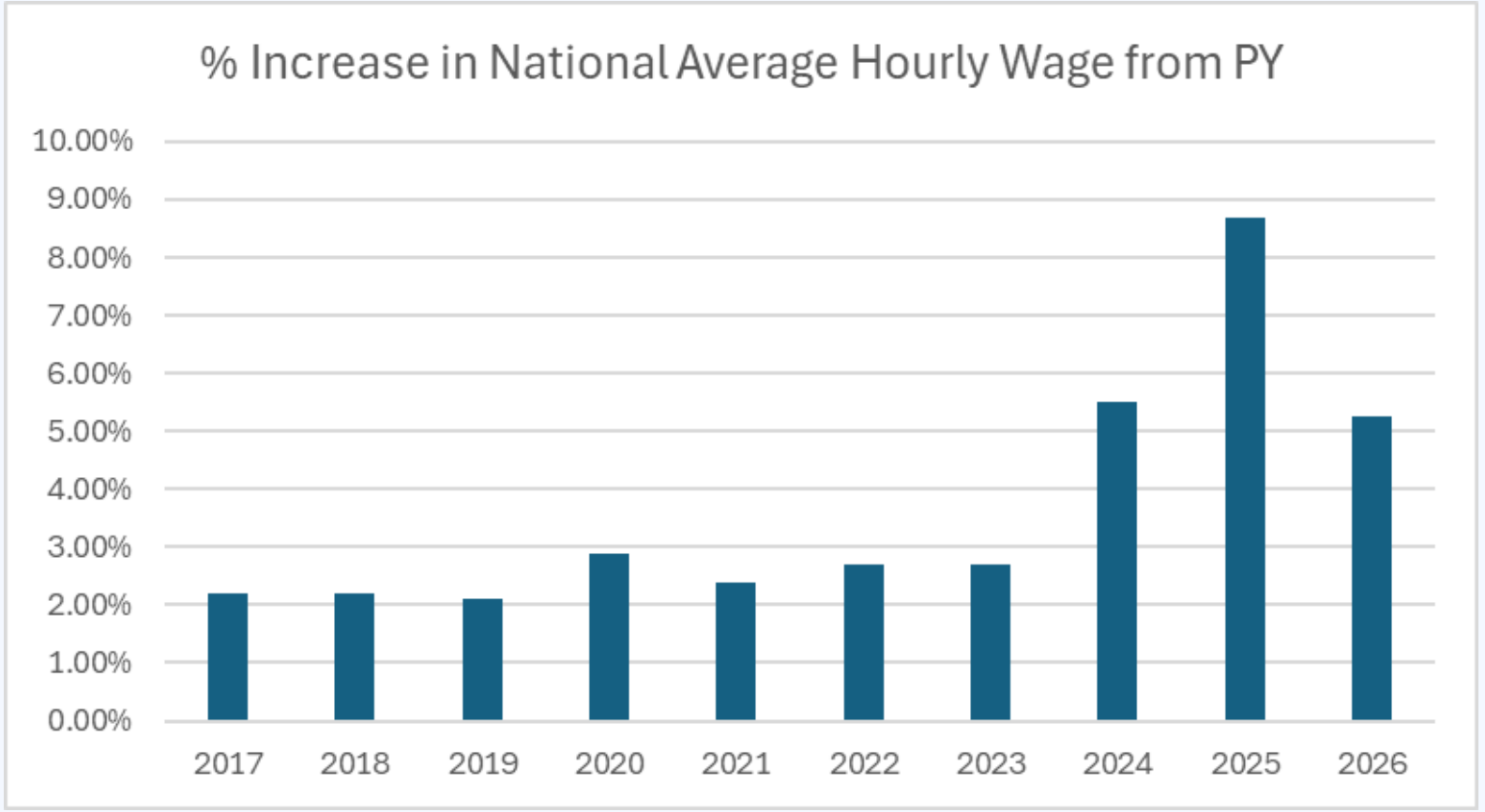
29 highest CBSAs are in California

CA Rural Floor = 1.4315, next highest wage index nationally is 1.3697

Lowest Nationally	**Rural Alabama**	**0.7393**

Medicare Hospital Reimbursement Update

Wage Index – FY 2026



Medicare Hospital Reimbursement Update

	FY 2016 Final	FY 2017 Final	FY 2018 Final	FY 2019 Final	FY 2020 Final	FY 2021 Final	FY 2022 Final	FY 2023 Final	FY 2024 Final	FY 2025 Final	**FY 2026 Final**	FY 2026 Pre-Rural Floor
Washington DC-MD							1.1131	1.1380	1.1522	1.2956	**1.2605**	1.0703
Arlington-Alexandria-Reston, VA-WV	1.0200	1.0163	1.0194	.9990	1.0079	.9994	1.0125	1.0310	1.0003	1.0113	**1.0211**	
Harrisonburg, VA	.8800	.8890	.8917	.8806	.9451	.9276	.9354	.9335	.8958	.9649	**.9737**	
Charlottesville, VA	.9270	.9270	.9618	.9090	.9371	.9651	.9350	.9141	.8789	.9576	**.9650**	
Winchester, VA-WV	.8648	.8377	.8962	.8879	.8966	.8959	.8871	.8826	.8637	.9245	**.9250**	.9157
Virginia Beach-Chesapeake-Norfolk, VA-NC	.9133	.8941	.8966	.8845	.8814	.8737	.8940	.9009	.8639	.9245	**.9250**	.8885
Richmond, VA	.9298	.9040	.8995	.9058	.9039	.9163	.9204	.9113	.8801	.9245	**.9250**	.8770
Lynchburg, VA	.8757	.9005	.8677	.8493	.8616	.8455	.8738	.8194	.8637	.9245	**.9250**	.8450
Staunton-Stuarts Draft, VA	.8290	.8479	.8574	.9293	.8896	.9363	.9645	.9871	.8773	.9245	**.9250**	.8445
Roanoke, VA	.9131	.8995	.8976	.8405	.8903	.8737	.8512	.8606	.8637	.9245	**.9250**	.8439
Blacksburg-Christiansburg-Radford, VA	.8175	.8079	.8190	.8289	.8414	.8478	.8519	.8425	.8657	.9245	**.9250**	.8284
Kingsport-Bristol, TN-VA	.7819	.7737	.7622	.7570	.8031	.8052	.7901	.8144	.8637	.9245	**.9250**	.7953
Rural Virginia	.7819	.7737	.7622	.7570	.8031	.8052	.7901	.8144	.8637	.9245	**.9250**	

Medicare Hospital Reimbursement Update

New Cost Report Forms – Medicare Advantage Negotiated Rates

- FY26 OPPS Proposed Rule (July 15, 2025)
- Cost Reports starting January 1st, 2026
- Hospitals to report median of negotiated MA rates for each MS-DRG (all plans)
- Purpose: Increase transparency and drive future payment policy
- CMS to provide specific cost report instruction in future update

Medicare Hospital Reimbursement Update

Medicare Outlier Reconciliation

- Change to Medicare outlier reconciliation for hospital cost reports starting 10/1/2024
- New Trigger = +/- 20% change in the CCR (instead of only 10 percentage points)
- Applies to Outlier payments exceeding $500,000
- New hospitals: All outlier payments required to be reconciled in the first cost reporting period
- Purpose: Expected to increase recoupment of overpayments

Medicare Hospital Reimbursement Update

Change to Retroactive Medicaid Eligibility

- One Big Beautiful Bill Act (OBBBA), signed July 4, 2025
- Current State – Most states cover 3 months retroactive Medicaid coverage from time of application
- OBBBA change – 1 months retroactive Medicaid coverage for Medicaid Expansion Adults. 2 months for all other Medicaid eligible
- Effective 1/1/2027
- Impact: Reduce Medicaid, increase UCC and medical debt

Medicare Hospital Reimbursement Update

Rural Health Transformation Program (RHTP)

- One Big Beautiful Bill Act (OBBBA), signed July 4, 2025
- $50B in funding for rural health providers
- $10B per year from 2026 to 2030
- 50% split among the states. 50% CMS formula driven (rural population, facilities, other conditions and CMS-determined factors)
- One time application, CMS approval deadline 12/31/2025

Medicare Hospital Reimbursement Update

RHTP Allowable Use of Funds

- Prevention and chronic disease management
- Payments to providers
- Technology solutions (telehealth, cybersecurity, etc)
- Training and recruiting (5 year obligation for clinicians)
- Value based care projects
- Opioid treatment
- Restructuring rural health delivery

Medicare Hospital Reimbursement Update

Low Volume Adjustment

- For FY 2025, hospitals had to request low-volume status by September 1, 2024, to be effective for discharges occurring October 1, 2024, through December 31, 2024. In their initial request, hospitals had the option to request low-volume status for January 1, 2025, through September 30, 2025, anticipating congressional action.

- Congress extended the low volume adjustment to September 30, 2025.

- Criteria will revert to 2010 methodology effective October 1, 2025.
  - 25 miles between nearest proximity hospital
  - Less than 200 Total Discharges

Medicare Hospital Reimbursement Update

Low Volume Adjustment

Fiscal Years	Road Miles	Total Discharges	Payment Adjustment
2019 through 2025	>15	< = 500	0.25
		> 500 < 3,800	0.25 – [0.25/3300] * (number of total discharges -500) = (95/330) – (number of total discharges/13,200)
2026 and subsequent years	>25	< 200	0.25

Medicare Hospital Reimbursement Update

Low Volume Adjustment

FY 2026 IPPS Impact File - Final Rule (August 2025)				
Provider Number	Name	Low-Volume Hospital Payment Adjustment, FY 2025 extension	Total Discharges*	Low Volume Payment*
490002	Russell County Hospital	1.164091	1,504	$ 454,262
490013	Sentara Halifax Regional Hospital	1.096894	2,521	$ 931,970
490019	Uva Health Culpeper Medical Center	1.041515	4,027	$ 617,435
490033	Warren Memorial Hospital	1.127045	2,306	$ 975,617
490037	Riverside Shore Memorial Hospital	1.127727	2,114	$ 731,530
490038	Smyth County Community Hospital	1.221364	1,005	$ 675,369
490060	Clinch Valley Medical Center	1.100682	2,471	$ 524,785
490084	Vcu Health Tappahannock Hospital	1.160758	1,716	$ 1,262,310
490088	Bedford Memorial Hospital	1.183485	1,378	$ 982,881
490089	Carilion Franklin Memorial Hospital	1.159242	1,871	$ 975,244
490090	Southside Community Hospital, Inc	1.076288	2,793	$ 464,871
490092	Bon Secours Southampton Memorial Hospital	1.212424	996	$ 763,086
490097	Southern Virginia Regional Medical Center	1.250000	469	$ 411,435
490098	Community Memorial Hospital	1.063030	3,315	$ 482,796
490111	Wythe County Community Hospital	1.162121	1,660	$ 791,965
490114	Lonesome Pine Hospital	1.016894	3,249	$ 595,657
490115	Twin County Regional Hospital	1.130909	1,872	$ 883,900
490116	Lewisgale Hospital Pulaski	1.177500	1,272	$ 693,407
490117	Carilion Tazewell Community Hospital	1.245152	662	$ 390,939
490126	Lewisgale Hospital Alleghany	1.180682	1,415	$ 968,617
490127	Buchanan General Hospital	1.233409	780	$ 444,124
490130	Riverside Walter Reed Hospital	1.119015	2,229	$ 1,079,454

*Total Discharges and Low Volume Payment based on most recently available cost report.

Medicare Hospital Reimbursement Update

Medicare Dependent Hospitals

The MDH status was not extended beyond FFY 2025.

Starting October 1, 2025, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid solely on the Federal rate.

Medicare Hospital Reimbursement Update

Medicare Dependent Hospitals

FY 2026 IPPS Impact File - Final Rule (August 2025)			
Provider Number	Name	MDH Flag, CAA 2024	HSP Rate for MDHs, FY 2025 extension
490002	Russell County Hospital	Y	$ 5,935.79
490038	Smyth County Community Hospital	Y	$ 6,869.90
490097	Southern Virginia Regional Medical Center	Y	$ 4,787.24
490116	Lewisgale Hospital Pulaski	Y	$ 7,263.18
490117	Carilion Tazewell Community Hospital	Y	$ 6,466.99

Medicare Hospital Reimbursement Update

NAHE Reimbursement

Medicare reimburses qualifying hospitals for costs related to Nursing and Allied Health Education (NAHE)

- General requirements
  - Approved educational activity recognized by a national approving body or state licensing authority
  - Enhance the quality of healthcare at the provider
  - Directly incur the training costs
  - Direct control of the program curriculum
  - Control the administration of the program (day-to-day operations)
  - Employ the teaching staff
  - Provide and control both classroom instruction and clinical training
- CMS has directed MACs to increase scrutiny on pass-through eligibility during audit

Medicare Hospital Reimbursement Update

NAHE Reimbursement

Worksheet D Part III

- Calculates inpatient program pass-through costs for NAHE
    - NAHE costs for routine cost centers times Medicare share
    - Result is carried to Worksheet E Part A line 57

Worksheet D Part IV

- Calculates ancillary program pass-through costs for NAHE
    - Calculates NAHE ancillary costs and apportions between inpatient and outpatient
    - Results are carried to Worksheet E Part A line 58 (IP) and Worksheet E Part B line 9 (OP)

Medicare Hospital Reimbursement Update

NAHE Reasonable Cost Payment

- In the 2026 proposed rule, CMS proposed significant changes to the formula for calculating net cost for NAHE programs.
- Tried to limit the types of indirect costs eligible to be included in the net cost calc.

Current Policy: Net Cost = total (direct + indirect costs) - tuition

Proposed Policy: Net Cost = (direct costs – tuition) + indirect costs

Medicare Hospital Reimbursement Update

NAHE Reasonable Cost Payment

- Direct and indirect costs are proportionally linked – as direct costs increase, indirect costs increase as well, resulting in higher reimbursement. Deducting tuition from direct costs would result in lower indirect costs being allocated as well.

- Proposed changes are the result of a D.C. Circuit court decision *Mercy St. Vincent Medical Center v. Becerra* – CMS was trying to calculate reimbursement using their updated policy.
  - Court ruled that direct costs have no impact on tuition.

- CMS received extensive comments on this issue and has decided not to finalize changes to the policy at this time.

Medicare Hospital Reimbursement Update

NAHE – MAC Audit Trends of Disallowance

- Increased scrutiny of NAHE costs by MACs in recent years.

- MACs disallowing NAHE costs for the following reasons:
  - Provider is not the legal operator of the program.
  - Provider not in “control” of the program. MACs are disallowing program cost if the students rotate to other facilities.

- Steps to reduce NAHE audit risk:
  - Ensure accreditation letters are up to date and accurate.
  - Important to have rotation schedules, copies of curriculum and time sheets or time studies of all those who provided training.

Medicare Hospital Reimbursement Update

OIG Audit Findings

- For Federal fiscal years 2019–2021 (audit period), each of the 12 MAC jurisdictions failed to comply with the contract requirements for audit and reimbursement desk review and audit quality (AR-4) for at least 1 of the 3 years.
- CMS identified 287 total audit issues among all MAC jurisdictions during the period, including MACs not performing proper reviews; inadequate review of graduate medical education and indirect medical education reimbursement; improper review of allocation, grouping, or reclassification of charges to cost centers; improper calculation and reimbursement for nursing and allied health programs; and inadequate review of bad debts.
- MAC officials from selected jurisdictions suggested multiple causes for the findings including unclear guidance from CMS, limited feedback on the cost report reviews, inadequate training, and staffing and workload issues.

Medicare Hospital Reimbursement Update

OIG Audit Recommendations and What's Next

1. Provide MACs with detailed explanations of Quality Assurance Surveillance Plan (QASP) results – Implemented.
2. Update the audit program to reflect revised CMS change requests and transmittals – Pending implementation (expected by Feb 2026).
3. Offer additional training and share best practices based on QASP results – Implemented.

- What's Next
  - Additional funding to MACs to increase staffing and training.
  - Expect increased scrutiny from MAC auditors.
  - Allow for additional time to review audit adjustments.

Zachary Bell
Zach.Bell@us.forvismazars.com

Vince Gurioli
Vince.Gurioli@us.forvismazars.com

David Hall
David.Hall@us.forvismazars.com

Thank you!