CMS Proposes Changes via the Inpatient Prospective Payment System

CAH Ambulance

Ambulances do not naturally fall under a critical access hospital's (CAH) cost-based umbrella. To be paid based on cost, an ambulance must belong to a CAH that is the only provider of ambulance services within a 35 mile drive of the CAH utilizing the *shortest* route (regardless if it is the fastest route).

CMS voiced concerns that some CAH ambulances do not meet this requirement for cost-based reimbursement due to another provider of ambulance services being within a 35 mile drive of the CAH, despite the ambulance service being unlicensed to transport patients to the CAH in question. CMS cites the example of a CAH located near the state's border where the other ambulance provider within a 35 mile drive is in the neighboring state and does not have the state licensure to transport patients to the CAH. Although the ambulance provider is licensed in its home state, it is not in the CAH's state and therefore is unable to transport patients to the CAH across state lines.

To address this, CMS has proposed changing the 35 mile rule to exclude ambulance providers not legally authorized to transport patients to or from the CAH. If this change is finalized, it will be effective for cost report periods beginning on or after October 1, 2019.

GME and IME Payment for Residents Rotating to CAHs

CMS has proposed a reconsideration of its previous interpretation of whether a CAH is considered a non-provider site for claiming IME and GME FTEs on a PPS cost report. In its 2014 IPPS rule, CMS opined that because a CAH provides services but is not always considered a hospital, residents who rotated to CAHs could not be counted as FTEs for an IPPS hospital's GME and IME calculations.

If, however, the CAH bears the cost of the residents, they could claim and be paid for the cost of those residents.

CMS is concerned their initial opinion acts as a disincentive to rotate physicians to rural areas, potentially adding to the problem of these areas being underserved. CMS has therefore proposed a change in their opinion to allow, beginning October 1, 2019, a PPS hospital to include the FTEs of residents who rotate to the CAH as long as it still meets the non-provider setting requirements.

If the CAH incurs the cost of those residents, they can still claim the cost.

Wage Index

There are wage index disparities between high and low wage index hospitals. These disparities are likely magnified by the time lag between the wage data utilized in setting the wage index and the method CMS uses to calculate a state's rural floor. The disparity between high and low wage index is also likely growing due to the current methodology where some low wage index hospitals may not be able to get themselves back to a proper wage index.

Wage data lag— Low wage index areas need to increase salaries to their employees but, due to the lag in calculating the wage index, that increase is not recouped for three years. CMS has proposed to break apart the various wage indexes into quartiles. Those hospitals in the lowest quartile (which it has proposed to define as any hospital with a wage index less than .8482) get 50 percent of the difference between their WI and the proposed .8482.

For example: a hospital has a wage index of .8000. Instead of receiving .8000 as its wage index for 2020, it would receive .8241 [(.8482-.8000)/2 + .8000].

The wage index and this proposal are intended to be budget neutral. As such, the proposal intends on taking the added wage index given to the bottom quartile hospitals from the top quartile hospitals. CMS has proposed the top quartile hospital be those with a wage index greater than 1.0351. For these highest quartile hospitals, CMS has proposed a decrease to their wage index equal to 3.4 percent of the difference between their WI and 1.0351.

For example: a hospital with a wage index of 1.04 would receive a wage index of 1.0398 [1.0400 - (1.0400-1.0351)*.034].

Those hospitals in the middle two quadrants will not be affected.

Rural Floor Calculation— A hospital's calculated wage index is subject to its state's rural floor. This means an urban hospital would not receive a lower wage index than the rural floor calculated for its state. In certain states, urban hospitals have reclassed to rural so as to set the rural floor at a higher amount than would have otherwise been calculated. Essentially, these states have banded together, resulting in all hospitals in their state having a higher wage index than they otherwise would have had.

To combat this issue, CMS has proposed pulling urban hospitals who have reclassed to rural from the rural floor calculation.

Because this could have a large effect on some hospitals' reimbursement, they have also proposed a two-year hold harmless period whereby a hospital will not see more than a five percent drop in its wage index in a year.

This proposal will essentially only hurt those hospitals currently benefiting from the rural floor, shifting those dollars to hospitals in the other states.

Again, the wage index is intended to be budget neutral. Since the proposal allows some hospitals to keep a higher wage index (not decrease their calculated wage index by more than 5 percentage points), CMS must otherwise spread that cost. In this proposal, it is looking to the market basket index and has proposed a budget neutrality adjustment of .998349.

UCC Payment

Currently, the uncompensated care payment is based on a three-year average of data. Calendar year 2020 was set to be three years' worth of uncompensated care cost as reported on Worksheet S-10 of the Medicare Cost Report.

Last year, CMS pushed the various Medicare Administrative Contractors to audit federal fiscal year 2015 cost reports for certain facilities specific to their S-10 reporting. Because we now have one year of audited data, with the other years unaudited, CMS worries the smoothing the three-year average was meant to bring to the calculation will be moot.

In response, they have proposed to utilize one year of S-10 data in calculating the 2020 UCC payment amount. The proposal is to use the fiscal year 2015 data, but CMS also seeks comment on utilizing the 2017 data.