The rural "Big Apple": How a single hospital can determine the Medicare acute facility wage index for an entire state

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Medicare fee-for-service (FFS) payments vary by geographic area. For inpatient and outpatient facility reimbursement, this is accomplished through the wage index. In the 2024 Final Rule, [1] the Centers for Medicare and Medicaid Services (CMS) changed its wage index calculation in response to numerous lawsuits. A consequence of the new calculation is that a single hospital can substantially influence, or even solely determine, an entire state's wage index. Changes in the wage indexes from one year to the next are budget-neutral at the national level. Because the wage index adjustment is budget-neutral, when one hospital's wage index (and therefore reimbursement) increases, there is an offsetting decrease to all other hospitals' payments.

This paper discusses how wage indexes have changed in the last several years, how the new calculation works,
and how hospitals located in New York City were able to increase the wage indexes for most of the state by more than 10 percentage points through reclassification as rural hospitals.

AT A GLANCE

1. The wage index is the primary way that Medicare's inpatient and outpatient payments are area-adjusted.
2. In 2024, in reaction to numerous lawsuits, CMS changed the wage index calculation.
3. As a result of the changes, California, Florida, New York, and other states have seen large increases affecting significant parts of the state. Facility reimbursement trends have exceeded 10% in the most highly impacted areas.
4. The wage index is budget-neutral, so when one area's wage index increases, payments in other areas decrease. Total dollars redistributed as a result of the wage index changes are in the billions of dollars.
5. This paper discusses how the wage index calculation works and provides a case study of the large changes in New York

What is Medicare's Hospital Wage Index?

Medicare FFS hospital payments are required by statute to be adjusted "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."[2] The wage index represents this adjustment, reflecting variation in average hourly hospital wages for labor market areas as defined by core-based statistical areas (CBSAs). The wage index also reflects geographic reclassifications of hospitals to other labor market areas, state-level minimums (the "rural floor"), and other rules.

1. The 2024 Final Rule is referenced repeatedly in this paper and can be found at https://www.federalregister.gov/documents/2023/08/28/2023-16252/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the. The 2025 Final Rule, Correction Notice (CN), and Interim Final Action with Comment Period (IFC) can be found at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page#rule. Inpatient Prospective Payment System (IPPS) fee schedules are based on the federal fiscal year (October through September). Throughout this paper, year references correspond to fiscal years, for example fiscal year (FY) 2024 is October 1, 2023, through September 30, 2024.
2. CMS. Wage Index. Retrieved December 27, 2024, from https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index.

Recent wage index changes

The table in Figure 1 shows the Inpatient Prospective Payment System (IPPS)[3] rural wage index for the top five most populous states, as well as the wage index for three cities in California. Key features are highlighted. In each state, a wage index is calculated for each urban area as well as a single rural wage index for the state. The rural wage index is shown because a key driver of recent changes to all wage indexes is the “rural floor,” which currently requires that each urban area in a state must have a wage index at least as high as the rural wage index of that state. Combined with the 2024 changes to the rural wage index calculation, the rural floor can determine the wage index for a significant proportion of the state, and in some cases the entire state.

FIGURE 1: RURAL WAGE INDEX BY STATE OVER TIME (AND A FEW CBSAS)

STATE/CBSA	2022 FR	2023 FR	2024 PR	2024 FR	2025 PR	2025 IFC[4]
California	1.2687	1.2534	1.5040	1.5189	1.4615	1.4510
Los Angeles		1.2970		1.5189		1.4510
San Diego		1.2737		1.5189		1.4510
San Francisco		1.8591		1.8744		1.7309
Texas	0.9085	0.8240	0.8689	0.8758	0.9012	0.8957
Florida	0.8027	0.8074	0.8449	0.9436	0.9181	1.0063
New York	0.8593	0.8515	1.2183	1.2181	1.1799	1.3056
Pennsylvania	0.8115	0.8336	0.9243	0.9211	0.9489	0.9367

PR = Proposed Rule

FR = Final Rule. Numbers include the impacts of any Correction Notices

IFC = Interim Final Action with Comment Period

Of note in Figure 1:

1. The rural wage index was relatively stable between 2022 and 2023 for these states, with the exception of Texas.
2. Starting in 2024, and continuing in 2025, the rural floor increased significantly in all of the states shown except Texas.
3. The California rural wage index increased from 1.2534 in 2023 to 1.5189 in 2024. In 2023, Los Angeles and San Diego were both slightly above the rural wage index. In 2024, because of the rural floor, the wage index for both areas increased over 15%.[5] San Francisco, with much higher wages than southern California, was unaffected by the rural floor.
4. In 2024 and 2025, there were large increases in the rural wage index between the Proposed and Final Rule. This is in large part because hospitals do not need to make final decisions about which area to reclassify into until after the release of the Proposed Rule (reclassifications are discussed in more detail later in this paper).

3. The IPPS wage index is also used for the Outpatient Prospective Payment System (OPPS). While this paper does not report OPPS impacts, conceptually similar results apply to OPPS.
4. In 2025, the wage index calculation was changed again, after the Final Rule, in response to another lawsuit. This had little impact on the states in Figure 1 but significantly reduced the IPPS wage index (but not the OPPS wage index) in several low-wage areas.
5. In 2023, nine of California’s 29 urban CBSAs were subject to the rural floor. In 2024, 20 were subject to the rural floor. The remaining nine CBSAs are all in northern California.

Most components of the wage index calculation, including both the impact of the rural floor and hospital reclassifications, are budget neutral. CMS applies budget-neutrality factors to offset the increases allowed by these policies and these factors can illustrate the magnitude of the 2024 calculation changes. The table in Figure 2 shows the two budget-neutrality factors most impacted by the recent changes, with key features highlighted.

FIGURE 2: SELECT BUDGET-NEUTRALITY FACTORS

	RECLASSIFICATION BUDGET NEUTRALITY FACTOR		RURAL FLOOR BUDGET NEUTRALITY FACTOR	
YEAR	PROPOSED RULE	FINAL RULE	PROPOSED RULE	FINAL RULE
2025	0.977	0.963	0.986	0.978[6]
2024	0.981	0.971	0.981	0.978
2023	0.985	0.984	0.994	0.992
2022	0.987	0.987	0.994	0.993

Actual factors published to six decimals. Shortened factors shown to ease interpretation.

The Reclassification Budget Neutrality Factor (left) affects the IPPS base rate (CMS's Table 1, released with the Final Rule) and therefore has a larger impact on rates. The Rural Floor Budget Neutrality Factor (right) is applied to wage indexes directly.

Of note in Figure 2:

1. Comparing 2023 to 2025, the combined impact of the two neutrality factors is about a 2% to 3% reduction, mostly to offset the higher wage indexes in areas benefitting from the wage index changes. Over $100 billion is paid by traditional Medicare via IPPS, suggesting the calculation change redistributed multiple billions of dollars relative to the calculation in effect in 2023.[7]
   - The Reclassification Budget Neutrality Factor fell in 2024 and again in 2025 when comparing Final Rules. The Rural Floor Budget Neutrality Factor fell in 2024 and remained stable in 2025. Both factors were relatively stable between 2022 and 2023.
   - Between 2023 and 2025, the Reclassification Budget Neutrality Factor fell 2.1 percentage points, from 0.984 to 0.963. This factor adjusts the National Adjusted Operating Standardized Amounts (NAOSA) and is not reflected in the final wage index value. The NAOSA amount affects most components of IPPS payments multiplicatively, meaning that hospitals unaffected by the new wage index calculations had payments reduced by close to 2.1 percentage points as a result of this budget-neutrality factor.
   - Between 2023 and 2025, the Rural Floor Budget Neutrality Factor fell 1.4 percentage points, from 0.992 to 0.978. This factor is directly reflected in the wage index so the wage indexes in our tables reflect the drop.
   - A change in the wage index will generally have a lesser impact than a change in the NAOSA amount because the wage index component does not adjust the total NAOSA amount, it only adjusts the labor portion.[8]

6. Based on the 2025 Correction Notice. An update to this factor was not published with the IFC.
7. In addition to traditional Medicare IPPS payments, the wage index also affects the outpatient prospective payment system (OPPS), as noted above. Further, many MA plans both pay a percentage of Medicare reimbursement to hospitals and receive revenue based on expected payments to providers, amplifying the nationwide impact.
8. The NAOSA amount is split into a labor amount and a nonlabor amount. The labor amount in 2025 was 67.6% of the total for hospitals with a wage index above 1.0 and 62.0% for those with a wage index less than or equal to 1.0. Certain other components of the operating portion of IPPS payments are either not directly or fully impacted by the wage index. The wage index also affects capital payments through its Geographic Adjustment Factor, which is a function of the wage index.

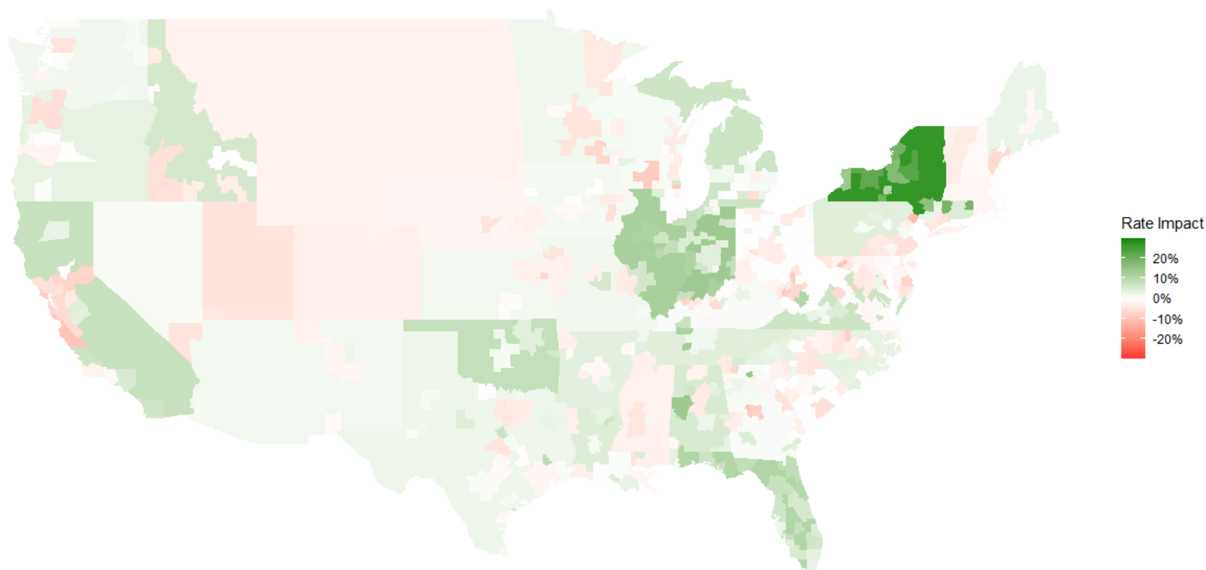
2. In 2022 and 2023, the two budget-neutrality factors were very similar in the Proposed and Final Rules. In 2024 and 2025, the factors are substantially different between the Proposed and Final Rules.
   - This divergence can be of particular importance to Medicare Advantage (MA) plans because the Proposed Rule is released before MA bids are submitted to CMS but the Final Rule is released after. This means that the information contained in the Proposed Rule has become less accurate for bid development since 2024.
   - The divergence also matters for certain accountable care organizations (ACOs), as some calculations depend on the Proposed Rule information.

The map in Figure 3 is a rough approximation of the impact that wage index changes have had on each county's IPPS payments across the contiguous United States between the final 2023 and 2025 factors. The impacts include the change in the Reclassification Budget Neutrality Factor and Rural Floor Budget Neutrality Factor. As this map shows, payment increases in some areas (green), are offset by decreases in other areas (red). Two points must be kept in mind when viewing this map:

1. While the map appears mostly green, many of the red areas are urban counties. Hospitals in the rural areas may also reclassify into these urban areas, so while states such as Georgia and Texas appear mostly light green, the states as a whole are likely receiving lower reimbursement than they would under 2023's calculation.
2. Payment changes to hospitals in an area may not exactly match the map, even in urban areas, because the map is based on what the wage index would be for a hospital with final classification in that geographic area and hospitals are able to reclassify out of an area. Other adjustments such as the maximum 5% year-over-year decrease are applied at the hospital level and not reflected.

FIGURE 3: APPROXIMATE IMPACT OF WAGE INDEX CHANGES ON IPPS RATES BETWEEN FY2023 AND FY2025

Assumes wage index impacts 60% of IPPS rates; includes wage index and reclassification budget neutrality factor changes



Area wage index calculations

An area's wage index calculations are mostly performed at the CBSA level,[9] and CBSAs are defined by a set of counties. For any area (urban or rural), the core of the wage index calculation is to sum up the wages and hours of all hospitals in that area then calculate the average wages per hour. The result for each area is then compared to national hourly hospital wages. The table in Figure 4 shows an illustrative example. The Rural Floor Budget Neutrality Factor is applied after this calculation. Importantly, if the resulting wage index for an urban area is less than the rural wage index for its state, then the urban area's wage index is set equal to the state's rural wage index.

FIGURE 4: BASIC AREA WAGE INDEX CALCULATION

PROVIDER	WAGES	HOURS	WAGES/HOURS
A	$30,000,000	700,000	$42.86
B	$85,000,000	2,000,000	$42.50
C	$185,000,000	3,800,000	$48.68
Total	**$300,000,000**	**6,500,000**	**$46.15**
National Average		**$54.96**	
Area's Wage Index (Pre-Neutrality Factors)		**0.8397 = 46.15/54.96**	

A provider's wage index is set to its area's wage index, using its post-reclassification CBSA. A small number of additional adjustments, such as a provision that a hospital's wage index cannot fall more than 5% year over year, are also applied.

Reclassifications and their impact on the 2024 rural wage index calculation

Hospitals do not necessarily receive the wage index of the area in which they are geographically located. Hospitals can "reclassify" into nearby areas, and reimbursement will be based on the wage index of their post-reclassification area. One reason why the ability for hospitals to reclassify makes intuitive sense is that a hospital just outside the county lines of a CBSA may be drawing from the same labor market as hospitals within the CBSA. When reclassification criteria are met, hospitals also may reclassify from one urban area to another nearby urban area when the nearby area had a higher wage index. There are two main types of reclassifications:

1. § 412.103 reclassifications: This type of reclassification allows urban hospitals to reclassify as rural.
2. Medicare Geographic Classification Review Board (MGCRB) reclassifications: This type of reclassification allows hospitals to reclassify into a nearby area, which can be urban or rural.

Hospitals receiving both types of reclassification are known as "dual reclass" hospitals.[10] Even before 2024, reclassifications of both types were very common.

Because of interactions between the two types of reclassifications and hold harmless provisions for hospitals affected by the reclassification policies, the rural wage index is calculated in three different ways, and the maximum is used.

The major change to the wage index calculation beginning in 2024 is that a hospital receiving a § 412.103 rural reclassification must now be treated exactly like a hospital that is geographically rural. In the 2024 Final Rule, CMS published the table in Figure 5, summarizing the old and new calculations.

9. The rural floor applies at the state level, so CBSAs spanning multiple states may have multiple wage indexes. Other parts of the calculations may also lead to providers in an area receiving different wage indexes.
10. There are multiple advantages to rural classification, one of which is different criteria for a MGCRB reclassification. See https://www.cms.gov/files/document/mgcrb-rules-december-15-2023.pdf.

FIGURE 5: CMS'S DESCRIPTION OF RURAL WAGE INDEX CALCULATIONS

SETS OF HOSPITALS USED IN THE RURAL FLOOR CALCULATION
A = Geographically rural hospitals
A1 = Subset of A with MGCRB or "Lugar" reclassification
B = Geographically urban hospitals with § 412.103 rural reclassification
B1 = Subset of B with MGCRB reclassification ("dual reclass" hospitals)
C = Cross-State MGCRB reclassification to rural area

CALCULATIONS (MAXIMUM IS USED)		
	2023 AND PRIOR	2024 AND LATER
Calculation 1	A	A + B
Calculation 2	A – A1	(A – A1) + (B - B1)
Calculation 3	A + (B – B1) + C	A + B + C

1. Calculation 1 performs the wage index calculation (as in our table in Figure 4 above) for rural hospitals. Before 2024, this was limited to geographically rural hospitals (A). Starting in 2024, this is both geographically rural hospitals (A) and hospitals with a § 412.103 reclass (B). Hospitals that reclassify out of the rural area are included in this calculation.
2. Calculation 2 performs the wage index calculation for rural hospitals that stay rural. In 2023 and earlier, this meant all rural hospitals (A) that do not reclassify out of the rural area (A1). Beginning in 2024, this now includes hospitals that receive a § 412.103 reclassification (B) but do not also reclassify out of the area. Hospitals that reclassify out of the rural area (dual reclass hospitals) are not included in this calculation (B1).
3. Calculation 3 is a third calculation that is similar to Calculation 1 but takes into account cross-state reclassifications (C).

Beginning in 2024, reclassifications have had a larger impact on the rural floor wage index, often driven by Calculation 2[11]. Few hospitals remain rural because urban areas must have a wage index at least as high as the rural floor, so Calculation 2 often has much lower volume than Calculations 1 and 3. Geographically rural hospitals (Set A in the calculation above) typically have much lower wages than geographically urban hospitals reclassified as rural (B). Therefore, in certain circumstances a geographically urban provider can dominate Calculation 2 by remaining classified as rural (B, but not B1) and cause the rural wage index to be far higher than the wages of geographically rural, or even urban, hospitals in the state. The following case study demonstrates how this happened in New York in 2025.

Case study: A hospital's use of reclassification rules to maximize reimbursement – and how it affected all of New York state

This section follows the behavior of a large inpatient acute hospital in Manhattan through CMS's wage index data. This hospital represents over 5% of the New York state wage data in CMS's data. In each of the last three years, the hospital has changed its CBSA, which has resulted in increasing its reimbursement. The table in Figure 6 shows its geographic classifications in the Final Rules for 2023 and 2024, the 2025 Proposed Rule, and the 2025 Final Rule. The wage index of each area is shown in each of the four time periods. The final area in each time period (highlighted), with the exception of the 2025 Interim Final Action with Comment Period (IFC), is the highest among the areas for that time period.

11. California is a notable exception, as discussed in the conclusion below.

FIGURE 6: FINAL RECLASSIFICATION CBSA ACROSS TIME

AREA	2023	2024	2025 PR	2025 IFC
Bridgeport-Stamford-Norwalk CT	1.3751	1.3357	1.1799	1.3258
New York City, NY	1.3329	1.3562	1.3090	1.3056
Nassau-Suffolk, NY	1.3099	1.3188	1.3247	1.3056
Rural NY	0.8515	1.2181	1.1799	1.3056
Hospital area after reclassification	Bridgeport-Stamford-Norwalk	New York City	Nassau-Suffolk	Rural NY

Between the 2025 Proposed and Final Rules, this hospital and another in the same provider system withdrew their MGCRB reclass applications, removing their dual reclass status. This choice to be classified as rural New York in 2025 raised New York's rural floor by 12.5 percentage points, relative to the 2025 Proposed Rule, significantly increasing the wage index of most of New York state with it, especially outside of New York City. The table in Figure 7 displays the wage index for select areas of New York for 2023 through 2025. All areas of New York state (not just the CBSAs shown) are now at the same wage index in the 2025 IFC.

FIGURE 7: SELECT NEW YORK AREA WAGE INDEXES 2023-2025

	2023		2024		2025	
AREA	PROPOSED RULE	FINAL RULE	PROPOSED RULE	FINAL RULE	PROPOSED RULE	IFC
New York City	1.3296	1.3329	1.3631	1.3562	1.3090	1.3056
Buffalo-Cheektowaga	1.0282	1.0258	1.2183	1.2181	1.1799	1.3056
Rochester	0.9108	0.9139	1.2183	1.2181	1.1799	1.3056
Rural NY	0.8536	0.8515	1.2183	1.2181	1.1799	1.3056

The impact of these moves is shown in the table in Figure 8. Figure 8 shows CMS's Calculation 2 (see Figure 5 above).

FIGURE 8: CMS CALCULATION 2 FOR RURAL NEW YORK'S WAGE INDEX, 2025

	2025 PROPOSED RULE			2025 FINAL RULE		
HOSPITAL	WAGES	HOURS	WAGES/HOUR	WAGES	HOURS	WAGES/HOUR
Select Hospitals	Not shown: not rural			$3,901,093,029	47,420,986	$82.27
All Others	$770,202,283	17,088,430	$45.07	$806,655,788	16,711,785	$48.27
Total	**$770,202,283**	**17,088,430**	**$45.07**	**$4,707,748,817**	**64,132,771**	**$73.41**
National Wages			$54.73			$54.96
Rural New York Calculation 2			0.8235			1.3355
Rural Floor Budget Neutrality Factor			0.9859			0.9775
Final Wage Index			**0.8118**			**1.3056**

Calculation 2 was not the highest of the rural calculations in the 2025 Proposed Rule. The 0.8118 is therefore not reported as New York's rural wage index in the Proposed Rule.

As shown in Figure 8, on a combined basis the "All Other" hospitals included in CMS's Calculation 2 are a much smaller portion of the total compared to these two hospitals and have a much lower wage index at an average wage of $48.27. The larger hospitals account for more than 80% of the total wages in Calculation 2. The resulting $73.41 average wage is greater than all other CBSA averages in the state, and thus the rural floor is used as the wage index for all areas in the state of New York.

Commentary and observations

In our review of the impacts in several states, each state has a unique story.

1. In several states, Calculation 2 is driving the increase; however, in California, Calculation 1 determines the state's rural wage index, and it is the northern California area that increases the wage index in southern California.
2. In Connecticut, a single hospital, the University of Connecticut John Dempsey Hospital, is the only hospital that is considered rural for Calculation 2 and therefore it solely determines the rural floor. It is also the highest wage hospital in the state, and thus all areas of Connecticut are not only set equal to this wage index, but every hospital in Connecticut is also assigned the maximum wage index possible. In the 2025 Final Rule, Connecticut's wage index is 1.3258; if instead the entire state's wages and hours were pooled into a single statewide calculation, its wage index would be about 1.06 prior to adjustment for neutrality factors or other impacts.
3. Massachusetts has a single wage index for the entire state in 2025, which was also true in 2023, before the changes that have been the focus of this paper.
4. In Illinois, the wage index increased substantially beginning with the Final Rule. In St. Louis, the wage index for Illinois providers is the Illinois rural floor of 1.0707, whereas most providers on the Missouri side receive a 0.9120 wage index. The volume of wages in St. Louis is relatively evenly split between Illinois and Missouri.

Conclusion

How will the wage index calculation look in the future? The current system is continuing to change as a result of litigation, with the most recent change being an Interim Final Action with Comment Period, which was released September 30, 2024, a day before the fiscal year 2025 IPPS rates were set to take effect and. This changed the FY 2025 rates by several percentage points in some states.[12] The Medicare Payment Advisory Commission (MedPAC) has been suggesting that Congress overhaul the wage index system since before the 2024 changes.[13] As a final reminder, when the wage index goes up in one area, because of budget neutrality, it redirects payments away from another area. The IPPS wage index will likely continue to be an area of change in the near future, with significant distributional effects across cities and states. Stakeholders will need to plan for the possibility of significant changes in facility reimbursement between the Proposed and Final IPPS Rules in the future.

12. The full text of the IFC is available at https://public-inspection.federalregister.gov/2024-22765.pdf.

13. MedPAC (June 2023). Chapter 9: Reforming Medicare's Wage Index Systems. Report to the Congress. Retrieved December 29, 2024, from https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch9_MedPAC_Report_To_Congress_SEC.pdf.

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