Issue Brief

FEDERAL ISSUE BRIEF • April 26, 2019

Proposed FY 2020 Medicare IPPS and LTCH Update Released

The Centers for Medicare & Medicaid Services released an extensive and very lengthy proposed rule to update both the Hospital Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System for fiscal year 2020.

Among the proposal's many items, the document addresses the following issues.

- the hospital market basket increase
- the MS-DRG documentation and coding payment add-on
- major revisions to the calculation of the area wage index
- new and revised technology add-on payments
- Medicare uncompensated care (Disproportionate Hospital Share payments)
- hospital-acquired conditions
- the hospital readmission program
- the hospital inpatient quality reporting system
- the hospital value-based purchasing program
- the Medicare and Medicaid promoting interoperability programs
- changes to the LTCH system

The document currently is on public display at the ***Federal Register*** office and is scheduled for publication Friday, May 3. A display version is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-08330.pdf.

COMMENT

CMS projects this proposal would apply to approximately 3,300 acute care hospitals and to approximately 390 LTCH facilities.

CMS states that "the rate increase, together with other changes to IPPS payment policies, would increase Medicare spending on inpatient hospital services in FY 2020 by approximately $4.7 billion."

This is a huge rule. Its long, some 1,824 pages.

Note: For many payment issues, the rule's Addendum (beginning on page 1,531) contains much concise and extremely helpful information.

The rule has three major items.

- rates and increases
- changes to the area wage index calculations
- proposed changes to the DSH data collection

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

MHA
MISSOURI HOSPITAL ASSOCIATION

continued

INPATIENT PROSPECTIVE PAYMENT SYSTEM

"Proposed Changes to Payment Rates under IPPS"

The proposed increase in operating payment rates would be approximately 3.2 percent. This reflects a projected hospital market basket update of 3.2 percent reduced by a 0.5 percentage point productivity adjustment as mandated by the ***Affordable Care Act***. This also reflects a proposed +0.5 percentage point add-on adjustment required by legislation for prior MS-DRG documentation and coding reductions.

Hospitals may be subject to other payment adjustments under the IPPS, including the following.

- penalties for excess readmissions
- penalty (1.0 percent) for worst-performing quartile under the Hospital-Acquired Condition Reduction Program
- upward and downward adjustments under the Hospital Value-Based Purchasing Program

Changes to the Area Wage Index Calculation

CMS proposes significant changes to the area wage index calculation.

CMS would increase the wage index for hospitals with a wage index value below the 25th percentile. These hospitals' wage indexes would be increased by half the difference between the otherwise applicable wage index value for that hospital and the 25th percentile wage index value across all hospitals.

CMS would decrease the wage index for hospitals above the 75th percentile so that Medicare spending does not increase as a result of this proposal.

CMS also proposes changes to the wage index "rural floor" calculation. Under 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. This is known as the "rural floor" provision. "It appears that hospitals in a limited number of states have used urban to rural hospital reclassifications to inappropriately influence the rural floor wage index value." CMS proposes removing urban to rural hospital reclassifications from the calculation of the rural floor wage index value beginning in FY 2020.

In addition, to mitigate payment decreases due to these proposals, CMS proposes a 5.0 percent cap on any decrease in a hospital's wage index from its final wage index for FY 2019. That is, under this proposal, a hospital's final wage index for FY 2020 would not be less than 95 percent of its final wage index for FY 2019.

Medicare Uncompensated Care Payments (Disproportionate Share Hospitals)

CMS proposes distributing roughly $8.5 billion in uncompensated care payments in FY 2020, an increase of approximately $216 million from FY 2019.

For FY 2020, CMS proposes using a single year of data on uncompensated care costs from Worksheet S-10 of the Medicare cost report for FY 2015 to distribute these funds. In addition, CMS seeks public comments on whether it should, due to changes in the reporting instructions that became effective for FY 2017, use a single year of Worksheet S-10 data from the FY 2017 cost reports.

MHA
MISSOURI HOSPITAL ASSOCIATION

Hospital-Acquired Conditions Reduction Program

CMS proposes to:

- Specify the dates to collect data used to calculate hospital performance for the FY 2022 HAC Reduction Program;
- clarify administrative processes for validating National Healthcare Safety Network Healthcare-associated Infection data submitted by hospitals to the Centers for Disease Control and Prevention.

Hospital Readmissions Reduction Program

CMS proposes to:

- Establish the performance period for the FY 2022 program year;
- update the definition of "dual eligible";
- adopt a subregulatory process to address potential nonsubstantive changes to the payment adjustment factor components.

Hospital Inpatient Quality Reporting Program

CMS proposes updating the Hospital IQR Program's measure set. Specifically by:

- removing the Claims-Based Hospitalwide All-Cause Readmission measure and replace with the proposed Hybrid Hospitalwide All-Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data measure beginning with the FY 2026 payment determination after two years of voluntary reporting of the Hybrid HWR measure; and establish reporting and submission requirements for the hybrid measures
- adopting two new opioid-related electronic clinical quality measures beginning with the CY 2021 reporting period/FY 2023 payment determination:
  - Safe Use of Opioids – Concurrent Prescribing eCQM, and
  - Hospital Harm – Opioid-Related Adverse Events eCQM

Hospital Value-Based Purchasing Program

CMS proposes that the Hospital VBP Program would use the same data as the HAC Reduction Program to calculate the NHSN HAI measures beginning with CY 2020 data collection, which is when the Hospital IQR Program will cease collecting data on those measures.

CMS also proposes that the Hospital VBP Program would rely on the process used by the HAC Reduction Program to validate the NHSN HAI measures to ensure that the measure rates are accurate for use in the Hospital VBP Program.

Medicare and Medicaid Promoting Interoperability Programs

CMS proposes an EHR reporting period of a minimum of any continuous 90-day period in CY 2021 for new and returning participants (eligible hospitals and CAHs) in the Medicare Promoting Interoperability Program attesting to CMS.

PROPOSED CHANGES TO PAYMENT RATES UNDER LTCH PPS

The LTCH site neutral payment rate cases will begin to be paid fully on the site neutral payment rate, rather than the transitional blended rate, for LTCH discharges occurring in cost reporting periods beginning in FY 2020.

Overall, for FY 2020, CMS expects LTCH PPS payments to increase by approximately 0.9 percent, or $37 million, which reflects the continued statutory implementation of the revised LTCH

continued

PPS payment system. LTCH PPS payments for FY 2020, for discharges paid using the standard LTCH payment rate, are expected to increase by 2.3 percent after accounting for the proposed annual standard federal rate update for FY 2020 of 2.7 percent, and an estimated decrease in outlier payments and other factors.

LTCH PPS payments for cases continuing to transition to the site neutral payment rates are expected to decrease by approximately 4.9 percent. This accounts for the LTCH site neutral payment rate cases that will no longer be paid a blended payment rate as the rolling statutory transition period ends for LTCH discharges occurring in cost reporting periods beginning in FY 2020.

LTCH Quality Reporting Program

CMS proposes to adopt two new quality measures.

I. CHANGES TO PAYMENT RATES UNDER IPPS (PAGE 1,531)

Rate Update

The proposed increase for general acute care hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users would be 3.2 percent. This reflects a projected hospital market basket update of 3.2 percent reduced by a 0.5 percentage point multifactor productivity adjustment for a net increase of **2.7 percent**.

Also included is a proposed +0.5 percentage point adjustment required by Section 414 of the ***Medicare Access and CHIP Reauthorization Act of 2015*** for prior documentation and coding payment reductions. The 2.7 and 0.5 amounts result in an increase of 3.2 percent.

CMS displays four applicable percentage increases to the standardized amount for FY 2020, as specified in the following table. The 3.2 percent market basket rate of increase below does NOT include the 0.5 percent documentation and coding adjustment (Refer to page 1,535).

MISSOURI HOSPITAL ASSOCIATION

continued

Proposed FY 2020 Applicable Percentage Increases for the IPPS				
FY 2020	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed Market Basket Rate-of-Increase	3.2	3.2	3.2	3.2
Proposed Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0	0	-0.8	-0.8
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0	-2.4	0	-2.4
Proposed MFP Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.5	-0.5	-0.5	-0.5
Proposed Applicable Percentage Increase Applied to Standardized Amount	2.7	0.3	1.9	-0.5

Standardized Payment Rates

The current FY 2019 standardized payment amounts, as corrected in the Oct. 3, 2018, ***Federal Register***, are as follows.

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 1.35 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.85 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 0.550Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -1.55 Percent)	
Wage Index Greater Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,856.27	$1,789.81	$3,773.51	$1,751.40	$3,828.68	$1,777.01	$3,745.93	$1,738.60
Wage Index Equal to or Less Than 1.0000							
Labor	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**	**Labor**	**Nonlabor**
$3,500.57	$2,145.51	$3,425.44	$2,099.47	$3,475.53	$2,130.16	$3,400.41	$2,084.12

The current (FY 2019) large urban labor rate is $3,856.27, and the nonlabor rate is $1,789.81, for a total of $5,646.08. The other area labor rate is $3500.57, and the nonlabor component is $2,145.51, for a total of $5,646.08.

The total labor/nonlabor amount for the full update (left column) (hospitals that submit quality data and are meaningful EHR users) is shown as $6,037.63 for both wage index areas – those greater than 1.0000 and those with values equal to or less than 1.0000 are in the table below. This number is wrong. CMS is showing an incorrect FY 2019 Geographic Reclassification Factor of 0.985932. That amount also was corrected in the Oct. 3, 2018, ***Federal Register*** to be 0.985335. Dividing the FY 2019 payment amounts by those reflected in the table below changes the FY 2020 base rate to $6,041.28.

MHA
MISSOURI HOSPITAL ASSOCIATION

continued

The table below reflects the original numbers with strikeouts and the corrected amounts. Interesting that the proposed FY 2020 standardized amounts are correct as shown.

The following table (Pages 1,592-1,594) illustrates the changes from the FY 2019 national standardized amount to the proposed FY 2020 national standardized amount. As noted above, the total FY 2019 rates for both the urban and other areas (large and other) is $5,646.08. These amounts are adjusted by the outlier, geographic and the rural demonstration reclassification factors, as shown below. The result is a total labor/nonlabor amount of $6,041.28. The $6,041.28 amount then is adjusted for FY 2020 by the items beginning with the proposed FY 2020 proposed update factor.

Changes from FY 2019 Standardized Amounts to the FY 2020 Standardized Amounts

Changes from FY 2019 Standardized Amounts to the FY 2020 Standardized Amounts				
	Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.7 Percent)	**Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.3 Percent)**	**Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.9 Percent)**	**Hospital Did OT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.5.Percent)**
FY 2020 Base Rate after removing: 1. FY 2019 Geographic Reclassification Budget Neutrality ~~(0.985932)~~ correct amount should be (0.985335) per Oct. 3, 2018, ***Federal Register*** 2. FY 2019 Operating Outlier Offset (0.948999) 3. FY 2019 Rural Demonstration Budget Neutrality Factor (0.999467)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4123.70 $4,126.19 Nonlabor (31.7%) $1,913.93 $1,915.09 (Combined labor and nonlabor = $6,041.28) If Wage Index is Less Than or Equal to 1.0000: Labor (62%): $3,743.33 $3,745.59 Nonlabor (38%): $2,294.30 $2,295.69 (Combined labor and nonlabor = $6,041.28)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4123.70 $4,126.19 Nonlabor (31.7%) $1,913.93 $1,915.09 (Combined labor and nonlabor = $6,041.28) If Wage Index is Less Than or Equal to 1.0000: Labor (62%): $3,743.33 $3,745.59 Nonlabor (38%): $2,294.30 $2,295.69 (Combined labor and nonlabor = $6,041.28)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4123.70 $4,126.19 Nonlabor (31.7%) $1,913.93 $1,915.09 (Combined labor and nonlabor = $6,041.28) If Wage Index is Less Than or Equal to 1.0000: Labor (62%): $3,743.33 $3,745.59 Nonlabor (38%): $2,294.30 $2,295.69 (Combined labor and nonlabor = $6,041.28)	If Wage Index is Greater Than 1.0000: Labor (68.3%): $4123.70 $4,126.19 Nonlabor (31.7%) $1,913.93 $1,915.09 (Combined labor and nonlabor = $6,041.28) If Wage Index is Less Than or Equal to 1.0000: Labor (62%): $3,743.33 $3,745.59 Nonlabor (38%): $2,294.30 $2,295.69 (Combined labor and nonlabor = $6,041.28)

Changes from FY 2019 Standardized Amounts to the FY 2020 Standardized Amounts				
	Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.7 Percent)	Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.3 Percent)	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.9 Percent)	Hospital Did OT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.5.Percent)
Proposed FY 2020 Update Factor	1.027	1.003	1.019	0.995
Proposed FY 2020 MS-DRG Recalibration Budget Neutrality Factor	0.998768	0.998768	0.998768	0.998768
Proposed FY 2020 Wage Index Budget Neutrality Factor	1.000915	1.000915	1.000915	1.000915
Proposed FY 2020 Reclassification Budget Neutrality Factor	0.986451	0.986451	0.986451	0.986451
Proposed FY 2020 Transition Budget Neutrality Factor	0.998349	0.998349	0.998349	0.998349
Proposed FY 2020 Operating Outlier Factor	0.949	0.949	0.949	0.949
Proposed FY 2020 Rural Demonstration Budget Neutrality Factor	0.999580	0.999580	0.999580	0.999580
Adjustment for FY 2020 Required under Section 414 of Pub. L. 114-10 (MACRA	1.005	1.005	1.005	1.005
Proposed National Standardized Amount for FY 2020 if Wage Index is Greater Than 1.0000; Labor/Nonlabor Share Percentage (68.3/31.7)	Labor: $3,977.31 Nonlabor: $1,845.99	Labor: $3,884.36 Nonlabor: $1,802.85	Labor: $3,946.33 Nonlabor: $1,831.61	Labor: $3,853.38 Nonlabor: $1,788.47
Proposed National Standardized Amount for FY 2020 if Wage Index is less Than or Equal to1.0000; Labor/Nonlabor Share Percentage (62.0/38.0)	Labor: $3,610.45 Nonlabor: $2,212.85	Labor: $3,526.07 Nonlabor: $2,161.14	Labor: $3,582.32 Nonlabor: $2,195.62	Labor: $3,497.95 Nonlabor: $2,143.90

The **labor-related** portion for areas with wage indexes greater than 1.0000 would continue at **68.3** percent. Areas with wage index values equal to or less than 1.000 would remain at **62.0**. (Page 1,539)

The change between the proposed FY 2020 amount and the current amount is $177.22, or a net increase of approximately 3.14 percent.

These amounts are before other adjustments, such as the hospital value-based purchasing, readmission and hospital-acquired conditions programs.

Proposed Changes to Payment Rates for Acute Care Hospital Inpatient Capital-Related Costs for FY 2020 (Page 1,617)

CMS proposes an FY 2020 capital rate of **$463.81**. The current amount is $459.41 (as corrected Oct. 3, 2018).

Proposed Outlier Payments (Refer to page 1,586)

CMS is adopting an outlier fixed-loss cost threshold for FY 2020 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, and any add-on payments for new technology, plus **$26,994**.

II. PROPOSED CHANGES TO THE HOSPITAL AREA WAGE INDEX (REFER TO PAGE 741)

Proposals to Address Wage Index Disparities between High and Low Wage Index Hospitals (Refer to page 815)

CMS proposes to reduce the disparity between high and low wage index hospitals by increasing the wage index values for certain hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality. CMS also is changing the calculation of the rural floor.

Based on the data for this proposed rule, the 25th percentile wage index value across all hospitals is 0.8482. If this policy is adopted in the final rule, this number would be updated based on final wage index values.

CMS proposes to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The proposed increase in the wage index for these hospitals would be equal to half the difference between the otherwise applicable final wage index value for a year for that hospital, and the 25th percentile wage index value for that year across all hospitals.

For example, assume the otherwise applicable final FY 2020 wage index value for a geographically rural hospital is 0.6663, and the 25th percentile wage index value for FY 2020 is 0.8482. Half the difference between the otherwise applicable wage index value and the 25th percentile wage index value is 0.0910 (that is, (0.8482 - 0.6663)/2)). Under CMS' proposal, the FY 2020 wage index value for such a hospital would be 0.7573 (that is, 0.6663 + 0.0910).

CMS proposes that this policy would be effective for at least four years, beginning in FY 2020, to allow employee compensation increases implemented by these hospitals sufficient time to be reflected in the wage index calculation.

To offset the estimated increase in IPPS payments to hospitals with wage index values below the 25th percentile, CMS proposes to decrease the wage index values for hospitals with high wage index values. CMS defines hospitals with wage index values above the 75th percentile wage index value across all

continued

hospitals for a fiscal year as "high wage index hospitals."

CMS proposes to decrease the wage index values for high wage index hospitals by a uniform factor of the distance between the hospital's otherwise applicable wage index and the 75th percentile wage index value for a fiscal year across all hospitals. Based on the data for this proposed rule, the 75th percentile wage index value is 1.0351. Therefore, for example, if high wage index Hospital A had an otherwise applicable wage index value of 1.7351, the distance between that hospital's wage index value and the 75th percentile is 0.7000 (that is, 1.7351 - 1.0351).

CMS would next estimate the uniform multiplicative budget neutrality factor needed to reduce those distances for all high wage index hospitals so that the estimated decreased aggregate payments to high wage index hospitals offset the estimated increased aggregate payments to low wage index hospitals. CMS estimates this factor is 3.4 percent for FY 2020.

In the example provided above, the distance between Hospital A's wage index value and the 75th percentile would be reduced by 0.0238 (that is, the prior distance of 0.7000 * 0.034), and therefore, the wage index for Hospital A after application of the proposed budget neutrality adjustment would be 1.7113 (that is, 1.7351 - 0.0238).

The statute provides that, for discharges on or after Oct. 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a state may not be less than the area wage index applicable to hospitals located in rural areas in that state. The statute also requires that a national budget neutrality adjustment be applied in implementing the rural floor.

CMS proposes to remove urban to rural reclassifications from the calculation of "the wage index for rural areas in the state in which the county is located."

CMS notes that absent further adjustments, the combined effect of the proposed changes to the FY 2020 wage index could lead to significant decreases in the wage index values for some hospitals, depending on the data for the final rule.

CMS proposes to place a 5 percent cap on any decrease in a hospital's wage index from the hospital's final wage index in FY 2019. In other words, CMS proposes that a hospital's final wage index for FY 2020 would not be less than 95 percent of its final wage index for FY 2019. This proposed transition would allow the effects of the proposed policies to be phased in over two years with no estimated reduction in the wage index of more than 5 percent in FY 2020.

III. PROPOSED PAYMENT ADJUSTMENT FOR MEDICARE DSHS FOR FY 2020 (§ 412.106) (REFER TO PAGE 869)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

The remaining amount, equal to an estimate of 75 percent of what otherwise would have been paid as Medicare DSH payments, is reduced to reflect changes in the percentage of individuals who are uninsured.

There are three factors in determining the amount of such payments.

MHA
MISSOURI HOSPITAL ASSOCIATION

continued

Proposed Calculation of Factor 1 for FY 2020 (Refer to page 880)

Factor 1 is the difference between CMS' estimate of: (1) the amount that would have been paid as Medicare DSH payments for the fiscal year in the absence of the new payment provision; and (2) the amount of empirically justified Medicare DSH payments that are made for the fiscal year, which takes into account the requirement to pay 25 percent of what would have otherwise been paid under section 1886(d)(5)(F) of the act. In other words, this factor represents CMS' estimate of 75 percent (100 percent minus 25 percent) of the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the act, for the fiscal year.

For purposes of calculating Factor 1 and modeling the impact of this FY 2020 IPPS/LTCH PPS proposed rule, CMS used the Office of the Actuary's December 2018 Medicare DSH estimates, which were based on data from the September 2018 update of the Medicare Hospital Cost Report Information System and the FY 2019 IPPS/LTCH PPS final rule IPPS Impact File.

The estimate of empirically justified Medicare DSH payments for FY 2020 is approximately $4.214 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2020). CMS proposes that Factor 1 for FY 2020 would be $12,643,011,209.74, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2020 ($16,857,348,279.65 minus $4,214,337,069.91).

Proposed Calculation of Factor 2 for FY 2020 (Refer to Page 888)

The statute states that, for FY 2018 and subsequent fiscal years, the second factor is 1 minus the percent change in the percent of individuals who are uninsured, as determined by comparing the percent of individuals who were uninsured in 2013 (as estimated by the secretary, based on data from the Census Bureau or other sources the secretary determines appropriate, and certified by the Chief Actuary of CMS) and the percent of individuals who were uninsured in the most recent period for which data are available (as so estimated and certified).

The Actuary's projections for CY 2019 and CY 2020 are as follows.

- percent of individuals without insurance for CY 2013: 14 percent
- percent of individuals without insurance for CY 2018: 9.4 percent
- percent of individuals without insurance for CY 2020: 9.4 percent
- percent of individuals without insurance for FY 2019 (0.25 times 0.094) + (0.75 times 0.094): 9.4 percent
- percent of individuals without insurance for FY 2020 (0.25 times 0.094) + (0.75 times 0.094): 9.4 percent
  1-|((0.094 - 0.14)/0.14)| = 1 - 0.3286 = 0.6714 (67.14 percent)

Therefore, the proposed Factor 2 for FY 2020 is **67.14** percent. It currently is 67.51 percent.

MISSOURI HOSPITAL ASSOCIATION

continued

The proposed FY 2020 uncompensated care amount is: $12,643,011,209.74 x 0.6714 = $8,488,517,726.22. The following shows the 75 percent amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" was $6.767 billion
- The FY 2019 "pool" is $8.273 billion
- The FY 2020 "pool" would be $8.489 billion

Proposed Calculation of Factor 3 for FY 2020 (Refer to page 905)

Factor 3 is equal to the percent, for each subsection (d) hospital, that represents the quotient of (1) the amount of uncompensated care for such hospital; and (2) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under section 1886(r) of the act for such period (as so estimated, based on such data).

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

Proposed Methodology for Calculating Factor 3 for FY 2020 (Refer to page 917)

CMS believes that, on balance, the FY 2015 Worksheet S-10 data are the best available data to use for calculating Factor 3 for FY 2020. However, as an alternative, CMS also has considered the use of FY 2017 data. CMS seeks public comments on this alternative and, based on the public comments received, CMS could adopt it in the FY 2020 final rule.

CMS proposes that, for purposes of determining uncompensated care costs and calculating Factor 3 for FY 2020, "uncompensated care" would continue to be defined as the amount on Line 30 of Worksheet S–10, which is the cost of charity care (Line 23) and the cost of non-Medicare bad debt and nonreimbursable Medicare bad debt (Line 29).

For FY 2020, CMS proposes to compute Factor 3 for each hospital.

Hospitals have 60 days from the date of public display of this FY 2020 IPPS/LTCH PPS proposed rule to review the table and supplemental data file published on the CMS website in conjunction with the proposed rule, and to notify CMS in writing of any inaccuracies. Comments that are specific to the information included in the table and supplemental data file can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov.

CMS says that 2,430 hospitals are projected to be eligible for DSH in FY 2020.

This is an abbreviated analysis. View the full analysis here.

MHA
MISSOURI HOSPITAL ASSOCIATION