

Acute Inpatient Prospective Payment System (IPPS)

1. Obtained IPPS wage indices for 2019 thru 2025 from Table 2-Case-Mix Index and Wage Index Table by CCN <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipp-final-rule-home-page>
2. Obtained provider county from the Provider of Service (POS)
3. NCH records
 - a. Keep only inpatient claims – claim type 60 and the 50 U.S. states plus the District of Columbia, minus Maryland, and plus Puerto Rico
 - b. Includes acute care hospitals – range 0001 thru 0879
 - c. Determine provider state and county per POS
 - d. AND CLM_TOT_CHRG_AMT > 0 AND CLM_MCO_PD_SW NE '1'
 - e. AND SUBSTR(PROVIDER_NUMBER,3,1) EQ '0'
 - f. AND SUBSTR(PROVIDER_NUMBER,5,1) NE 'V'
 - g. AND SUBSTR(PROVIDER_NUMBER,6,1) NOT IN ('E','F')
 - h. AND SUBSTR(PROVIDER_NUMBER,3,3) NOT IN ('897','898','899','998','999')
 - i. AND PROVIDER_NUMBER NOT IN ('050146','050660','220162','330154','330354','360242','390196','450076','100079','100271','500138')
 - j. AND PROVIDER_NUMBER NOT IN (SOLE_COMM_HOSP);

Table 1: IPPS Labor Percentage

| Fiscal Year | Greater than 1 | | Less than 1 | |
|-------------|----------------|-----------|-------------|-----------|
| | Labor | Non-Labor | Labor | Non-Labor |
| 2019 | 0.683 | 0.317 | 0.62 | 0.38 |
| 2020 | 0.683 | 0.317 | 0.62 | 0.38 |
| 2021 | 0.683 | 0.317 | 0.62 | 0.38 |
| 2022 | 0.676 | 0.324 | 0.62 | 0.38 |
| 2023 | 0.676 | 0.324 | 0.62 | 0.38 |
| 2024 | 0.676 | 0.324 | 0.62 | 0.38 |
| 2025 | 0.676 | 0.324 | 0.62 | 0.38 |

| | | | |
|---|-----------------|----------|--|
| | CLM PMT AMT | \$10,247 | Claim payment amount from NCH |
| + | DEDUCTABLE AMT | \$1,132 | Beneficiary inpatient deductible amount |
| + | COINSURANCE AMT | \$0 | Beneficiary Part A coinsurance liability amount |
| | NET PAYMENT | \$11,379 | Claim payment plus deductible and coinsurance |
| × | | | |
| (| NAT LABOR PCT | 0.62 | Labor related share |
| × | CURR INDEX | 0.7477 | Current wage index |
| + | NON-LABOR PCT | 0.38 | Non-labor related share |
| | | 0.84 | Current wage ratio: $0.62 \times 0.7477 + 0.38 = 0.84$ |
| ÷ | | | |
| (| NAT LABOR PCT | 0.62 | Labor related share |
| × | PREV INDEX | 0.8112 | Prior wage index |
| + | NON-LABOR PCT | 0.38 | Non-labor related share |
| | | 0.88 | Prior wage ratio: $(0.62 \times 0.8112 + 0.38) = 0.88$ |
| | NEW WAGE RATIO | 0.96 | New wage ratio = $(0.84 / 0.88)$ |
| × | ADJ PAYMENT | \$10,872 | Adjusted payment = $\$11,379 \times (0.84 / 0.88)$ |
| – | DEDUCTABLE AMT | \$1,132 | Beneficiary inpatient deductible amount |
| – | COINSURANCE AMT | \$0 | Beneficiary Part A coinsurance liability amount |
| | NEW PAYMENT | \$9,740 | New payment amount including adjustment |

This method is adjusting the claim payment amount from NCH, which includes the DRG outlier approved payment amount, disproportionate share, indirect medical education, and total PPS capital. It does not include pass-thru amounts, beneficiary-paid amounts (i.e., deductibles and coinsurance); or any other payer reimbursement.

Skilled Nursing Facility Prospective Payment System

1. Obtained SNF wage indices for 2019 thru 2025 from <https://cms.gov>. Starting with the FY2023 wage indices, apply the 5% cap on any decrease in the wage index from the prior fiscal year. (As a simplifying assumption, we are treating all facilities in our historical data as existing facilities to which this 5% cap applies since we expect most facilities in a CBSA would receive the capped value.)
2. Obtained provider county from the Provider of Service (POS) file
3. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files
4. NCH records
 - a. Keep only SNF claims – claim type 20 or 30
 - b. Include provider range 5000 thru 6499
 - c. Determine provider state and county per POS
5. Apply wage adjustment
 - a. Apply Urban/Rural wage index by state and county
 - b. Use the appropriate labor percentage from Table 2
 - c. Apply wage index adjustment

Table 2: SNF Labor Percentage

| | |
|------|---------|
| 2019 | 0.70500 |
| 2020 | 0.70900 |
| 2021 | 0.71300 |
| 2022 | 0.70400 |
| 2023 | 0.70800 |
| 2024 | 0.71100 |
| 2025 | 0.72000 |

| | | | |
|---|-----------------|---------|---|
| | CURR INDEX | 0.7121 | SNF PPS wage index of current year |
| – | PREV INDEX | 0.7327 | SNF PPS wage index of prior year |
| | NET INDEX | –0.0206 | Difference between current and prior wage index |
| × | LABOR SHARE | 0.7040 | Labor related share of claim year (e.g., 2022) |
| | WAGE INDEX ADJ | –0.0145 | Wage difference times labor related share |
| | NAT LABOR | 0.7040 | Labor related share of claim year (e.g., 2022) |
| × | PREV INDEX | 0.7327 | SNF PPS wage index of prior year |
| | WAGE ADJ FACTOR | 0.5158 | Previous index times labor related share |
| | 1 | 1 | |
| – | LABOR SHARE | 0.7040 | Labor related share of claim year (e.g., 2022) |
| | NONLABOR SHARE | 0.2960 | Non-labor related share of claim year |
| | CLM PMT AMT | 5507.85 | Claim payment amount from NCH |
| ÷ | TOT ADJ FACTOR | 0.8118 | Wage payment adjustment factor plus non-labor share |
| | BASE PMT RATE | \$6,785 | Claim payment times payment adjustment factor |
| × | WAGE INDEX ADJ | –0.0145 | Wage difference times labor related share |
| | ADJ PMT AMT | –\$98 | Final adjustment to claim payment amount |
| + | CLM PMT AMT | \$5,508 | Claim payment amount from NCH |
| | NEW PMT AMT | \$5,410 | New payment amount including adjustment |

Home Health Prospective Payment System (HH PPS)

1. Obtained HH-PPS CBSA wage indices for 2019 thru 2025 from <https://www.cms.gov/files/zip/cy-2025-final-hh-pps-wage-index.zip>
2. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files
3. NCH records
 - a. Keep only HH-PPS claims – claim type 10
 - b. Include claims with a type of bill equal to 32 or 33 and claim frequency code not equal to 0 or 2
 - c. Drop DME claim lines paid under fee schedule where revenue center not equal 029x, 060x, or 0274
 - d. Add wage index to claims by beneficiary SSA state and county from claim
 - e. Use the appropriate labor percentage from Table 3.
 - f. Sum claim lines to the claim level
 - g. Apply adjustment

Table 3: HHA Labor Percentage

| | |
|------|---------|
| 2019 | 0.76100 |
| 2020 | 0.76100 |
| 2021 | 0.76100 |
| 2022 | 0.76100 |
| 2023 | 0.76100 |
| 2024 | 0.74900 |
| 2025 | 0.74900 |

| | | | |
|---|----------------|---------|--|
| × | CLM PMT AMT | \$1,443 | Claim payment amount from NCH |
| (| NAT LABOR PCT | 0.74900 | Labor related share |
| × | CURR INDEX | 0.8017 | Current wage index |
| + | NON-LABOR PCT | 0.25100 | Non-labor related share |
| | | 0.8515 | Current wage ratio: $(0.74900 \times 0.8017 + 0.25100) = 0.8515$ |
| ÷ | | | |
| (| NAT LABOR PCT | 0.76100 | Labor related share |
| × | PREV INDEX | 0.8159 | Prior wage index |
| + | NON-LABOR PCT | 0.23900 | Non-labor related share |
| | | 0.8599 | Prior wage ratio: $(0.76100 \times 0.8159 + 0.23900) = 0.8599$ |
| | NEW WAGE RATIO | 0.9902 | New wage ratio = $(0.8515 / 0.8599)$ |
| | ADJ PAYMENT | \$1,429 | Adjusted payment = $\$1,443 \times (0.8515 / 0.8599)$ |

This method is adjusting the claim line payment amount from NCH, which includes the HH-PPS outlier approved payment amount.

Physician Fee Schedule

1. Obtained 2019-2023 relative value units (RVUs) and 2019-2025 geographic practice cost indexes (GPCIs) from <https://www.cms.gov/medicare/payment/fee-schedules/physician/pfs-relative-value-files> and <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice> for all jurisdictions.
2. NCH Records
 - a. Extracted physician claim lines with claim types 71 or 72
 - b. Merge RVUs to each claim line by HCPCS code and first modifier code
 - c. Merge GPCIs to claim based on contractor and locality
 - d. Use the appropriate facility or non-facility practice expense RVU
 - i. Facility is where the place of service equals one of the following
02, 19, 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 61, 56
 - e. Multiply the previous RVU by the previous GPCI for work, practice, and malpractice expenses
 - f. Multiply the previous RVU by the current GPCI for work, practice, and malpractice expenses. The current GPCI is the final 2025 GPCIs for all provider locations.
 - g. Divide the current rate by the previous rate to obtain a percent difference
 - h. Multiply the percent difference by the line payment, resulting in the final adjustment value
 - i. Add the final adjustment value to the line payment to obtain an adjusted payment

| | Work | Practice Expense | Malpractice | RVU × GPCI Sum | |
|-----------------|--------|------------------|-------------|----------------|-------------------------------------|
| <u>Previous</u> | | | | | |
| RVU | 1.16 | 0.68 | 0.07 | | |
| GPCI | × 1 | 1.046 | 0.658 | | |
| | 1.16 | + 0.71128 | + 0.04606 | = 1.91734 | Prior year payment rate |
| <u>Current</u> | | | | | |
| RVU | 1.16 | 0.68 | 0.07 | | |
| GPCI | × 0.99 | 1.044 | 0.86 | | |
| | 1.1484 | + 0.70992 | + 0.0602 | = 1.91852 | Current year payment rate |
| | | | ÷ 0.0615% | | Percent difference of payment rates |
| | | | × \$43.26 | | Line payment amount from NCH |
| | | | \$0.03 | | Final adjustment to claim payment |
| | | | + \$43.26 | | Line payment amount from NCH |
| | | | \$43.29 | | New payment including adjustment |

The GPCIs measure geographic differences in physician wages, wages of clinical and administrative staff, cost of contracted services (e.g. accounting and legal services), cost to rent office space, and the cost of professional liability insurance. The GPCIs assume that medical supplies (including pharmaceuticals) and medical equipment are purchased in national markets and no geographic adjustment is made for these components of a physician practice.

Outpatient Prospective Payment System (OPPS)

1. Obtained IPPS wage indices for 2019 thru 2025 from Table 2-Case-Mix Index and Wage Index Table by CCN: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipp-final-rule-home-page>.
2. Obtained provider county from the Provider of Service (POS) file
3. NCH records
 - a. Keep only outpatient claims - claim type 40
 - b. Limit to OPPS claims where status code equals P, S, T, V, J1, or J2
 - i. In addition, status code of X thru 2014
 - c. Exclude non-PPS cancer hospitals, OPPS only hospitals, CMHCs, and children's hospitals
 - d. Determine provider state and county per POS
4. Apply wage adjustment
 - a. Use provider reclassification if it exists
 - b. Else do not adjust
 - c. Removed prior year wage index
 - d. Calculate current year wage ratio
 - e. Apply wage index adjustment

| | | |
|--|----------|---|
| LINE PMT AMT | \$97.65 | Line payment amount from NCH |
| ÷ $(0.6 \times \text{WAGE INDEX} + 0.4)$ | 0.90526 | Remove prior year wage index |
| UNADJSTD PMT | \$107.87 | Unadjusted payment amount |
| $(0.6 \times \text{WAGE 2025} + 0.4)$ | 0.90364 | Apply current year wage index |
| × UNADJSTD PMT | \$107.87 | Unadjusted payment amount |
| NEW PMT AMT | \$97.48 | New payment amount including adjustment |

This process is adjusting the labor related portion of the standard OPPS national unadjusted payment rates to account for geographic wage differences. Except for 2025, these wage indices are the same as those in the fiscal year based IPPS but adopted into the OPPS on a calendar year basis. For 2025, OPPS uses the CMS-1808-CN wage indices instead of the CMS-1808-IFC wage indices per final rule CMS-1809-F. Certain services such as those with status indicators of G, H, K, R, and U are not adjusted by a wage index, as the payment does not include a labor related portion (i.e. G and K represent drugs, H is devices, R is blood and blood products, U is brachytherapy sources).

ESRD Prospective Payment System (ESRD PPS)

1. Obtained ESRD PPS CBSA wage indices for 2019 thru 2025 from <https://www.cms.gov/medicare/payment/prospective-payment-systems/end-stage-renal-disease-esrd/esrd-payment-regulations/cms-1805-f>. For the 2021 wage index only, apply a 5% cap on any decrease from its 2020 wage index. Starting with the 2023 wage indices, apply the 5% cap on any decrease in the wage index from the prior year. (As a simplifying assumption, we are treating all facilities in our historical data as existing facilities to which the 5% cap applies since we expect most facilities in a CBSA would receive the capped value.)
2. Convert prior year CBSA wage indices to state/county by merging with County crosswalk files.
3. Apply wage adjustment for ESRD beneficiaries on dialysis to ESRD PPS amounts only.
 - a. Keep only claims ESRD PPS for Dialysis Facilities - include claims with a claim type 40 and type of bill equal to 72x and exclude claims with condition code 84
 - b. Adjust only lines paid under ESRD Dialysis PPS: revenue center 0821, 0831, 0841, 0851, 0881
 - c. Determine wage index by provider state and county per POS
 - d. Use the appropriate labor percentage from Table 4
 - e. Calculate current year wage ratio using most recent wage index
 - f. Calculate prior year wage ratio using the claim year wage index
 - g. Apply wage index adjustment

Table 4: ESRD PPS Labor Percentage

| 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---------|---------|---------|---------|---------|---------|---------|
| 0.52300 | 0.52300 | 0.52300 | 0.52300 | 0.55200 | 0.55200 | 0.55200 |

| | | | |
|---|---------------------------|----------|--|
| | CLM LINE PMT AMT | \$198.99 | Claim line payment amount from NCH |
| – | OUTLIER AMT | \$0.00 | Outlier payment |
| – | TDAPA | \$24.21 | Transitional add-on payment adjustment |
| – | TPNIES | \$0.00 | Transitional add-on payment adjustment for new and innovative equipment and supplies |
| – | (&ADD_ON x PREV INDEX) | \$85.35 | Self-dialysis add-on adjustment x Prior wage index: (\$95.60 x 0.8928) |
| | NET PAYMENT | \$89.43 | Claim line payment less adjustments |
| × | | | |
| (| NAT LABOR PCT | 0.5230 | Labor related share from year of claim (e.g. 2021) |
| × | CURR INDEX | 0.9362 | Current wage index |
| + | NON-LABOR PCT | 0.4770 | Non-labor related share from year of claim (e.g. 2021) |
| | | 0.9668 | Current wage ratio: (0.5230 × 0.9362 + 0.4770) = 0.9668 |
| ÷ | | | |
| (| NAT LABOR PCT | 0.5230 | Labor related share from year of claim (e.g. 2021) |
| × | PREV INDEX | 0.8928 | Prior wage index |
| + | NON-LABOR PCT | 0.4770 | Non-labor related share from year of claim (e.g. 2021) |
| | | 0.9439 | Prior wage ratio: (0.5230 × 0.8928 + 0.4770) = 0.9439 |
| | ADJ PAYMENT | \$91.60 | Adjusted payment = \$89.43 × (0.9668 / 0.9439) |
| + | OUTLIER AMT | \$0.00 | Outlier Payment |
| + | TPADA | \$24.21 | Transitional drug add-on payment adjustment |
| + | TPNIES | \$0.00 | Transitional add-on payment adjustment for new and innovative equipment and supplies |
| + | (&ADD_ON x CURR INDEX) | \$89.50 | Self-dialysis add-on adjustment x Current wage index: (\$95.60 x 0.9362) |
| | NEW PAYMENT | \$205.31 | New payment amount including adjustment |

*The outlier payment, transitional drug add-on payment adjustment and transitional add-on payment adjustment for new and innovative equipment and supplies are not wage-adjusted. The self-dialysis training add-on (\$95.60 since 2017) is fully wage-adjusted when the condition code is 73 or 87.

Uncompensated Care Payments (UCP)

1. Obtain FY 2024 and FY 2025 Final Medicare DSH Supplemental Data from <https://www.cms.gov/files/zip/fy-2025-ipps-final-medicare-dsh-supplemental-data-file.zip>
2. Records excluded from DSH Supplemental Data:
 - a. Exclude Sole Community Hospitals (SCH) that are projected to be paid a facility-specific rate
 - b. UCP status for FY 2025 = “SCH”
 - c. UCP status for FY2024 = “SCH” and UCP status for FY2024 = “No” or missing
 - d. Records with UCP status for FY2024 = “SCH” and UCP status for FY2025 = “Yes” were kept. That is, facilities that switched from SCH status to standard status.
3. National claims History (NCH) records
 - a. Keep only inpatient claims - claim type 60
 - b. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service)
 - c. Exclude SCH in FY 2025 (as reflected in Supplemental DSH exhibit in FY 2025 Final IPPS rule)
 - d. Exclude rehab hospitals and facilities that have tied out/terminated according to “STAR”
4. Match UCP from claim to UCP from FY 2024 and FY 2025 IPPS Rules.
5. To account for supplemental payments to Indian Health Service/Tribal hospitals and hospitals in Puerto Rico, an additive adjustment equal to the provider’s supplemental payment divided by the total uncompensated care payment for all providers is applied to the Factor 3’s for these providers to apply in the historical period when no supplemental payments existed.
6. Providers found on the supplemental FY 2024 DSH exhibit and not found on the supplemental FY 2025 DSH exhibit and providers with FY 2025 UCP status = “N” are assigned a Factor 3 value of 0.000.
7. Calculate the gross UCP dollars for 2023 after replacing FY 2023 Factor 2 (0.6571) with FY 2025 Factor 2 (0.5429). This is the total of the re-priced UCP for this set of providers.
8. For providers with no 2023 UCP, but with inpatient claim, the re-priced UCP per claim equals the gross UCP adjustment multiplied by the FY 2025 Factor 3 divided by the number of claims.
9. Below exhibit is illustration of adjustment for calendar year 2023 claims.

| Provider Number | FY 2024 UCP Status | Actual 2023 UCP | | FY 2025 DSH Suppl. Data | | Re-priced UCP Claims | |
|---------------------------|--------------------|-----------------|------------------|-------------------------------------|-------------|----------------------|-----------|
| | | Dollars (000) | Number of claims | Projected to receive DSH in FY 2025 | Factor 3 | Gross (000) | Per Claim |
| | YES | \$5,541,917 | | YES | 1.000000013 | \$4,593,462 | |
| | NO | \$13 | | NO | 0.000000000 | | |
| | n/a OR SCH | \$17,775 | | n/a OR SCH | 0.000000000 | | |
| | Subtotal | \$5,559,705 | | | 1.000000013 | | |
| | Factor 2 | | 0.6571 | | 0.5429 | | |
| 111111 | YES | \$3,616.8 | 4,039 | YES | 0.00077866 | \$3,576.8 | \$885.56 |
| 222222 | YES | 1,590.2 | 1,261 | YES | 0.00038270 | 1,757.9 | 1,394.07 |
| 333333 | YES | 1,348.4 | 3,395 | YES | 0.00025803 | 1,185.3 | 349.12 |
| 444444 | YES | 159.3 | 264 | YES | 0.00004912 | 225.6 | 854.73 |
| 555555 | YES | 69.9 | 110 | YES | 0.00002559 | 117.6 | 1,068.77 |
| 666666 | YES | 3,440.7 | 2,253 | YES | 0.00064754 | 2,974.4 | 1,320.21 |
| 777777 | YES | 1,610.7 | 1,389 | YES | 0.00034553 | 1,587.2 | 1,142.69 |
| ...some data not shown... | | | | | | | |

**Competitive Bid Program for
Durable Medical Equipment Prosthetic Orthotics Supplies (DMEPOS)**

OACT calculates Managed Care payment amounts for CY2026 based on the 5-year average of Fee-For-Service (FFS) claims from CY2019 to CY2023. The historical FFS claim payment amounts represent the payment methods that were in place during that time period. We adjust the DMEPOS Claims to account for the changes in the prices associated with the former Competitive Bidding Program (CBP) in order to appropriately set MA Ratebook amounts that reflect the payment methods consistent with the MA bid year to which the rates will be applied. In order to reflect the new single payment amounts (SPA) for DMEPOS in the base years, we use the following methodology to re-price DMEPOS claims for each year 2019 to 2023 for all HCPC codes associated with the former CBP:

1. Download single payment amounts for DMEPOS for the former CBP HCPCS codes including geographic areas and product categories from the CMS website located at <https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule/dme25>
2. Create a re-pricing table combining all DMEPOS items and geographic areas.
3. Identify FFS DMEPOS payments using National Claims History (NCH) Records as loaded into Integrated Data Repository (IDR)
 - a. Extract DME claim lines with claim type 72, 81 or 82.
 - b. Determine whether DME claim line HCPCS code was subject to competitive bidding.
 - c. Determine if DME claim was subject to competitive bidding based on NCH zip code.
 - d. Include only Fee-for-Service claims.
 - e. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service.)
 - f. Exclude Beneficiaries enrolled in MAO Cost Plans.
 - g. Calculate Medicare maximum payment by multiplying allowed charge amount by the share to be borne by Medicare, or 77.7%.
4. Determine the re-priced payment amount for DMEPOS Competitive Bidding by multiplying the single payment amounts (for the HCPCS code in the geographic area as defined by the zip code) by unit quantity.
5. Calculate adjustment to reimbursements to account for implementation of DMEPOS Competitive Bidding
 - a. Obtain percent change ratio by dividing the difference of the re-priced payment amount and Medicare maximum payment by the Medicare maximum payment. Exclude claim if percent change ratio is greater than 100%.
 - b. Apply savings ratio to covered payment amount (actual amount paid from claim.)
 - c. Summarize claim payments by SSA state and county for qualified CBA claims.
 - d. Multiply covered claim payments by percent change ratio to obtain Medicare savings.

| | | |
|---|---------------|--|
| | 219.84 | Allowed charge amount |
| × | <u>0.777</u> | Medicare share |
| | 170.82 | FFS Medicare maximum payment amount (MDCR_Max_Paid) |
| | 22.43 | Single payment amount for HCPCS Code A7032 in zip code 10506 |
| × | 6 | unit quantity |
| × | <u>0.777</u> | Medicare share |
| | 104.57 | New Medicare Single payment amount (CBA_Bid_Amt) |
| | -0.388 | Percent change = (CBA_Bid_Amt – MDCR_Max_Paid) / MDCR_Max_Paid |
| × | <u>175.87</u> | Covered payment amount (actual claim payment amount) |
| | -68.24 | Change in spending |

**Adjusted FFS Payments based on Competitive Bid Program (CBP) for
Durable Medical Equipment Prosthetic Orthotics Supplies (DMEPOS)**

Section 1834(a)(1)(F) of the ACA mandates adjustments to the fee schedule amounts for DMEPOS furnished on or after January 1, 2016, based on information from the former Competitive Bidding Program (CBP). The adjusted fee schedule amounts were developed using the average of SPAs from the former CBP to be applied in different regions and separated by rural and non-rural areas. Below is the process used to adjust the DMEPOS Claims in Non-CBA areas using the CBP adjusted FFS payment amounts. OACT calculates Managed Care payment amounts for CY2026 based on the 5-year average of Fee-For-Service (FFS) claims from CY2019 to CY2023. In order to reflect the new former CBP adjusted DMEPOS FFS payment amounts in the base years, we use the following methodology to re-price DMEPOS claims for each year 2019 to 2023 for Non-CBP claims:

1. Download DMEPOS adjusted FFS payment amounts for Non-CBA areas including Rural and Non-Rural geographic areas and product categories from the CMS website located at <https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule/dme25>
2. Create a re-pricing table combining all DMEPOS items and geographic areas for Rural and Non-Rural Non-CBA areas.
3. Identify FFS DMEPOS payments using National Claims History (NCH) Records as loaded into Integrated Data Repository (IDR).
 - a. Extract DME claim lines with claim type 72, 81 or 82.
 - b. Determine whether DME claim line HCPCS code was subject to competitive bidding.
 - c. Determine if DME claim was not already subject to competitive bidding based on zip code from the NCH.
 - d. Include only Fee-for-Service claims.
 - e. Exclude ESRD beneficiaries (beneficiary with active dialysis period at time of service.)
 - f. Exclude Beneficiaries enrolled in MAO Cost Plans.
 - g. Calculate Medicare maximum payment by multiplying allowed charge amount by the share to be borne by Medicare, or 77.7%.
4. Determine the re-priced payment amount based on DMEPOS Competitive Bidding by multiplying the single payment amounts (for the HCPCS code in the geographic area defined by the zip code) by unit quantity.
5. Calculate adjustment to reimbursements to account for implementation of adjusted FFS payment amounts
 - a. Obtain percent change ratio by dividing the difference of the re-priced payment amount and Medicare maximum payment by the Medicare maximum payment. Exclude claim if percent change ratio is greater than 100%.
 - b. Apply Percent Change ratio to covered payment amount (actual amount paid from claim.)
 - c. Summarize claim payments by SSA state and county for qualified claims.
 - d. Multiply covered claim payments by percent change ratio to obtain Medicare savings.

| | | |
|---|--------|--|
| | 219.84 | Allowed charge amount |
| × | 0.777 | Medicare share |
| | 170.82 | FFS Medicare maximum payment amount (MDCR_Max_Paid) |
| | 37.24 | Fee schedule amount for HCPCS Code A7032 in zip code 10985 |
| × | 6 | unit quantity |
| × | 0.777 | Medicare share |
| | 173.61 | New Medicare Single payment amount (CBA_Bid_Amt) |
| | -0.016 | Percent change = (CBA_Bid_Amt – MDCR_Max_Paid) / MDCR_Max_Paid |
| × | 175.87 | Covered payment amount (actual claim payment amount) |
| | -2.81 | Change in spending |