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CMS proposes $4.7 billion more for inpatient spending, changing wage index

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CMS Administrator Seema Verma

The CMS wants to alter the wage index to address a disparity that has previously been responsible for millions of dollars in improper payments to hospitals across the country.

The CMS wants to increase the wage index that sets the nation's hospital payments to address a disparity in the system. Urban hospitals would be on the losing end of this change. The rule aims to change the formula to pay rural hospitals, which have some of the lowest reimbursement rates in the country.

The agency late Tuesday released its annual proposed update for the hospital inpatient prospective payment system for federal fiscal 2020 that starts in October. Overall, the CMS projected total Medicare spending on inpatient hospital services, including capital, to climb by $4.7 billion in fiscal 2020.

The CMS called for hospitals that have a wage index value below the 25th percentile to get an increase that is "half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals."

The proposal would be in effect for at least four years starting this October. The CMS also suggested decreasing the wage index for hospitals above the 75th percentile so "Medicare spending does not increase as a result of this proposal." Wage-index adjustments are budget-neutral on a national basis.

The agency also proposed a 5% cap on any decrease to the wage index for fiscal 2020 compared with 2019.

A federal provision currently ensures that the wage indexes applied to urban hospitals cannot be lower than the rural area wage index. The intent was to prevent some urban hospitals being paid less than the average rural hospital in their state. However, the CMS said that "hospitals in a limited number of states have used urban and rural hospital reclassification to inappropriately influence the rural floor wage index value."

To address this disparity, the agency proposed removing the urban to rural hospital reclassifications for calculating the rural floor wage index value starting in federal fiscal 2020.

The wage index has long been a point of frustration for hospitals and policymakers. Any proposed tweaks to the formula pit urban versus rural providers. HHS Secretary Alex Azar last month acknowledged "absurdity" in the Medicare wage index during a Senate Finance Committee hearing. He said HHS is seeking comments on revising the entire wage index system but cautioned that HHS can only change the index so much on its own; congressional approval is needed for more sweeping modifications. Policy experts believe that's unlikely to happen given that some hospitals are getting paid too much at the expense of others.

HHS' Office of Inspector General in November reported that the wage index formula resulted in nearly $140.5 million in overpayments to 272 hospitals from 2014 to 2017. In that report, the OIG recommended an overhaul of the wage index system to mend a number of vulnerabilities, including the CMS' inability to penalize hospitals that submit inaccurate wage data and the fact that Medicare administrative contractors' limited reviews don't always catch inaccurate data.

Beyond the wage index changes, the agency proposed continuing add-on payments for two types of the pricey breakthrough cancer treatment called chimeric antigen receptor T-cell therapy, or CAR-T, which can cost as much as $1 million a patient.

That payment change received the most immediate public reaction from industry.

"Based on our initial review, we are pleased that (the CMS) has increased the new technology add-on payment rate, including for CAR-T therapies," said Tom Nickels, executive vice president of the American Hospital Association. "Hospitals and health systems have been taking on this financial burden to ensure access to these life-saving treatments for patients, and while this proposal is not a permanent solution, it will help in the short-term."

Nickels in a prepared statement also lauded the proposed 90-day

reporting period for attestation for the Promoting Interoperability Programs, calling it "a move that will reduce regulatory burden on hospitals."

The CMS is also proposing a new add-on payment pathway for devices that are considered breakthrough technologies by the Food and Drug Administration. The FDA's breakthrough pathway is intended to expedite development of new drugs and devices that can treat a serious or life-threatening illness or address an unmet need and are better than a treatment already on the market.

The agency hopes to ensure that a new technology or treatment is available as soon as it is cleared by the FDA, but the CMS' current policy for add-on payments makes it hard to prove a product is better than one already on the market.

So the CMS is proposing that if a device participated in one of the FDA's expedited programs and received marketing authorization from the FDA, then the CMS would consider the product new and not similar to an existing technology.

"Under this proposal, the medical device would only need to meet the cost criterion to receive the add-on payment. This change would begin with applications received for new technology add-on payments for (fiscal) 2021," the agency said in a release.

The agency also plans to make a small boost in uncompensated care payments to hospitals. The CMS proposes to distribute roughly $8.5 billion in uncompensated care payments for fiscal 2020, an increase of about $216 million from the current fiscal year.

In the 2020 IPPS proposed rule, the CMS is also seeking changes to quality programs, including the **Hospital Readmission Reduction Program**. Among other things, the CMS would adopt eight factors to use when considering if measures should be removed, similar to what's been done with the value-based reporting program.

The CMS also proposed several changes to the Hospital Inpatient Quality Reporting Program which reduces payments to hospitals that fail to meet requirements. For this program, the agency wants to adopt two new opioid-related electronic clinical quality measures starting in calendar year 2021. One of the measures is on concurrent prescribing of opioids and the other is related to opioid-adverse events.

Another proposed change is to remove the Claims-Based Hospital-Wide All-Cause Readmission measure and replace it with a hybrid measure that includes the Claims and Electronic Health Record Data measure. This newly combined measure would mandate reporting beginning in federal fiscal 2026 after two years of voluntary reporting.

For long-term care hospitals, the CMS is proposing a payment increase of about 0.9%, or $37 million in fiscal 2020.

However, prospective patient system payments for cases that are still transitioning to site-neutral payment rates are expected to decline by 4.9%.

Inline Play
