THE
NATIONAL LAW REVIEW

CMS Proposes Changes to Medicare Wage Index that Would Increase Reimbursement Rates to Rural Hospitals at the Expense of Urban Hospitals

Wednesday, June 26, 2019

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Healthcare Law Blog

Health Law & Managed Care
All Federal

On May 3, 2019, the Centers for Medicare & Medicaid Services ("CMS") published a comprehensive proposed rule ("Proposed Rule") to revise the Medicare payment structure for inpatient prospective payment systems ("IPPS") hospitals. According to the preamble of the Proposed Rule, the purpose of the Proposed Rule is to bump up Medicare's reimbursements to rural hospitals, some of which receive the lowest rates in the country.

Unfortunately for urban hospitals, any proposed changes in the Medicare reimbursement system must be budget-neutral; therefore, any increase in rural hospital reimbursement must be matched with an equal and offsetting decrease in urban hospital reimbursement.[1] As reported in the Kaiser Health News on June 3, 2019, the Kaiser Family Foundation likens this to a Robin Hood-like effect – robbing from the rich to give to the poor. Like in Sherwood Forest, there are winners and losers in the world of Medicare reimbursement.

Wage Index: How it all Works

IPPS hospitals are paid a preset rate for each Medicare admission, based on the patient's Medicare Severity-adjusted Diagnosis Related Group ("MS-DRG").[2] The MS-DRG considers several factors including: principal diagnosis, complications and comorbidities, surgical procedures, age, gender, and discharge destination.

Furthermore, under the Social Security Act, CMS is required to vary the labor portion of the standardized federal IPPS reimbursement rates to account for differences in area wage levels to reflect "the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."[3] For short-term acute care hospitals, CMS must update this index annually.[4] When drafting the wage index, CMS refers to the "Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation" to derive an "average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation)." The final index is a ratio comparing the specific labor market area's average hourly wage to the national average hourly wage.

The wage index can have significant effects on reimbursement rates. For example, according to CMS, "a hospital in a rural community could receive a Medicare payment of about $4000 for treating a beneficiary admitted for pneumonia while a hospital in a high wage area (like many urban communities) could receive a Medicare payment of nearly $6000 for the same case, due to differences in their wage index."

Proposed Changes and the Urban/Rural Divide

As described in the Proposed Rule, CMS's proposed changes attempt to address common concerns that "the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals,"[5] and, as noted by the Office of Inspector General of the U.S. Department of Health and Human Services in an 2018 Audit Report, the wage index may not accurately measure local labor prices. Under the

proposed rule, CMS plans to introduce three basic changes to the current wage index payment structure for fiscal year ("FY") 2020.

First, CMS intends to increase the wage index for hospitals with a wage index value below the 25th percentile.[6] The increase would be determined by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals.[7] In order to ensure sufficient time to reflect hospital employee compensation increases in the index, the policy would be effective for at least 4 years, beginning in FY 2020.[8]

Second, to offset the increase in spending, CMS intends to decrease reimbursement rates for hospitals above the 75th percentile.[9] This complementary decrease is necessary to conform with budget neutrality requirements.[10] To provide some level of insulation from rapid changes in reimbursement rates, the policy would include a 5-percent cap on any decrease in a hospital's wage index from its final wage index for FY 2019.[11] Additionally, CMS intends to preserve the rank order of the hospitals relative reimbursement rates, affirming that rank order "generally reflects meaningful distinctions between the employee compensation costs faced by hospitals in different geographic areas."[12]

Third, CMS proposes changes to the wage index "rural floor" calculation. CMS proposes removing urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.[13] Under current law, the IPPS wage index value for an urban hospital cannot be less than the wage index value applicable to hospitals located in rural areas in the state—the "rural floor" provision.[14] However, according to an April 23, 2019 CMS Fact Sheet and as referenced in the Proposed Rule, urban hospitals in a limited number of states have inappropriately used this provision to influence the rural floor wage index value "at the expense of hospitals in other States, which also contributes to wage index disparities."[15]

You Can Please Some of the People all of the Time ….

As noted above and as described in the Proposed Rule, CMS's wage index proposal creates winners and losers. Not surprisingly, both parties have been vocal in their support and disdain for the wage index proposals.

For example, on April 24, 2019, Craig Becker, the President and Chief Executive Officer of the Tennessee Hospital Association ("THA"), issued the following statement:

For years, the Medicare [area wage index] has benefited hospitals in high income states at the expense of hospitals in states like Tennessee – particularly our rural hospitals – which have struggled to remain financially viable under this inequitable situation.

Yesterday's announcement by CMS recognizes this longstanding unfairness and creates a reasonable path forward to provide much needed relief for Tennessee's hospitals. This change will help secure the continued availability of healthcare services in communities across Tennessee and can provide a more sustainable future for all hospitals.

We applaud CMS' leadership on this issue and are grateful for the continued support from Tennessee's congressional delegation in advocating for [area wage index] reform.

Most recently, in an Opinion published by the Jackson Sun on June 25, 2019, Lamar Alexander, U.S. Senator, Tennessee, echoed the THA in its support of the Proposed Rule and wrote that the Proposed Rule, "will help ensure Americans can access health care close to their homes by attempting to level the playing field between urban and rural hospitals that rely on the Medicare hospital payment system."

On the other side of the divide, the American Hospital Association ("AHA") – which includes rural and urban hospitals among its membership – took a more nuanced position in its June 24, 2019 comments to the Proposed Rule. While recognizing the shortcomings of the wage index, AHA challenged the need to balance increases in rural hospital reimbursement with decreases in urban hospital reimbursement:

The AHA appreciates CMS's recognition of the wage index's shortcomings and supports improving the wage index values for low-wage hospitals. However, this should not be accomplished by penalizing other hospitals, especially in light of the fact that Medicare currently reimburses all inpatient PPS hospitals below the cost of care. Importantly, CMS is not bound by statute to apply budget neutrality for wage index modifications as proposed. As such, we support increasing the wage index values of low-wage hospitals, but urge the agency to use its existing authority to do so in a non-budget neutral manner.

In the June 3, 2019 Kaiser Health News article referenced above, the Massachusetts Health & Hospital Association ("MHHA") is reported to have gone even further than the AHA in its critique of the Proposed Rule. In an emailed

statement issued by Michael Sroczynski who oversees the MHHA's government lobbying efforts, the MHHA questioned the use of the wage index as a tool to address rural/urban disparities in Medicare reimbursement. As reported by Modern Healthcare in an April 27, 2019 article, "CMS throws rural hospitals a lifeline with wage index changes," MHHA objects to "providing relief to one subset of hospitals by arbitrarily cutting payments to another subset of hospitals that have genuinely higher labor costs." In considering MHHA's position, the article notes that the Commonwealth's hospitals have historically been at the higher end of the wage index.

Finally, Paul Ginsburg, Director of the USC-Brookings Schaeffer Initiative for Health Policy and a member of the Medicare Payment Advisory Commission, is quoted by Modern Healthcare in the April 27, 2019 article as saying that the Medicare wage index mechanism and the data upon which it draws are deeply flawed and the changes proposed in the Proposed Rule do not seem to address these flaws. "Rather than fix it, they are saying it is not very accurate so we are going to move up the low end and cut back the high end, which is really getting even further away from the philosophy of a payment system—to use good data to make these decisions."

In his final assessment of the Proposed Rule and its wage index-related provision, Mr. Ginsburg said to Modern Healthcare that, given the system's core flaws, the ultimate impact of the wage index changes is uncertain. "You really don't know what these changes are going to be accomplishing, for better or worse."

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[1] 84 F.R. at 19395-96. "Under section 1886(d)(8)(D) of the [Social Security] Act, the [CMS] Secretary is required to adjust the standardized amounts so as to ensure that aggregate payments under the IPPS after implementation of the provisions of sections 1886(d)(8)(B), 1886(d)(8)(C), and 1886(d)(10) of the Act are equal to the aggregate prospective payments that would have been made absent these provisions." 84 F.R. at 19589.

[2] Social Security Act § 1886(d) (42 U.S.C. § 1395ww).

[3] Social Security Act § 1886(d)(2)(H), (d)(3)(E).

[4] Social Security Act § 1886(d)(3)(E)(i).

[5] 84 F.R. at 19162.

[6] 84 F.R. at 19395.

[7] 84 F.R. at 19395.

[8] 84 F.R. at 19395.

[9] 84 F.R. at 19396

[10] 84 F.R. at 19395-96.

[11] 84 F.R. at 19398.

[12] 84 F.R. 19395-96.

[13] 84 F.R. at 19387-89.

[14] Social Security Act § 1886(d)(8)(E). 42 C.F.R. 412.103.

[15] 84 F.R. at 19162.