Medicare Wage Index Seminar

Michigan Health & Hospital Association

Federal Fiscal Year 2020
Medicare Wage Index Seminar
Michigan Health & Hospital Association
FFY 2020
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Medicare Wage Index Seminar  
Michigan Health & Hospital Association  
FFY 2020  
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Medicare Wage Index System
Part I: Wage Index and Occupational Mix

Michigan Health & Hospital Association
June 27, 2018

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Overview

• General Overview of Wage Index
• Wage Index Development Timeline
• Calculation of AHW
• Wage Index Review/Assessment
• Occupational Mix
• Proposed Changes
General Overview

- Wage Index reflects the relative hospital wage level for each geographic area compared to the national average
- Social Security Act Section 1886(d)(3)(E)(i):

  \[ \text{The Secretary shall adjust ... the DRG prospective payment rates ... for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.} \]

General Overview

- Wage index is calculated based on wage data from hospital cost reports
- About a 4 year lag between cost reporting year and when it is included in wage index
  - FFY 2020 wage index based on cost report years beginning in FFY 2016: FYEs 9/30/16, 12/31/16, 3/31/17 and 6/30/17 cost reports

General Overview

- S-3 worksheets in the Medicare cost report contain data related to a hospital’s salary and contract labor workforce – costs, hours, fringe benefits
- Wages are also adjusted for occupational mix
- Excludes CAHs and exempt hospitals and other providers
- Used for other payment systems: HOPPS, SNF, HHA, Hospice, LTCH, IRF, IPF
General Overview

- Adjusted salaries and hours for each hospital in a CBSA are combined to provide the totals for the CBSA to calculate an adjusted average hourly wage for the area.
- Adjusted salaries and hours for every hospital nationally are combined to calculate national adjusted average hourly wage.
- Each area’s adjusted average hourly wage is divided by the national adjusted average hourly wage to provide an unadjusted wage index.

General Overview

- Several adjustments and exceptions
  - Rural Floor – No hospital can receive a wage index less than its statewide rural wage index.
  - Imputed Floor – CMS calculates a rural wage index for all-urban states (DE, NJ, & RI). CMS has once again proposed to do away with imputed floor.
  - Frontier States – Sets a wage index floor of 1.00 for states with at least 50% of counties have less than 6 people per square mile (MT, NV, ND, SD, & WY).
  - Out-Migration Adjustment – increase in the wage index for hospitals located in counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index.

General Overview

- Geographic Reclassification – Hospitals may apply for reclassification on an individual, county, or statewide basis to receive the wage index of a nearby urban or rural area.
- Wage index also reduced by a Rural Floor Budget Neutrality Factor.
- Highest Wage Index: Santa Cruz-Watsonville, CA – 1.9046
- Lowest Wage Index (excluding Puerto Rico): Rural Alabama – 0.6701
Example of Wage Index Calculation

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Occ Mix Adj Wages</th>
<th>Hours</th>
<th>AHW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$60,969,000</td>
<td>1,355,915</td>
<td>$44.97</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$50,715,800</td>
<td>1,406,912</td>
<td>$43.16</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$710,525,300</td>
<td>3,996,403</td>
<td>$43.10</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$108,576,685</td>
<td>2,852,060</td>
<td>$42.11</td>
</tr>
<tr>
<td>Total</td>
<td>$441,786,785</td>
<td>9,321,323</td>
<td>$43.10</td>
</tr>
</tbody>
</table>

- National AHW: $42.95
- Preliminary Wage Index: 1.0036
- Rural Floor BNA: 0.994733
- Final Wage Index: 0.9983

Example of Impact of Wage Index on Hospital Payments

<table>
<thead>
<tr>
<th>Wage Index</th>
<th>Labor-related Portion</th>
<th>Nonlabor-related Portion</th>
<th>Total Operating DRG Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than or Equal to 1</td>
<td>$3,506.83</td>
<td>$2,149.35</td>
<td>$5,656.18</td>
</tr>
<tr>
<td>Greater Than 1</td>
<td>$3,863.17</td>
<td>$1,793.01</td>
<td>$5,656.18</td>
</tr>
</tbody>
</table>

- Add-On For Indirect Medical Education: 0.2400
- Add-On For Disproportionate Share Hospitals: 0.0400
- Standardized Amount Plus IME & DSH: $7,015.47
- Case Mix Index: 1.60
- Medicare Discharges (D): 5,000
- Total Operating DRG Amount: $58,123,786

Wage Index Timeline – FFY 2020

- May 18, 2018 – Release of Preliminary FY 2020 wage index and occupational mix public use files (PUF)
- September 4, 2018* – Deadline for Hospitals to request revisions to their Worksheet S-3 Wage Data and OMS
- November 16, 2018 – Deadline for MACs to complete desk reviews
- January 31, 2019* – Posting of revised PUF on CMS website
Wage Index Timeline

• February 15, 2019* – Deadline for hospitals to submit requests for:
  — Corrections to errors in the February PUFs due to CMS or FI/MAC mishandling of the wage index data
  — Revisions of desk review adjustments to their wage index data as included in the February PUFs (and to provide documentation to support the request)

• March 2019 – Completion of appeals by MACs and transmission of Final Wage Data to CMS

• April 4, 2019* – Deadline for hospitals to appeal FI/MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the FI’s/MAC’s determination

Wage Index Timeline

• April/May 2019 – Approximate date for publication of the FY 2020 proposed rule & tables
• April 30, 2019* – Release of final FY 2020 wage index and occupational mix data PUFs on CMS Web page
• May 30, 2019* – Deadline for hospitals to submit correction requests to both CMS and their FI/MAC to correct errors due to CMS or FI/MAC mishandling of the final wage and occupational mix data; deadline for revisions to CMS corrections made within 13 days of April 30 and at least 14 days before May 30
• August 1, 2019 – Approximate date for publication of the FY 2020 final rule
• October 1, 2019 – Effective date of FY 2020 Wage Index

Wage Index Tables

• Released as part of proposed and final IPPS rules
• Used to be in the Federal Register, now published on CMS website
• Table 2: Wage index and other information by hospital CCN
• Table 3: Wage index information by CBSA number
• Impact File: 50+ data fields for each hospital by CCN
• Link CMS Wage Index Files: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html
Calculation of AHW

- Providers submit wage index data to CMS On Cost Report Worksheet S-3 PT. II, III, IV and V, which is used for wage index calculation:
  - Salaries and Wage Related Costs (from general ledger)
    - Hospital Employees
    - Home Office and Related Party Employees
    - Contract labor
  - Hours Related to Paid Salaries (Payroll)

Calculation of AHW

- For short periods, CMS uses the longest period; if 2 short periods of equal length, CMS uses more recent.
- CMS annualizes short period data and applies an inflation factor based on mid-point of cost reporting period.
- The salary total on Worksheet A is revised to include contract A&G, housekeeping, and dietary as reported on the wage survey
- A portion of overhead salaries and hours and wage-related costs are allocated to excluded areas such as sub-providers or non-reimbursable cost centers

Wage Index Review/Assessment

- Focus review on paid hours first – review pay categories and mapping on the cost report
- Verify documentation can be made available quickly for FI audit review
- Compare most recent PUF file to prior years and investigate significant changes
**Wage Index Review/Assessment**

- Confirm all hours and benefits are being properly recorded
- Convert all hours reported to be based on payroll data not General Ledger data
- Review all re-classes to ensure all salary re-classes are needed and recorded correctly as well as recording the associated hours
- Review all pension cost/distributions reported and adjust any of these wage related costs reported to the new methodology provided by CMS

**Reporting Hours**

- Only **paid** hours are to be included for wage index reporting:
  - Regular Hours (Including Paid Lunch Hours)
  - Overtime Hours
  - Paid Holiday
  - Vacation and Sick Leave Hours
  - Paid Time-Off Hours
  - Hours Associated with Severance Pay
  - Jury Duty
  - Bereavement
- Reclass applicable hours for each A-6 reclass that effects salary

**Reporting Hours**

- The following hours should be removed for wage index reporting:
  - On Call Hours (report hours for workers who are contracted solely for the purpose of being on call on appropriate contract labor line)
  - Differential OT hours that are recorded (i.e. if an employee works 1 hour, but the time is recorded at 1.5, then .5 hours should be removed)
  - Bonus Hours
  - Shift Differential Hours
  - Buy/Sell back PTO
  - Buy/Sell back vacation
  - Hours related to Capitalized Salaries
  - Leave of Absence (unpaid)
Reporting Hours

- The following hours should be removed for wage index reporting (continued):
  - Family Medical Leave (unpaid)
  - Disability (unpaid)
  - Baylor Plan; employees work 36 hours, but get paid for 40 hours – remove 4 hour difference.
  - Seasonal Plan; employees work certain months of the year, but get paid for 52 weeks – remove the time not actually employed.
  - Severance hours; General rule: if severance is booked as a "salary" expense then include hours, if severance is booked as a non-salary expense then do not include hours.
  - Holiday Pay for nurses who work a paid holiday. They could be paid regular pay + holiday pay + overtime – make sure that hours are not being double counted.

Contract Labor

- Potential areas for contract labor:
  - Patient Care Contract Labor (Line 11)
  - Management and Administrative Services (Line 12)
  - Physician Part A Contract Labor (Line 13)
  - A&G Contract Labor (Line 28)
  - Housekeeping Contract Labor (Line 33)
  - Dietary Contract Labor (Line 35)
- Contract labor should be supported by invoices
- Must include labor costs and corresponding hours; do not include other costs: equipment, supplies, travel
- Usually help overall AHW

Contract Labor (cont.)

- Patient Care Contract Labor (Line 11)
  - Services under contract rather than by employees for direct patient care and management services
  - Do not include Part B services
  - Examples of common contract labor are Nurses, PT, OT, RT, ST, Sleep Clinic, Infection Control, MRI, Cath Lab, Lithotripsy, Pharmacy, Per fusionists and Lab
  - Do not include costs applicable to excluded units reported on line 9 and 10
Contract Labor (cont.)

- Physician Part A Contract Labor (Line 13)
  - Contract labor for Part A Physician services (excluding teaching)
  - Costs and time should be supported by contracts and/or time studies
  - Do not include the costs for Part A Physicians services from the home office allocation and/or related organizations (to be reported on Line 15)
  - Do not include any contracted interns and residents (to be reported on Line 7.01)
  - Do not include any costs applicable to excluded units if reported on line 9 and 10

Contract Labor (cont.)

- A&G Contract Labor (Line 28)
  - Line used to report contract labor costs that a hospital incurs in carrying out its administrative and/or general management functions
  - These expenses must be reported on Worksheet A, line 5 and any subscripts
  - Generally this area can have the highest AHW
  - These items normally also will draw a lot of scrutiny from the MAC so it is critical to have all the data needed to support your amounts reported
  - Examples of the types of contract labor reported on Line 28
    - Legal
    - Tax Preparation
    - Cost Report Preparation
    - Purchasing Services
    - Information and Data Processing services
    - Audit

Wage Related Costs

- Needs to be allocated between core and excluded areas
- Includes:
  - 401(k) Employer Contributions
  - Tax Sheltered Annuity (TSA) Employer contribution
  - Qualified and Non-Qualified Pension Plan Cost
  - Prior Year Service Cost
  - 401(k)/TSA Plan Administration Fees
  - Legal/Accounting/Management Fees – Pension Plan
  - Employee Managed Care Program Administration Fees
  - Health Insurance (Purchased or Self-Funded)
  - Prescription Drug Plan, Dental, Hearing & Vision Plans
  - Life Insurance (If employee is owner or beneficiary)
  - Accident Insurance (If employee is owner or beneficiary)
Wage Related Costs

- Includes (cont.):
  - Disability Insurance (if employee is owner or beneficiary)
  - Long Term Care Insurance (if employee is owner or beneficiary)
  - Worker’s Compensation Insurance
  - Retiree Health Care Costs (only current year)
  - FICA – Employers Portion Only
  - Medicare Taxes – Employers Portion Only
  - Unemployment Insurance
  - State or Federal Unemployment Taxes
  - Executive Deferred Compensation
  - Day Care Cost and Allowances
  - Tuition Reimbursement

- Other Wage Related Costs (Line 18):
  - Cafeteria Subsidy
  - Parking Lot Subsidy (most likely to meet the 1% Test)
  - Licensing fees for Nurses, Techs, etc.
  - Transportation Subsidy
  - Employee Wellness and fitness center program
  - Salaried Physician Malpractice insurance

- 1% Test - Each wage related costs other than core must exceed 1% of total salaries from Worksheet S-3, Part III, Lines 3 and 4, Column 4; Cannot lump costs together to get over 1% threshold
- Other wage related costs must also be allocated between allowable and excluded areas (Line 19)

Wage Related Costs - Pension

- The pension cost to be included equals a hospital's average cash contributions deposited to its defined benefit pension plan over a 3-year period, or number of years that the hospital has sponsored a defined benefit plan if less than 3 years
- The averaging period is the 36 months ending on the last day of the wage index cost reporting period.
- This is a change from FY 2016 Final Rule where the averaging period was the 36 consecutive calendar month period centered on the midpoint of the cost reporting period used for wage index.
- For example, the FY 2020 wage index will be based on Medicare cost reporting periods beginning during FFY 2016 and will reflect the average pension contributions made in hospitals’ cost reporting periods beginning during FFYs 2014, 2015, and 2016
Wage Related Costs - Pension

- Hospitals may determine a “prefunding balance” based on pension contributions made but not reflected in the wage index during certain prior periods.
- Find the most current CMS Wage Index Pension Cost Worksheet and Wage Index Prefunding Worksheet at the below link:
  [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2019-Wage-Index-Pension-Cost-Guidelines.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2019-Wage-Index-Pension-Cost-Guidelines.html)

Occupational Mix Adjustment

- Section 304(c) of Public Law 106-544 amended section 1886(d)(3)(E) of the Social Security Act requires CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program.
- The purpose of occupational mix is to control for the effect of the hospitals’ employment choices on the wage index.

Occupational Mix Adjustment

- If you staff with higher RN levels your wage index is higher so Occupational Mix Adjustment controls that effect.
- Markets with an expensive mix of employees and contract labor have their AHW adjusted downward; those with a cheaper mix of employees and contract labor have their AHW increased.
- Was supposed to help rural hospitals, but because of minimum staffing levels often hurts these areas.
Occupational Mix Adjustment

• The occupational mix adjustment factor is based on the national nursing average hourly rate divided by the hospital's nursing average hourly rate
• A portion of each hospital's salaries and wage-related costs are adjusted for the occupational mix, based on the hospital's nursing category salaries as a percentage of total salaries
• If a hospital did not submit data, it automatically receives the average adjustment for the other hospitals in the urban or rural area
• If no hospitals in an area submit a survey, all hospitals receive an adjustment factor of 1.0

Occupational Mix Adjustment

• Occupational mix survey conducted every three years
• All IPPS hospitals are instructed to report
• Does not apply to CAHs, excluded hospitals, or other providers
• Most recently, the 2016 Survey was due to the MAC by July 1, 2017
• Hospitals have some ability to submit revisions in subsequent years
• Based on paid salaries and hours data for Calendar Year 2016
• Impacts Medicare payments for FFYs 2019-2021

Occupational Mix Adjustment

• Direct input from Nursing Administration is crucial
• Prepare Nursing Administration to assist, as needed, and respond to Medicare Administrative Contractor (CMS auditors) questions if needed with Finance personnel.
• We do not seek uniformity – Nursing models and roles vary hospital to hospital.
Occupational Mix Adjustment

- The survey is very simple looking:

Occupational Mix Adjustment

- The occupational categories derive directly from the BLS employee categories and CMS uses the BLS definitions for these categories
- Include employees, directly hired and acquired under contract for the following categories:
  - RNs
  - LPNs and Surgical Technologists
  - Nursing Assistants and Orderlies
  - Medical Assistants
  - All Other Occupations

Occupational Mix Adjustment

- Do not include employees in areas excluded from IPPS, such as skilled-nursing facilities, psychiatric, or rehabilitation units or facilities.
- Also do not include employees or contract labor whose services are excluded from the IPPS, such as physician Part B, PAs, NPs and interns and residents.
- If home office or related organization personnel provide only administrative services, report their wages and hours in the “All Other Occupations” category.
- To the extent that there are home office or related organization personnel that are engaged in nursing activities, they must be reported in the appropriate nursing subcategory.
Occupational Mix Adjustment

- Nursing personnel in the following cost centers are included in the appropriate nursing subcategory:
  - Nursing Administration
  - Adults and Pediatrics (General Routine Care)
  - Intensive Care Unit
  - Coronary Care Unit
  - Burn Intensive Care Unit
  - Surgical Intensive Care Unit
  - Other Special Care (specify)
  - Nursery
  - Operating Room
  - Recovery Room
  - Delivery Room and Labor Room
  - Electrocardiology
  - Renal Dialysis
  - Ambulatory Surgical Center (Non-Distinct Part)
  - Other Ancillary Clinics
  - Emergency
  - Observation Beds

- Personnel in other areas or nurses who are performing solely administrative functions, would be included in the “All Other Occupations” category.

- Workers should be classified in the occupation that requires their highest level of skill.
- If there is no measurable difference in skills, workers are to be included in the occupation in which they spend the most time.
- Minimize RN hours and maximize lower nursing categories to increase occupational mix adjustment.
- Occupational mix instructions, including definitions of nursing categories are available online: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html)

Nursing Categories - RNs

- Excluded from the survey are advance practice nurses who are billed under Medicare Part B.
- Include the following in “All Other”
  - Nursing Administration
  - RNs that do not provide direct care
  - RNs in “includable nursing departments” that are in educational positions, administrative positions, supervisory positions, that do not provide direct patient care themselves.
Nursing Categories - LPNs

- Licensed Practical Nurses and Surgical Technologists
- LPNs
  - Care for ill, injured, convalescent or disabled persons
  - May work under the supervision of an RN
  - Licensing is required
- Surgical Technologists
  - Assist in operations under the supervision of surgeons, RNs, or other surgical personnel

Nursing Categories – Nursing Assistants and Orderlies

- Nursing Assistants
  - Provide basic patient care under direction of nursing staff.
  - Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens.
  - May transfer or transport patients.
- Orderlies
  - Transport patients to areas such as operating rooms or x-ray rooms using wheelchairs, stretchers, or moveable beds.
  - May maintain stocks of supplies, or clean and transport equipment.

Nursing Categories - Medical Assistants

- Performs administrative and certain clinical duties under the direction of physician, including scheduling appointments, maintaining medical records, billing, and coding for insurance purposes.
- Clinical duties may include taking and recording vital signs and medical histories, preparing patients for examination, drawing blood, and administering medications as directed by physician.
- Do not include physician assistants, phlebotomists, information technology personnel, health information management personnel, medical secretaries, ward clerks, and general business office personnel.
Nursing Categories – All Other

- Non-nursing personnel
- Include nurses that function solely in administrative or leadership roles, that do not directly supervise staff nurses who provide patient care, and do not provide any direct patient care themselves.
- Do not include personnel from IPPS-excluded areas.
- Include the wages and hours of personnel from the home office or related organizations if they perform solely administrative functions and work in IPPS cost centers and outpatient departments that are included in the wage index.

Occupational Mix Calculation

Past Proposals for Wage Index

- Tax Relief and Health Care Act of 2006, Congress mandated a MedPAC report on revision of the wage index
- June 2006 MedPAC Report with recommendations to Congress
  - Congress should repeal existing wage index system
  - Allow Secretary to establish new system:
    - Uses BLS data from all employers and industry-specific occupational weights,
    - Adjusted for geographic differences in the ratio of benefits to wages,
    - Adjusted at the county level and smooths large differences between counties
    - Transition period.
Past Proposals for Wage Index

- CMS engaged Acumen to evaluate MedPAC recommendations
  -Reports dated April 2009 and March 2010
  -Use BLS data to construct wage index
  -MedPAC’s blending and smoothing method is not well suited to the existing Medicare wage index.
  -Some hospitals would experience declines in their wage index values as a result of more accurately defining labor markets.
  -Acumen recommended further exploration of labor market definitions using a wage area framework based on hospital-specific characteristics, such as the commuting times from hospitals to population centers, to construct a more accurate hospital wage index.
- April 2011 Report from Acumen to revise wage index to account for commuting patterns

Past Proposals for Wage Index

- The ACA required that the Secretary submit to Congress a plan that comprehensively reforms the wage index applied to the Medicare hospital IPPS and take into considerations from MedPAC and Acumen reports
- Report Issued April 2012
- HHS recommended using a Commuting Based Wage Index (CBWI) to establish a labor market area and wage index value for each hospital (as opposed to labor market areas)
- Use information on commuting flows between geographic units that are smaller than MSAs, such as Census Tracts or ZIP Codes.
- Commuting data would be used to identify areas from which a hospital hires its workers and to determine the proportion of its workers hired from each area to calculate hospitals-specific wage index.

Past Proposals for Wage Index

- Commuting data would be used to identify areas from which a hospital hires its workers and to determine the proportion of its workers hired from each area to calculate hospitals-specific wage index.
- Eliminate sharp differences or cliffs in a wage index just because the nearby hospital is in a different or adjacent CBSA
- A more up to date reporting system for collecting commuting data from hospitals would have to be established
- In FFY 2019 Proposed Rule, CMS once again is asking for comments related to the wage index system
Takeaways

- The wage index is one of the last areas PPS hospitals can impact future payments and should be reviewed yearly for opportunities to increase dollars and reduce hours.
- Assessment of your cost report is the key.
- Prepare adjustments annually and review Public Use Files to confirm accuracy and to help improve your AHW.
- Monitor development timeline to ensure you meet deadlines.
- The wage index system continues to be assessed by CMS and other stakeholders, but currently there are no planned changes.
Medicare Wage Index System
Part II: Medicare Geographic Reclassification
Michigan Health & Hospital Association
June 27, 2018

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Agenda/Content

- Overview of MGCRB Wage Index Reclassification
- Overview of Urban to Rural Reclassification
- Multiple Reclassifications
  - Prior prohibition
  - Court challenges
  - Policy changes
    - 2016 Interim Final Rule
    - FFY 2018 IPPS Proposed Rule
- 2-step reclass – “Rurban” Strategy
  - New opportunities for urban hospitals
  - Considerations
  - Case studies

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Background

- CMS designates areas as urban or rural for a variety of purposes
- For hospital PPS purposes, CMS has adopted Metropolitan and Micropolitan Statistical Areas as defined by the Office of Management and Budget (OMB)
- Collectively, Metropolitan and Micropolitan Statistical Areas called Core-Based Statistical Areas or CBSAs
- A Metropolitan Statistical Area (MSA) is a CBSA associated with at least one urbanized area that has a population of 50,000+ that comprises the central county or counties containing the core, plus adjacent outlying counties that have a high degree of social and economic integration
Background

- An "urban area" is defined as an area within an MSA or a metropolitan division
- 11 largest MSAs divided into metropolitan divisions
- A "rural area" is defined as any area outside an urban area
- Urban/rural status typically adjusted and redefined every 10 years, based on the national census
- Approximately 460 different urban and rural areas for IPPS/OPPS
- CMS releases updated wage indices for areas each year as part of the IPPS rulemaking process
Background

- The Medicare program also has an in-between status called "Lugar status"
- These "Lugar counties" would otherwise be rural based on OMB labor market area delineations
- Because of their proximity and commuting patterns to one or more MSAs, they are treated as being a part of the MSA to which the greatest number of workers in that county commute
- Hospitals in these counties are referred to as "Lugar hospitals"

MGCRB Reclassification

- Hospitals can apply to the Medicare Geographic Classification Review Board (MGCRB) to receive the wage index of a nearby urban or rural area
- Reclassification available on individual, county-wide group or state-wide basis; no state-wide reclassifications have ever been approved
- Applications must be submitted on MGCRB forms and received by the MGCRB on or before the first business day in September
- The MGCRB has 180 days to approve or deny applications – end of February
- Administrative appeal rights for denied applications; no court review

- If approved, the hospital receives the wage index of the target reclassified area beginning the following October 1 for IPPS and January 1 of the following year for OPPS
- Approved reclassifications are effective for a 3-year period
- Regulations allow for withdrawals, terminations and reinstatements each year in the event the home geographic area wage index exceeds the reclassified wage index
- Rural hospitals reclassified to an urban area only treated as urban for wage index purposes; rural for all others
- Regulations for MGCRB criteria and procedures at 42 CFR 412.230 et seq.
MGCRB – Individual Reclass

- For individual reclassification, a hospital must meet 3 criteria
- Home area wage test
  - Applicant’s 3-year average hourly wage (AHW) is at least equal to a specified threshold of the AHW of other hospitals in its home area
  - 108% for urban hospitals and 106% for rural hospitals
  - Waived for hospitals that are or have ever been classified as a rural referral center (RRC)
  - Does not apply for single hospital MSAs

MGCRB – Individual Reclass

- Target area wage test
  - Applicant’s 3-year AHW is at least equal to a specified threshold of the AHW of other hospitals in the target area
  - 84% for urban hospitals and 82% for rural hospitals
  - 82% for hospitals that are or have ever been classified as an RRC
- Proximity criteria
  - Applicant must show it is within a specified distance of the target area
  - 15 miles for urban hospitals and 35 miles for rural hospitals
  - A hospital that is currently an RRC or sole community hospital (SCH) may reclassify to the closest urban area or another rural area (if closer than any other urban area) even if greater than the 15 or 35 miles proximity criteria

Urban to Rural Reclass

- Urban to rural a/k/a Section 401 a/k/a 412.103 reclassification
- Regulations at 412.103 allow hospitals located in urban areas to reclassify as rural if they meet certain criteria
  - Located in a rural census tract of an MSA based on the Rural-Urban Commuting Area (RUCA) codes
  - Located in an area designated by any law or regulation of the state in which it is located as a rural area, or the hospital is designated as a rural hospital by any state law or regulation
  - Would qualify as a SCH or RRC if actually located in a rural area
Urban to Rural Reclass

- Application for 412.103 reclassification must be mailed to the CMS Regional Office
- Hospitals can apply for 412.103 reclassification at any time during the year
  - If applying for RRC status, must file during the hospital’s last cost reporting quarter to be effective as of the start of the upcoming cost reporting year
- CMS has 60 days to approve or deny application

Urban to Rural Reclass

- CMS has 60 days to approve or deny application
- Rural status effective as of the date received by the CMS RO
- Treated as rural for all “subsection (d)” purposes – i.e., IPPS purposes
  - Still urban for other purposes
    - Direct GME – SSA § 1886(h)
    - Capital PPS? – SSA § 1886(g)

Urban to Rural Reclass

- Rural status is effective unless there is a change in the circumstances under which the classification was approved or until cancelled by the hospital
- Cancellation
  - Non-RRCs: provide at least 120 days notice prior to end of cost reporting period; cancellation effective as of start of next cost-reporting period
  - RRCs: provide at least 120 days notice prior to end of FFY; cancellation effective as of start of FFY; must have rural status for at least one full 12-month cost-reporting period
Multiple Reclassifications

- Two methods for a hospital to reclassify
  - MGCRB wage index reclassification
  - Urban to rural a/k/a 412.103 a/k/a Sec. 401 reclassification
- When CMS implemented the regulations for rural reclassification at 42 CFR 412.103, it amended the MGCRB regulations to prohibit hospitals with 412.103 rural status from also being reclassified by the MGCRB
- CMS was concerned that hospitals would use both reclassification processes to "game" the system

Providers challenged CMS and won in 2 federal appellate court decisions
- Geisinger Community Medical Center v. Secretary, United States Department of Health & Human Services (3rd Cir. 2015)
- Lawrence & Memorial Hospital v. Burwell (2nd Cir. 2016)

2016 Interim Final Rule

- A hospital with a MGCRB wage index reclassification can be approved for a 412.103 reclassification and keep its MGCRB reclassification
- A hospital with 412.103 rural status can use the less stringent wage index and proximity criteria applicable to rural hospitals (106% and 82% wage tests, 35-mile proximity) for MGCRB reclassification (instead of 108% and 84% wage tests, 15-mile proximity)
- For home area wage test, compare to hospitals in area hospital actually located; not hospitals in the state rural area
### 2016 Interim Final Rule
- Can get MGCRB reclassification back to home urban area
- A hospital with dual reclassifications will be treated as urban for wage index purposes and rural for other Medicare purposes
- A Lugar hospital that receives a 412.103 reclassification will still receive the urban wage index based on its Lugar status

### FFY 2018 IPPS Rule
- CMS clarified that RRC applications must be submitted during the final quarter of the cost-reporting year
- SCHs or RRCs utilizing the special access rule can apply for reclassification to their home urban area or the closest urban area outside of its geographic home
- Did not finalize proposal that evidence of approval of SCH/RRC must be submitted to the MGCRB by the first business day after January 1 (i.e., after the September 1 MGCRB application submission deadline); must be before MGCRB decision

### The "Rurban" Strategy
- Allows urban hospitals to reclassify to rural and apply for MGCRB reclassification using the more flexible rural wage index reclassification rules
- Urban hospitals should carefully evaluate options to consider the impact of:
  - Timing requirements and applications
  - Impact on all inpatient and outpatient payments, not just wage index
  - Could impact other payors as well (including Medicare Advantage)
  - 340B eligibility and effective dates
  - In some cases, the strategy may necessitate short-term pain for a long-term gain...
The "Rurban" Strategy

- Other considerations for rural reclassification besides wage index reclassification
  - Sole Community Hospital Status, Rural Referral Center Status, Medicare Dependent Small Rural Hospital Status
  - 340B Status
    - Ordinary method for 340B eligibility is to have a DSH adjustment of at least 11.75%
    - SCHs and RRCs may qualify if their DSH adjustment is at least 8%
    - BUT, subject to the Orphan Drug exclusion
    - Quarterly enrollment process for 340B

- Medical Education Payments
  - MGCRB reclass does not impact medical education payments, but 412.103 reclass may
  - For medical education payments, 412.103 reclassification treats the hospital as rural for some purposes and urban for other
  - Rural for:
    - 30% upward adjustment to existing IME FTE cap under 413.79(c)(2)(i)
    - Can build new program IME FTE cap under 413.79(e)(3)
  - Urban for DGME FTE cap (i.e., no DGME FTE cap increase and cannot build new DGME FTE cap)
  - If hospital returns to urban status before 10 years, it loses the cap increases
  - If rural status remains for 10 years, changes may become permanent
  - Can take several years for the IME benefits to fully kick in due to 3-year rolling average and IRB ratio lookback
The "Rurban" Strategy

• Other considerations for rural reclassification besides wage index reclassification
  – Operating DSH cap of 12% for certain categories of hospitals
  – Loss of capital DSH payments
  – Bundled payment programs
    • Treated as rural for Comprehensive Care for Joint Replacement and the proposed Cardiac Bundled Payment
    • Stop-loss thresholds under the programs are lower for rural hospitals, but rural hospitals have the same upside gain potential as urban hospitals

• May impact other payors: Medicaid, TRICARE, commercial

• Does not impact exempt units/facilities
  • rehabilitation
  • psychiatric

Filing deadlines and effective dates for hospitals applying for 412.103 reclass, RRC status, MGCRB reclass and 340B based on cost-reporting year end:

<table>
<thead>
<tr>
<th>412.103</th>
<th>FYE 7/31</th>
<th>FYE 9/30</th>
<th>FYE 11/30</th>
<th>FYE 12/31</th>
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</thead>
<tbody>
<tr>
<td>RRC Filing</td>
<td>1/1/2018</td>
<td>4/1/2018</td>
<td>7/1/2018</td>
<td>10/1/2018</td>
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<tr>
<td>RRC Effective</td>
<td>1/1/2018</td>
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<tr>
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<tr>
<td>MGCRB Effective [IPPS]</td>
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<tr>
<td>MGCRB Effective [OPPS]</td>
<td>10/1/2017</td>
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<tr>
<td>340B Enrollment</td>
<td>7/1/2017</td>
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<td>340B Effective</td>
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<td>10/1/2017</td>
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</tbody>
</table>
The "Rurban" Strategy

If the hospital is not applying for RRC status, the filing dates get much less complicated:

<table>
<thead>
<tr>
<th>Date</th>
<th>412.103 Filing and Effective</th>
<th>MGCRB Effective (IPPS)</th>
<th>MGCRB Effective (OPPS)</th>
</tr>
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<tbody>
<tr>
<td>9/1/2017</td>
<td>10/31/2017</td>
<td>10/1/2018</td>
<td>1/1/2019</td>
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</tbody>
</table>

Rurban Strategy Case Studies

• #1: urban teaching hospital with no existing reclass
  – § 412.103 to RRC & wage index reclass to adjacent MSA
  – Medicare lost revenue = $(650,000) over 1st 9 months
  – Medicare gain over next 27 months = $6 million
  – Acquired 340B status under lower 8% RRC threshold
    • Kicked in 7/1/2017, savings = $3.4 million/year
  – 30% increase in IME FTE Cap
    • ~$1 million by year 3 of reclass
  – Can renew every 3 years thereafter
    • Without down stroke in 1st 9 months; ~$2.8 million/year

• #2: urban hospital with no existing reclass; 12/31 FYE
  – § 412.103 to RRC & wage index reclass using special access rules to MSA 90 miles away, next closest 100+ miles away
  – Medicare lost revenue = $(6 million) over 1st 9 months
  – Medicare gain over next 27 months = $11 million
  – Can renew every 3 years thereafter
    • Without down stroke in 1st 9 months; ~$4 million/year
Rurban Strategy Case Studies

#3: urban SCH with existing MGCRB reclass
- 412.103 reclassification to based on state law/regulation
- Gets 7.1% add-on to OPPS payments for rural SCHs
- Filed new MGCRB to another urban area within 35 miles with higher wage index
- Paid based on HSR for operating IPPS payments
- Benefit of MGCRB reclass is for capital IPPS & OPPS
  • ~1.4 million/year

#4: urban SCH with no existing MGCRB reclass
- 412.103 reclassification
- MGCRB reclassification back to home area
- Dropped down to rural floor for about 10 months
- Gets 7.1% add-on to OPPS payments for rural SCHs
- No IPPS down stroke because paid under HSR

#5: urban hospital with existing MGCRB reclass
- Applied for 412.103 reclassification to obtain SCH status
  - via 25 mile market share test (available because reclassed as rural)
  - urban hospitals can only use 35 mile test for SCH status
- Increase IPPS payments because paid under HSR
- Plus, gets urban wage index for OPPS via existing MGCRB reclass
- And, 7.1% add-on to OPPS payments for rural SCHs
- $10+ million/year
Rurban Strategy Case Studies

• #6: urban hospital with no existing MGCRB reclass
  – Home area at state rural floor
  – higher wage index target area 33 miles away
  – Didn’t meet home aware wage test
  – Filed for 412.103 reclass/RRC status
  – Avoided home area wage tests and can use the 35 mile proximity test
  – Qualified for 340B based on lower RRC threshold
## FY 2020 Hospital Wage Index Development Timetable

### (May 2018 through October 2019)

<table>
<thead>
<tr>
<th>Date: May 18, 2018</th>
<th>Task: Release of two preliminary FY 2020 wage index files: 1) unaudited FY 2016 Worksheet S-3 wage data file, and 2) CY 2016 occupational mix survey data. The FY 2016 wage data file includes Worksheet S-3 wage data from cost reports submitted to HCRIS through approximately May 15, 2018. The CY 2016 occupational mix file consists of survey data that was included in the FY 2019 April 27, 2018 PUF. The files exclude hospitals designated as CAHs as of May 2017. Notice sent from CMS to MACs regarding the September 4, 2018, deadline for hospitals to request revisions to the wage index and occupational mix data as reflected in the preliminary files. Notice must be forwarded by the MACs to hospitals they service to alert hospitals to the availability of the preliminary wage data file for their review and to inform hospitals of their opportunity to request revisions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 4, 2018</td>
<td>Deadline for hospitals to request revisions to their Worksheet S-3 wage data and CY 2016 occupational mix data as included in the May 18, 2018 preliminary PUFs, and to provide documentation to support the request. MACs must receive the revision requests and supporting documentation by this date. MACs will have approximately 10 weeks to complete their reviews, make determinations, and transmit revised data to CMS’s Division of Acute Care (DAC).</td>
</tr>
<tr>
<td>November 6, 2018</td>
<td>Deadline for MACs to notify State hospital associations regarding hospitals that fail to respond to issues raised during the desk reviews. The purpose of the letter is to inform the State association and its member hospitals that a hospital’s failure to respond to matters raised by the MAC can result in lowering an area’s wage index value and, therefore, lower Medicare payments for all hospitals in the area.</td>
</tr>
<tr>
<td>November 16, 2018</td>
<td>Deadline for MACs to complete all desk reviews for hospital wage data and transmit revised Worksheet S-3 wage data and occupational mix data to DAC. Worksheet S-3 wage data must be sent to DAC in electronic format (HCRIS hdt format. Occupational mix data must be sent to DAC on the Excel spreadsheet provided by DAC for specific use by MACs.</td>
</tr>
</tbody>
</table>
January 31, 2019

Release of revised FY 2020 wage index and occupational mix files as PUFs on the CMS Web site. These data will have been desk reviewed and verified by the MACs before being published. Also, a file including each urban and rural area’s average hourly wages for the FYs 2019 (final) and 2020 (preliminary) wage indexes will be provided on the CMS Web site.

February 15, 2019

Deadline for hospitals to submit requests (including supporting documentation) for: 1) corrections to errors in the January PUFs due to CMS or MAC mishandling of the wage index data, or 2) revisions of desk review adjustments to their wage index data as included in the January PUFs (and to provide documentation to support the request). MACs must receive the requests and supporting documentation by this date. No new requests for wage index and occupational mix data revisions will be accepted by the MACs at this point, as it is too late in the process for MACs to handle data that is new in a timely manner.

March 22, 2019

Deadline for the following:

1. MACs to transmit final revised wage index data (in HCRIS hdt format) to DAC for inclusion in the final wage index. Worksheet S-3 wage data must be transmitted in HCRIS hdt format. Occupational mix data must be sent to DAC on the electronic Excel spreadsheet provided by DAC for specific use by MACs. All wage index data revisions must be transmitted to DAC by this date.

2. MACs must also send written notification to hospitals regarding the hospitals’ February 15, 2019 correction/revision requests by this date.

April 4, 2019

Deadline for the following:

1. Deadline for hospitals to appeal MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the MAC’s determination. It should be noted that during this review, CMS does not consider issues such as the adequacy of a hospital’s supporting documentation, as CMS believes that the MACs are generally in the best position to make evaluations regarding the appropriateness of these types of issues (which should have been resolved earlier in the process). The request must include all correspondence between the hospital and MAC that documents the hospital’s attempt to resolve the dispute earlier in the process. Data that was incorrect in the preliminary or January wage index data PUFs, but for which no correction request was received by the February 15, 2019 deadline, will not be considered for correction at this stage.
2. **NEW** - Deadline for hospitals to dispute data corrections made by CMS of which the hospital is notified after the January 31, 2019 PUF and at least 14 calendar days prior to April 4, 2019 (i.e., March 21, 2019), that do not arise from a hospital’s request for revisions.

Requests must be received by CMS by this date. A copy of the appeal with complete documentation shall be sent to the MAC.

**Note:** Hospitals shall send an electronic and a hard copy of the appeal with complete documentation supporting their request; appeals submitted via fax will NOT be accepted. Electronic copies (including all supporting documentation) shall preferably be sent in PDF files to ensure compatibility with CMS software. Spreadsheets shall be sent in Excel.

Appeals shall be sent electronically to wageindexreview@cms.hhs.gov

Hard Copies shall be sent to the CMS Central Office at:
Centers for Medicare & Medicaid Services
C/o Wage Index, CMM/HAPG/DAC
Room C4-08-06
7500 Security Boulevard
Baltimore, Maryland 21244-1850

**Note:** If the supporting documentation files being sent via email are too large to be sent through email, then send an electronic copy of the appeal letter, and most pertinent documents (spreadsheets and/or pdf files) to the email address above (and note in the email that complete supporting documentation will be sent via hard copy and USB drive); hospitals must still send a complete hard copy with supporting documentation to the address above. The hard copy and USB drive shall be submitted to CMS by the April 4, 2019 deadline.

**April/May, 2019**

Approximate date proposed rule will be published; includes proposed wage index, which is calculated based on the revised wage index data through the end of February; 60-day public comment period and 45-day withdrawal deadline for hospitals applying for geographic reclassification.

**Early April 2019**

Final FY 2020 wage index data compiled and sent by CMS to MACs for verification. This verification of the final wage and occupational mix data by the MACs is necessary to ensure that the correct data for each hospital has been properly transmitted and received. The MACs will have approximately 1 week in which to complete the verification.
Notice sent from CMS to each MAC regarding the April 27, 2018, release of the final FY 2019 wage index data PUFs and the May 30, 2018, deadline for hospitals to request corrections to the wage and occupational mix data as reflected in the final files.

Notice must be forwarded by MACs to hospitals they service to alert hospitals to the availability of the final wage index and occupational mix data files for their review in the April 30, 2018 PUF, and to inform hospitals that this will be their last opportunity to request corrections to errors in the final data. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final April PUFs. Data that was incorrect in the preliminary or January wage index data PUFs, but for which no correction request was received by the February 15, 2019 deadline, will not be considered for correction at this stage.

**April 30, 2019**

Release of final FY 2020 wage index and occupational mix data PUFs on CMS Web page. Hospitals will have approximately 1 month to verify their data and submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data.

**May 30, 2019**

Deadline for the following:

1. Deadline for hospitals to submit correction requests to both CMS and their MAC to correct errors due to CMS or MAC mishandling of the final wage and occupational mix data as posted in the April 30, 2019 PUF. Changes to data will be limited to situations involving errors by CMS or the MAC that the hospital could not have known about before review of the final April PUFs. **CMS and the MACs must receive all requests by this date via mail and email to the addresses above.**

2. **NEW** - Deadline for hospitals to dispute data corrections made by CMS of which the hospital is notified on or after 13 calendar days prior to April 4, 2019 (i.e., March 22, 2019), and at least 14 calendar days prior to May 30, 2019 (i.e., May 16, 2019), that do not arise from a hospital’s request for revisions. (Data corrections made by CMS of which a hospital is notified on or after 13 calendar days prior to May 30, 2019 (i.e., May 17, 2019) may be appealed to the Provider Reimbursement...
CMS and the MACs must receive requests with complete documentation by this date via mail and email to the addresses above.

NOTE: CMS emphasizes that data that were incorrect in the preliminary or January wage index data PUFs, but for which no correction request was received by the February 16, 2018, deadline, will not be changed at this stage for inclusion in the wage index. In general, a hospital disputing an adjustment is required to request a correction by the first applicable deadline; hospitals that do not meet the procedural deadlines set forth earlier will not be permitted to challenge later, before the PRRB, the failure of CMS to make a requested data revision. Each correction request must include all information and supporting documentation needed for CMS and the MAC to determine whether or not the hospital’s request meets the criteria for a correction to their data at this point in the wage index development. The MACs and DAC will review each request upon receipt and consult to determine whether or not the request qualifies for correction of the final wage or occupational mix data.

**August 1, 2019**

Approximate date for publication of the FY 2020 final rule; wage index includes final wage index data corrections.

**October 1, 2019**

Effective date of FY 2020 wage index.
### Part II - Wage Data

<table>
<thead>
<tr>
<th>Wkst. A Line Number</th>
<th>Wkst. A Amount Reported</th>
<th>Reclassification of Salaries (from Wkst. A-6)</th>
<th>Adjusted Salaries (column 2 ± column 3)</th>
<th>Paid Hours Related to Salaries in column 4</th>
<th>Average Hourly Wage (column 4 ÷ column 5)</th>
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</tbody>
</table>

**Total salaries (see instructions):**

**Non-physician anesthetist Part A:**

**Non-physician anesthetist Part B:**

**Physician-Part A - Administrative:**

**Physician and Non Physician-Part B:**

**Non-physician-Part B for hospital-based RHC and FQHC services:**

**Interns & residents (in an approved program):**

**Contracted interns & residents (in an approved program):**

**Home office and/or related organization personnel:**

**SNF:**

**Excluded area salaries (see instructions):**

**Contract labor: Direct Patient Care:**

**Contract labor: Top level management and other management and administrative services:**

**Contract labor: Physician-Part A - Administrative:**

**Home office and/or related organization salaries and wage-related costs:**

**Home office salaries:**

**Related organization salaries:**

**Home office: Physician Part A - Administrative:**

**Home office & Contract Physicians Part A - Teaching:**

**Wage-related costs: core:**

**Wage-related costs: other:**

**Excluded areas:**

**Non-physician anesthetist Part A:**

**Non-physician anesthetist Part B:**

**Physician Part A - Administrative:**

**Physician Part B:**

**Wage-related costs (RHC/FQHC):**

**Interns & residents (in an approved program):**

**Home office wage-related (core):**

**Related organization wage-related (core):**

**Home office: Physician Part A - Administrative - wage-related (core):**

**Home office & Contract Physicians Part A - Teaching - wage-related (core):**
### Part II - Wage Data

<table>
<thead>
<tr>
<th>Line Number</th>
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<td>Employee Benefits Department</td>
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<td>27</td>
<td>Administrative &amp; General</td>
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<td>28</td>
<td>Administrative &amp; General under contract (see instructions)</td>
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<td>29</td>
<td>Maintenance &amp; Repairs</td>
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<td>30</td>
<td>Operation of Plant</td>
<td>8</td>
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<td>31</td>
<td>Laundry &amp; Linen Service</td>
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<td>32</td>
<td>Housekeeping</td>
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<td>33</td>
<td>Housekeeping under contract (see instructions)</td>
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<td>34</td>
<td>Dietary</td>
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<tr>
<td>35</td>
<td>Dietary under contract (see instructions)</td>
<td>13</td>
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<td>36</td>
<td>Cafeteria</td>
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<td>37</td>
<td>Maintenance of Personnel</td>
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<td>38</td>
<td>Nursing Administration</td>
<td>16</td>
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<td>39</td>
<td>Central Services and Supply</td>
<td>17</td>
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<td>40</td>
<td>Pharmacy</td>
<td>18</td>
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</tbody>
</table>

### Part III - Hospital Wage Index Summary

1. Net salaries (see instructions)  
2. Excluded area salaries (see instructions)  
3. Subtotal salaries (line 1 minus line 2)  
4. Subtotal other wages and related costs (see instructions)  
5. Subtotal wage-related costs (see instructions)  
6. Total (sum of lines 3 through 5)  
7. Total overhead cost (see instructions)
<table>
<thead>
<tr>
<th>Amount Reported</th>
<th>Part IV - Wage Related Cost</th>
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<tr>
<td></td>
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<tr>
<td>1</td>
<td>401k Employer Contributions</td>
</tr>
<tr>
<td>1</td>
<td>Tax Sheltered Annuity (TSA) Employer Contribution</td>
</tr>
<tr>
<td>1</td>
<td>Nonqualified Defined Benefit Plan Cost (see instructions)</td>
</tr>
<tr>
<td>1</td>
<td>Qualified Defined Benefit Plan Cost (see instructions)</td>
</tr>
<tr>
<td>5</td>
<td>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</td>
</tr>
<tr>
<td>5</td>
<td>401k/TSA Plan Administration fees</td>
</tr>
<tr>
<td>6</td>
<td>Legal/Accounting/Management Fees-Pension Plan</td>
</tr>
<tr>
<td>6</td>
<td>Employee Managed Care Program Administration Fees</td>
</tr>
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<td>8</td>
<td>HEALTH AND INSURANCE COST</td>
</tr>
<tr>
<td>8</td>
<td>Health Insurance (Purchased or Self Funded)</td>
</tr>
<tr>
<td>8.01</td>
<td>Health Insurance (Self Funded without a Third Party Administrator)</td>
</tr>
<tr>
<td>8.02</td>
<td>Health Insurance (Self Funded with a Third Party Administrator)</td>
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<tr>
<td>8.03</td>
<td>Health Insurance (Purchased)</td>
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<tr>
<td>9</td>
<td>Prescription Drug Plan</td>
</tr>
<tr>
<td>10</td>
<td>Dental, Hearing and Vision Plan</td>
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<tr>
<td>11</td>
<td>Life Insurance (If employee is owner or beneficiary)</td>
</tr>
<tr>
<td>12</td>
<td>Accident Insurance (If employee is owner or beneficiary)</td>
</tr>
<tr>
<td>13</td>
<td>Disability Insurance (If employee is owner or beneficiary)</td>
</tr>
<tr>
<td>14</td>
<td>Long-Term Care Insurance (If employee is owner or beneficiary)</td>
</tr>
<tr>
<td>15</td>
<td>Workers' Compensation Insurance</td>
</tr>
<tr>
<td>16</td>
<td>Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)</td>
</tr>
<tr>
<td>17</td>
<td>TAXES</td>
</tr>
<tr>
<td>17</td>
<td>FICA-Employer Portion Only</td>
</tr>
<tr>
<td>18</td>
<td>Medicare Taxes - Employers Portion Only</td>
</tr>
<tr>
<td>19</td>
<td>Unemployment Insurance</td>
</tr>
<tr>
<td>20</td>
<td>State or Federal Unemployment Taxes</td>
</tr>
<tr>
<td>21</td>
<td>OTHER</td>
</tr>
<tr>
<td>21</td>
<td>Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above(see instructions))</td>
</tr>
<tr>
<td>22</td>
<td>Day Care Cost and Allowances</td>
</tr>
<tr>
<td>23</td>
<td>Tuition Reimbursement</td>
</tr>
<tr>
<td>24</td>
<td>Total Wage Related cost (Sum of lines 1 through 23)</td>
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<tr>
<td></td>
<td>Part B - Other than Core Related Cost</td>
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<tr>
<td>25</td>
<td>Other Wage Related Costs (specify)</td>
</tr>
<tr>
<td></td>
<td>25</td>
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</tbody>
</table>
### Part V - Contract Labor and Benefit Cost

#### Hospital and Hospital-Based Component Identification:

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<thead>
<tr>
<th>Component</th>
<th>Contract Labor</th>
<th>Benefit Cost</th>
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</thead>
<tbody>
<tr>
<td>1. Total facility contract labor and benefit cost</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2. Hospital</td>
<td>2</td>
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</tr>
<tr>
<td>3. Subprovider- IPF</td>
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</tr>
<tr>
<td>4. Subprovider- IRF</td>
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<td>4</td>
</tr>
<tr>
<td>5. Subprovider- (Other)</td>
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<td>5</td>
</tr>
<tr>
<td>6. Swing Beds-SNF</td>
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<td>6</td>
</tr>
<tr>
<td>7. Swing Beds-NF</td>
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<td>7</td>
</tr>
<tr>
<td>8. Hospital-Based SNF</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>9. Hospital-Based NF</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>10. Hospital-Based OTC</td>
<td>10</td>
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</tr>
<tr>
<td>11. Hospital-Based HHA</td>
<td>11</td>
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</tr>
<tr>
<td>12. Separately Certified ASC</td>
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</tr>
<tr>
<td>13. Hospital-Based Hospice</td>
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<tr>
<td>14. Hospital-Based Health Clinic RHC</td>
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<tr>
<td>15. Hospital-Based Health Clinic FQHC</td>
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</tr>
<tr>
<td>16. Hospital-Based-CMHC</td>
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</tr>
<tr>
<td>17. Renal Dialysis</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>18. Other</td>
<td>18</td>
<td>18</td>
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</tbody>
</table>
4005.2 Part II - Hospital Wage Index Information.--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the PPS. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II, III and IV, are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete Worksheet S-3, Parts II, III, and IV, for IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to the IPPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line. For Worksheet A-6 reclassifications, see instructions for column 3 of this worksheet.

NOTE: Lines 4 and 22 apply to physician’s Part A administrative costs.

NOTE: Capitalized labor costs (salaries, hours, and wage-related costs) including, but not limited to, capital projects associated with lines 1 and 2 of Worksheet A must not be included on Worksheet S-3, Parts II and III.

Column 2

General instructions for completing column 2:

1. For each line item (except for wage-related costs on lines 17 through 25 or as otherwise indicated), report in column 2, the direct salaries and wages, including amounts for related paid vacation, holiday, sick leave, other paid-time-off (PTO), severance pay, and bonus pay for personnel associated with the line item.
2. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in column 2, with related direct salaries and wages to be considered an allowable cost for the wage index.
3. Paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay must be reported in the same cost center as the related direct salaries and wages. For example, do NOT report the direct salaries and wages of an employee in one cost center and report the employee’s paid vacation in a different cost center.
4. To be considered an allowable salary cost (i.e., direct salaries and wages plus paid vacation, holiday, sick leave, other PTO, and severance pay), the associated hours must also be reported in column 5. (See exceptions in column 5 instructions for bonus pay and overtime pay. Also, for wage-related costs, there are no associated hours.)
5. Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

NOTE: Methodology for including and accruing direct salaries, paid vacation, paid holiday, paid sick, and other PTO in the wage index:

Salary cost--The required source for costs on Worksheet A is the general ledger (see §4013 and 42 CFR 413.24(e)). Worksheet S-3, Part II, (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the general ledger. A hospital’s current year general ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent year (current year accruals). Include on Worksheet S-3, Part II, the current year costs incurred from the general ledger; that is, both the current year costs paid and the current year accruals. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital’s current year general ledger and should not be included on the hospital's current year Worksheet S-3, Part II.)
Hours--The source for paid hours on Worksheet S-3, Part II, is the provider’s payroll report. Hours are included on the payroll report in the period the associated expense is paid. Include on Worksheet S-3, Part II, the hours from the current year payroll report, including hours associated with costs expensed in the prior year but paid in the current year. The payroll report time period must cover the weeks that best match the provider’s cost reporting period. (Hours associated with costs expensed in the current year but not paid until the subsequent year (current year accrual) are not included on the current year payroll report and should not be included on the hospital’s current year Worksheet S-3, Part II.) Although this methodology does not provide a perfect match between paid costs and paid hours for a given year, it approximates a match between costs and hours.

NOTE: The above methodology is recommended by CMS but does not preclude using a different approach that would produce a more accurate finding for purposes of the wage index. A hospital must obtain approval from its contractor to use a different methodology. For example, when the hospital is unable to match the general ledger and payroll report direct salaries and hours within the exact dates of its cost reporting period, they may request approval to accrue salaries and hours on Worksheet S-3, Part II (up to 15 days before the cost reporting period beginning date or 15 days after the cost reporting period ending date in order to include 365 or 366 days, depending on the year). Accrued costs must have associated hours and must be excluded from the subsequent Worksheet S-3, Part II.

Regardless of the methodology used, costs and hours reported must be consistent. That is, accrued costs must have associated hours reported in the same cost center and in the same cost reporting period. The hospital must ensure that supporting documentation for both salaries and hours are based on actual data maintained in a form that permits validation by the contractor. The use of estimates for these amounts is unacceptable for the wage index.

Line 1--Enter from Worksheet A, column 1, line 200, the direct salaries and wages, including the amounts for related paid vacation, holiday, sick leave, other PTO, severance pay, and bonus pay, paid to hospital employees. See Worksheet A instructions (§4013).

Lines 2 through 10--The amounts reported must be adjusted for vacation, holiday, sick, other paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 8 the salaries for employees associated with excluded areas lines 9 and 10.

Line 2--Enter the salaries for directly-employed Part A non-physician anesthetist (for rural hospitals that have been granted CRNA pass-through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract CRNA cost must be included on line 11. Report in column 5, the hours that are associated with the costs in column 4 for directly employed and contract Part A CRNAs.

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the contractor. Do not include salary costs for physician assistants, clinical nurse specialists, nurse practitioners, and nurse midwives.

Line 4--Enter the physician Part A administrative salaries, (excluding teaching physician salaries), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 7. Subscript this line and report salaries for Part A teaching physicians on line 4.01.

Line 5--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist on-call salaries and salaries billed under Part B that are included in line 1. Under Medicare, these services are related to patient care and billed separately under Part B. Also include
physician salaries for patient care services reported for rural health clinics (RHC) and FQHCs included on Worksheet A, column 1, lines 88 and/or 89 as applicable. Do not include on this line amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.

Line 6—Report on line 6 the non-physician on-call salaries and salaries reported for hospital-based RHC and FQHC services included on Worksheet A, column 1, lines 88 and/or 89, as applicable. Do not include on this line amounts that are included on lines 9 and 10 for the SNF or excluded area salaries.

Line 7—Enter from Worksheet A the salaries reported in column 1 of line 21 for interns and residents. Subscript this line and report salaries for contracted interns and residents in an approved program on line 7.01. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 9 and 10. Additionally, contract intern and resident costs must be included on line 11. DO NOT include contract intern and residents costs on line 13. Report in column 5, the hours that are associated with the costs in column 4 for directly employed and contract interns and residents.

Line 8—If you are a member of a home office or related organization as defined in CMS Pub. 15-1, chapter 21, §2150, enter from your records, the wages and salaries for home office and/or related organization personnel that are included in line 1. Wage related costs are not included on this line.

Lines 9 and 10—Enter on line 9 the amount reported on Worksheet A, column 1 for line 44 for the SNF. On line 10, enter from Worksheet A, column 1, the sum of lines 20, 23, 40 through 42, 45, 45.01, 46, 94, 95, 98 through 101, 105 through 112, 114, 115 through 117, and 190 through 194. DO NOT include on lines 9 and 10 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for line 10.

General Instructions for Contract Labor:

Only contract labor costs reported on the provider’s trial balance and, therefore, on Worksheet A, column 2, are included on Worksheet S-3, Part II. Contract labor costs not reported in the proper cost center are disallowed from the wage index calculation. In general, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, other supporting documentation is required, such as a representative sample of invoices which specify the wage costs, hours, and non-labor costs. Attestations or declarations from the vendor or hospital are not acceptable in lieu of supporting documentation for wages, hours, wage-related costs, and non-labor costs. Hospitals must be able to provide such documentation when requested by the contractor. Report only personnel costs associated with the contract. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule. That is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3. For contractors that work a regular schedule in addition to being on-call, report the on-call wages, but not the hours associated with the time the contractors are on-call. Do not include wages or hours associated with Part B services.

Line 11—Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined below. Do not include costs applicable to excluded areas reported on line 9 and 10. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 7.01, respectively). Include on this line contract pharmacy and laboratory wage costs as defined below.
Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services. Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Contract pharmacy services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

Contract laboratory services are furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts.

If you have no contracts for direct patient care as defined above, enter a zero in column 2. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 2.

Line 12--Enter the amount paid for contracted top level management services, and other contract management and administrative services furnished under contract, rather than by employees. Include on this line contract management and administrative services associated with cost centers other than those listed on lines 26 through 43 (and their subscripts) of this worksheet that are included in the wage index.

Contracted Top Level Management: Include the amount paid for top level management services, as defined below, furnished under contract rather than by employees. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract top level management services DO NOT include the following: physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the top level management contracts listed above. Per instructions on Worksheet S-2, Part II, for top level management contracts, submit to your Medicare contractor the aggregate wages and hours.

Other Contract Management and Administrative Services: Examples of other contract management and administrative services that would be reported on line 12 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the contract. DO NOT include on line 12 any contract labor costs associated with lines 26 through 43 and subscripts for these lines.

Line 13--Enter from your records the amount paid under contract (in accordance with the general instructions for contract labor) for Part A physician services - administrative, excluding teaching physician services. DO NOT include contract I & R services (to be included on line 7). DO NOT include the costs for Part A physician services from the home office allocation and/or
from related organizations (to be reported on line 15). Do not include wages or hours associated with Part B services.

**Line 14**—For cost reporting periods beginning before October 1, 2015, enter the salaries and wage-related costs (as defined on lines 17 and 18) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 8 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office/related organization salary to the hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital, then enter a zero in column 2. All costs for any related organization (as defined in CMS Pub. 15-1, chapter 10; 42 CFR 413.17; and CMS Pub. 15-1, chapter 21, §2150ff through §2153ff), must be shown as the cost to the related organization. For cost reporting periods beginning on or after October 1, 2015, do not use this line but use lines 14.01 and/or 14.02.

**Line 14.01**—For cost reporting periods beginning on or after October 1, 2015, enter the salaries paid to personnel affiliated with a home office, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1, but are included in Worksheet A, column 2, column 4 (if reported on Worksheet A-6), and/or column 6 (if reported on Worksheet A-8-1). In addition, add the home office salaries included on line 8. The amounts reported on this line must be based on recognized methods of allocating an individual's home office salary to the hospital. If no home office exists or if you cannot accurately determine the hours associated with the home office salaries that are allocated to the hospital, then enter a zero in column 2. All costs for any home office (as defined in 42 CFR 413.17; and CMS Pub. 15-1, chapter 21, §2150ff through §2153ff), must be shown as the cost to the home office. Report only home office salary costs on this line; report home office wage-related costs on line 25.50.

**Line 14.02**—For cost reporting periods beginning on or after October 1, 2015, enter the salaries paid to personnel affiliated with a related organization (other than home office), who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1, but are included in Worksheet A, column 2, column 4 (if reported on Worksheet A-6), and/or column 6 (if reported on Worksheet A-8-1). In addition, add the related organization salaries included on line 8. The amounts reported on this line must be based on recognized methods of allocating an individual's related organization salary to the hospital. If no related organization exists or if you cannot accurately determine the hours associated with the related organization salaries that are allocated to the hospital, then enter a zero in column 2. All costs for any related organization (as defined in CMS Pub. 15-1, chapter 10; and 42 CFR 413.17), must be shown as the cost to the related organization. Report only related organization salary costs on this line; report related organization wage-related costs on line 25.51.

**NOTE:** Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 15. Do not report any wages, wage-related costs, or hours associated with excluded areas (lines 9 and 10). Report the cost of home office services, whether employee or contract labor, in the most closely matched cost centers on Worksheet A (lines 4 through 17), column 2, and on the corresponding lines of Worksheet S-3, Part II (lines 26 through 43). Report allowable contract labor costs, if applicable, in accordance with instructions on lines 28, 33, or 35. If a wage related cost associated with the home office is not “core” (as described in the Worksheet S-3, Part IV) and is not a category included in “other” wage related costs on line 18 (see Worksheet S-3, Part IV, and line 18 instructions below), the cost cannot be services related to teaching and supervision of interns and residents, included on line 14, or subscripts. For example, if a hospital’s employee parking cost does not meet the
criteria for inclusion as a wage-related cost on line 18, any parking cost associated with
home office staff cannot be included on line 14, or subscripts.

Line 15--For cost reporting periods beginning before October 1, 2015, enter from your records the
salaries and wage-related costs for Part A physician services - administrative, excluding teaching
physician Part A services, from the home office allocation and/or related organizations. For cost
reporting periods beginning on and after October 1, 2015, report only the salary costs on this line
and report the wage-related costs (as defined on lines 17 and 18) on line 25.52.

Line 16--For cost reporting periods beginning before October 1, 2015, enter from your records the
salaries and wage -related costs for teaching physician Part A services from the home office
allocation and/or related organizations. Also report on this line Part A teaching physicians’ salaries
under contract. For cost reporting periods beginning on and after October 1, 2015, report only the
salary costs on this line and report the wage -related costs (as defined on lines 17 and 18) on
line 25.53.

Lines 17 through 25 and 25.50 through 25.53--In general, the amount reported for wage-related
costs must meet the “reasonable cost” provisions of Medicare. For pension and executive deferred
compensation costs see the instructions below in Part IV. NOTE: Wage -related costs on
lines 25.50 through 25.53 are not tied to wage-related costs reported on Worksheet S-3, Part IV.

For those wage-related costs that are not covered by Medicare reasonable cost principles, a hospital
shall use generally accepted accounting principles (GAAP). For example, for purposes of the wage
index, disability insurance cost should be developed using GAAP. Hospitals are required to
complete Worksheet S-3, Part IV, a reconciliation worksheet to aid hospitals and contractors in
implementing GAAP when developing wage-related costs. Upon request by the contractor or
CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation,
showing that the reporting practice is widely accepted in the hospital industry and/or related field
as support for the methodology used to develop the wage-related costs. If a hospital does not
complete Worksheet S-3, Part IV, or, if the hospital is unable, when requested, to provide a copy
of the standard used in developing the wage-related costs, the contractor may remove the cost from
the hospital’s Worksheet S-3 due to insufficient documentation to substantiate the wage-related
cost relevant to GAAP.

NOTE: All costs for any related organization must be shown as the cost to the related
organization. (For Medicare cost reporting principles, see CMS Pub. 15-1, chapter 10,
§1000. For GAAP, see FASB 57.) If a hospital’s consolidation methodology is not in
accordance with GAAP or if there are any amounts in the methodology that cannot be
verified by the contractor, the contractor may apply the hospital’s cost-to-charge ratio to
reduce the related party expenses to cost.

NOTE: All wage -related costs, including FICA, workers compensation, and unemployment
compensation taxes, associated with physician services are to be allocated according to
the services provided; that is, those taxes and other wage-related costs attributable to
Part A administrative services must be placed on line 22, to Part A teaching services
must be placed on line 22.01, and to Part B (patient care services) must be placed on
line 23. Line 17 must not include wage-related costs that are associated with physician
services.

Line 17--Enter the core wage-related costs from Worksheet S-3, Part IV, line 24. (See note below
for costs that are not to be included on line 17). Only the wage-related costs reported on
Worksheet S-3, Part IV, line 24, are reported on this line. (Wage-related costs are reported in
column 2, not column 1, of Worksheet A.)

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9
and 10. Instead, these costs are reported on line 19. Also, do not include the wage-
related costs for physicians Parts A and B, non-physician anesthetists Parts A and B,
Health Insurance and Health-Related Wage Related Costs:

The following are the allowable health insurance and health-related costs for the wage index.

1) Purchased Health Insurance:
   - Premium costs.
   - Costs paid to external organizations for plan administration.

2) Self (or Self-Funded) Health Insurance:
   - Costs paid to external organizations for plan administration.
   - Without a Third-Party Administrator (TPA).
     - Costs the hospital incurs in providing services under the plan to its employees. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.) Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.
   - Hospital’s payment to unrelated health care providers for services rendered, under the plan, to hospital’s employees.
   - With a TPA.
     - Amount the TPA pays to the hospital or other health care providers for services rendered under the plan. (For domestic claims, the hospital must provide documentation from its TPA to demonstrate that payments for services rendered to employees are based on a discount from full charges. Also, the payments must be reasonable; that is, the costs included for domestic claims must not exceed the amount that commercial insurers pay the hospital for the same services rendered to non-employees.) Employee withholdings and contributions are employee costs, not hospital costs. Hospitals are not permitted to treat as hospital wage-related costs the amounts that their employees incur for their health insurance benefits.

NOTE: Hospitals and contractors are not required to remove from domestic claims costs, the personnel costs that are associated with hospital staff who deliver the services to employees.

3) Health-Related Services: Inpatient and outpatient health services that are not covered under the hospital’s health insurance plan, but are provided to employees at no cost or at a discount, for example, employee physicals, flu shots, smoking cessation, and weight control programs, are to be included as a core wage-related cost. (Domestic claim charges must be reduced to cost. Costs must also exclude any copayments and deductibles paid by employees.)

NOTE: Hospitals and contractors are not required to remove from domestic claims costs, the personnel costs that are associated with hospital staff who deliver the services to employees.

Line 18--Enter the total of “other” wage-related costs. Line 18, column 4, must equal the sum of Worksheet S-3, Part IV, line 25, and its subscripts. Complete instructions for Worksheet S-3, Part IV, line 25, are below in §4005.4.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 9 and 10. Instead, these costs are reported on line 19. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.
Line 19--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 9 and 10.

Lines 20 through 25, and 25.50 through 25.53--Enter from your records the core wage-related costs for each category of employee listed. Do not include the other wage-related costs reported on Worksheet S-3, Part II, line 18, and Worksheet S-3, Part IV, line 25. Do not include wage-related costs for excluded areas reported on line 19. Subscript line 22, and report the wage-related costs for Part A teaching physicians reported on line 4.01, on line 22.01. On line 23, do not include wage-related costs related to non-physician salaries reported for hospital-based RHCs and FQHCs services included on Worksheet A, column 1, lines 88 and/or 89, as applicable. These wage-related costs are reported separately on line 24.

Line 25.50--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) paid to personnel who are affiliated with a home office whose salaries are reported on line 14.01.

Line 25.51--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) paid to personnel who are affiliated with a related organization (other than home office) whose salaries are reported on line 14.02.

Line 25.52--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) for Part A physician services - administrative, excluding teaching physicians Part A services, from the home office allocation and/or related organizations, whose salaries are reported on line 15.

Line 25.53--For cost reporting periods beginning on or after October 1, 2015, enter the core wage-related costs (as defined on line 17) for teaching physicians Part A services from the home office allocation and/or related organizations, whose salaries are reported on line 16.

NOTE: Other wage related costs associated with the home office are reported on Worksheet S-3, Part II, line 18, and on Worksheet S-3, Part IV, line 25, and its subscripts. For lines 25.50 through 25.53 of Worksheet S-3, Part II, if a wage-related cost associated with the home office is not “core” (as described in the Worksheet S-3, Part IV), the cost must not be included on line 14 and its subscripts, or on line 25 and its subscripts.

Lines 26 through 43--These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. Enter the direct salary and wages with related salary amounts for paid vacation, holiday, sick, other PTO, severance, and bonus pay from Worksheet A, column 1, for lines 26, 27, 29 through 32, 34, and 36 through 43. Enter the contract labor costs from Worksheet A, column 2, for lines 28, 33, and 35.

Line 26--Salaries and hours reported on this line correlate to the salaries reported on line 4, column 1 of Worksheet A, for the personnel working in the Employee Benefit Department, or the Human Resources Department. Do not report costs or hours associated with other hospital employees on this line.
Lines 28, 33, and 35--Enter the amount paid for services performed under contract (in accordance with the general contract labor instructions above), rather than by employees, for A&G, housekeeping, and dietary services, respectively. Continue to report on the standard lines (line 27, 32, and 34), the amounts paid for services rendered by employees not under contract. Only contract labor costs reported on Worksheet A, column 2, column 4 (if reported on Worksheet A-6), and/or column 6 (if reported on Worksheet A-8-1), are included on these lines. Contract labor costs not reported in the proper cost center on Worksheet A, are excluded from the wage index.

Line 28--Administrative and General (A&G) costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 28, the contract services that are included on Worksheet A, line 5, and subscripts, columns 2, 4 and/or 6 (“Administrative and General”). Contract information and data processing services, legal, tax preparation, cost report preparation, and purchasing services are examples of contract labor costs that would be included on this line and must not be reported on lines 11 or 12. Do not include on line 28 the costs for top level management contracts (these costs are reported on line 12). Do not include on this line contract labor which is more closely matched to another overhead cost center, such as, but not limited to, contract housekeeping or dietary services, which must be reported on line 33 or line 35.

Lines 32 through 35--All hospitals must incur costs for housekeeping and dietary services, either direct, under contract, or both. It is not acceptable to report zeroes for housekeeping or dietary services. Report wages and hours for housekeeping services on either line 32 (direct) or line 33 (contract), and for dietary services, on either line 34 (direct) or line 35 (contract). See 79 FR 49965 (August 22, 2014). Hospitals are encouraged to ensure that their contracts clearly specify the salaries, wages, and hours related to all of their contract labor. If, in rare instances, hours for these services cannot be determined exactly from the contract, determine the hours based on a reasonable estimation. Examples of reasonable estimates are regional average hourly rates, including an average of the wages and hours for dietary and housekeeping services of other hospitals in the same CBSA. Hospitals also may conduct time studies to determine hours worked. If regional averages or time studies cannot be used, data from the Bureau of Labor Statistics may be used to obtain average wages and hours for housekeeping and dietary services.

Column 3--Enter on each line, as appropriate, the salary and wages portion (as defined in column 2 instructions) of any reclassifications made on Worksheet A-6.

Column 4--Enter on each line the result of column 2 plus or minus column 3.

Column 5--Enter on each line the number of paid hours corresponding to the amounts reported in column 4. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 15 (including subscripts), lines 26 through 43 (including subscripts), and Part III, line 7, if the hours cannot be determined, then the associated salaries must not be included in columns 2 through 4.

NOTE: The hours reported in column 5 must reflect any changes to salaries reported in column 3. Report the on-call wages for employees and contractors that work a regular schedule in addition to being on-call (not present at the hospital but off-site and ready to be called in if needed); however, do not report the on-call hours. Report both the wages and hours for on-call employees and contractors when they are called in to work. Overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 7 must be based on 2080 hours per year for each full time intern and resident employee. The hours reported for salaried employees who are
paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week.

NOTE: Workers who are contracted solely for the purpose of providing services on-call can only be included on Worksheet S-3 when they actually work the on-call schedule; that is, they are actually delivering patient care at the hospital, or are at the hospital so as to be available to deliver patient care. If either of these latter two scenarios occur, then both the wages and associated hours actually worked must be included in the appropriate contract labor line on Worksheet S-3. Do not include wages or hours associated with Part B services.

Column 6--Enter on all lines (except lines 17 through 25) the average hourly wage resulting from dividing column 4 by column 5.

4005.3 Part III - Hospital Wage Index Summary.--This worksheet provides for the calculation of a hospital’s average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

Columns 1 through 6--Follow the same instructions discussed in Part II, except for column 6, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 6, 7, 7.01, and 8. Add to this amount lines: 28, 33, and 35.

Line 2--From Part II, enter the sum of lines 9 and 10.

Line 3--Enter the result of line 1 minus line 2.

Line 4--From Part II, enter the sum of lines 11, 12, 13, 14, 14.01, 14.02, and 15. (Line 16 is omitted from Part III, line 4, because physicians’ teaching services are excluded from the wage index.)

Line 5--From Part II, enter the sum of lines 17, 18, 22, 25.50, 25.51, and 25.52. Enter on this line in column 6 the wage-related cost percentage computed by dividing Part III, column 4, line 5, by Part III, column 4, line 3. Round the result to 2 decimal places.

Line 6--Enter the sum of lines 3 through 5.

Line 7--Enter from Part II above, the sum of lines 26 through 43. If the hospital’s ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 26 through 43 for calculating the percentage.)

4005.4 Part IV - Wage Related Costs.--The hospital must provide the contractor with a complete list of all core wage related costs included in Part II (§4005.2), lines 17 and 19 through 25. This worksheet provides for the identification of such costs.

For lines 1 through 23, for wage related costs not covered by Medicare reasonable cost principles (excluding the reporting of certain defined benefit pension costs; see instructions below), a hospital shall use GAAP in reporting wage related costs. In addition, some costs such as payroll taxes, which are reported as a wage related cost(s) on Worksheet S-3, Part IV, are not considered fringe benefits for Medicare cost finding.

See instructions for line 25 on including “other” wage related costs in the wage index that are not a core wage related cost reported on lines 1 through 23.
Enter on each line as applicable the corresponding amount from your accounting books and/or records.

**Line 3**—Report pension cost for defined benefit pension plans that do not meet the applicable requirements for a qualified pension plan under section 401(a) of the Internal Revenue Code.

The policy adopted in the federal fiscal year (FFY) 2012 IPPS final rule (CMS-1518-F; 76 FR 51586-51590, August 18, 2011) does not change the reporting basis for these costs.

**NOTE:** These plans generally are not funded by a funding vehicle that is for exclusive benefit of employees or their beneficiaries and do not qualify for special tax benefits, such as tax deferral of employer contributions. For such unfunded defined benefit plans, the costs of these plans are reported on a cash basis which recognizes benefit payments made during the current period. Typically these plans supplement the basic qualified defined benefit plan or provide benefits to a select class of employees, such as executives.

**Line 4**—Commencing with cost reporting periods used for the FFY 2013 wage index, report pension cost for defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code for the wage index. The allowable pension costs to be reported for these defined benefit pension plans shall be determined in accordance with the policy adopted in the FFY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586-51590, August 18, 2011), modified in the FY 2016 IPPS final rule (CMS 1632-F; 80 FR 49505-49508, August 17, 2015) and as discussed below. Enter the pension costs from your records or from the Wage Index Pension Cost Schedule available for download from the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html. (See CMS Pub. 15-1, chapter 21, §2142.)

**Policy**

**Defined Benefit Pension Plan:** A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by employees. This section applies only to defined benefit pension plans which meet the applicable requirements for a qualified pension plan under §401(a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions.

**Pension Contributions:** Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider. Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under §401(a) of the Internal Revenue Code. For purposes of the wage index, provider pension payments shall be measured on a cash-basis without regard to CMS Pub. 15-1, chapter 23, §2305. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, and real property. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider’s account is debited. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan records do not show a separate accounting of the actuarially determined cost estimates, contribution deposits, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the funding attributable to each employer.
Source of Documentation for Pension Contributions: Providers are required to obtain contribution data from the pension trustee, insurance carrier, Schedule B or SB of IRS Form 5500, and if applicable, from accounting records showing the allocation of total plan contributions to each participating provider. These records must be maintained as needed for subsequent periods.

Reasonable Compensation: In order for pension costs to be allowable, the benefits payable under the plan (attributable to employer contributions) together with all other compensation paid to the employee must be reasonable in amount.

Defined Benefit Pension Plan Costs for the Wage Index: The annual pension to be included in the wage index shall be the average annual employer contributions made by or on behalf of the provider (on a cash basis) to all defined benefit plans covered under this section during the averaging period. Contribution payments must satisfy the allowability requirements outlined above; see “Pension Contributions” and “Reasonable Compensation” above. A reversion of plan assets shall be treated as a negative contribution payment and a negative pension cost resulting from a reversion of plan assets shall offset a provider’s other wage related costs.

In the FY 2016 IPPS final rule and effective with the FY 2017 wage index, the averaging period used to compute the average defined benefit pension cost for the wage index was modified. Prior to this modification, the averaging period was generally the 36 consecutive calendar month period centered on the midpoint of the cost reporting period used for the wage index (the cost reporting period used for the wage index shall hereafter be referred to as the wage index cost reporting period). Beginning with the FY 2017 wage index, generally, the averaging period is based on the base cost reporting period, plus the prior two cost reporting years (36 months).

A provider who adopts a new defined benefit pension plan and has no other defined benefit plan in existence during the averaging period may elect to exclude from the averaging period all cost reporting periods ending prior to the date the new plan was adopted. No defined benefit pension cost is reportable for a wage index cost reporting period that is excluded from the averaging period in accordance with this paragraph. An election to claim costs for a newly adopted plan based on an averaging period of less than 36 months must be applied on a consistent basis for all wage index cost reporting periods for which the 36 month averaging period contains the plan effective date.

If the wage index cost reporting period does not represent a 12 month period, the annual pension cost otherwise determined in accordance with this section shall be prorated to reflect the number of months in the wage index cost reporting period.

For the FY 2013 through FY 2022 wage index only, a provider may include a prefunding installment as a component of pension cost regardless of whether or not the plan(s) which gave rise to the prefunding balance are still in existence. The annual prefunding installment shall equal 1/10th of the prefunding balance. A prefunding installment that is not reflected in the pension cost for a wage index cost reporting period may not be reassigned and added to the pension cost reported for wage index purposes in any subsequent period. The prefunding balance equals the excess, if any, of (i) provider contributions made (on a cash-basis) to its defined benefit pension plans during the look-back period over (ii) the pension costs included in the wage-index for the same look-back period. A provider’s share of the total contributions made under a pension plan that covers multiple providers or employers shall be determined on a basis consistent with the methodology used to determine the wage index pension costs for the cost reporting periods included in the prefunding balance. The look-back period shall consist of consecutive provider cost reporting periods commencing no earlier than October 1, 2002 and ending with the provider’s cost reporting period immediately prior to the FY 2013 wage index cost reporting period. The look-back period may not include any cost reporting period for which the provider is unable to provide documentation of the contributions made or the pension costs included in the wage index;
all prior cost reporting periods must also be excluded in order to satisfy the requirement that the look-back period consist of consecutive cost reporting periods. A provider who establishes a prefunding balance must submit documentation to the Medicare contractor to support the calculation of the prefunding balance and annual prefunding installment. A prefunding worksheet with complete instructions is available for download from the CMS website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html.

Pension Plan with Multiple Entities: If a hospital participates in a pension plan or retirement system that also covers other entities, the hospital must report its respective 3-year average pension cost (or prefunding balance) reflecting only the hospital's allocated share of total plan contributions, and not including any share of pension costs of other entities. For each hospital, this is accomplished by first determining the hospital's allocated portion of pension contribution for each year of the 3-year average, and then computing the 3-year average for that hospital based only on that hospital's respective allocated pension contributions. This is consistent with the regulations at 42 CFR 413.24(a), which state, in pertinent part, that providers must provide adequate cost data based on their financial and statistical records. Therefore, a provider may not claim as an allowable cost the costs of services associated with another entity. It is not appropriate to compute the 3-year average (or prefunding balance) based on the total contributions made to the plan by all participating entities and then determine a hospital's allocated portion of the 3-year average cost (or prefunding balance) because there are instances in which the 3-year average could be skewed because a hospital may be including pension costs from another entity in its 3-year average. Specifically, if the allocated percentage of total plan contributions for one or more of the participating entities changes during the 3-year average, the average will be skewed. The allocated percentage to each entity can change due to mergers, changes in plan coverage, or other factors. We also note that the allocation of contributions between the various entities participating in a pension plan or pension system should agree with the methodology used for plan reporting purposes and/or financial statement purposes, and the methodology used should be applied consistently over time. Furthermore, if wage index reporting is required for two or more hospitals covered under the same pension plan or retirement system, those hospitals must ensure that the allocation of plan contributions for each reporting period is determined on a consistent basis to avoid duplicate reporting of costs.

Examples

Example 1 (prefunding balance and prefunding installment):

- Provider’s FY 2017 wage index cost reporting period is 01/01/2013-12/31/2013. The look-back period ends with the cost reporting period immediately prior to the cost reporting period used for the FY 2013 wage index. Since the FY 2013 wage index was based on the providers 1/1/2009-12/31/2009 cost reporting period, the look-back period ends on 12/31/2008. Assuming the provider has always reported costs on a calendar year basis, the earliest possible cost reporting period in the look-back period is the period commencing 01/01/2003 (first cost reporting period commencing on or after 10/01/2002).
• The provider is able to document its pension contributions (on a cash basis) and the pension costs included in the wage index for all cost reporting periods except for the 2004 year. Therefore, 2004 and all prior cost reporting periods must be excluded from the look-back period. The data for 2005 through 2008 is as follows:

<table>
<thead>
<tr>
<th>Cost Reporting Year</th>
<th>Cash Basis Contributions</th>
<th>Wage-Index Pension Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$400,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>2006</td>
<td>$800,000</td>
<td>$0</td>
</tr>
<tr>
<td>2007</td>
<td>$0</td>
<td>$600,000</td>
</tr>
<tr>
<td>2008</td>
<td>$650,000</td>
<td>$700,000</td>
</tr>
</tbody>
</table>

• Because the pension cost reported in the wage index for 2005 was higher than the cash contributions made during that same period, the provider may elect to drop 2005 (and all prior periods) from the look-back period.

• Although the contributions made in 2007 were also less than the pension cost reported for that same period, the provider cannot exclude 2007 without also excluding 2006 (look-back period must consist of consecutive cost reporting periods).

• Although the contributions made in 2008 were less than the pension cost reported in that same period, the provider cannot exclude 2008 since the look-back period must end with 2008 because that is the cost reporting period immediately prior to the FY 2013 wage index cost reporting period.

• The prefunding balance based on a 2006-2008 look-back period is $150,000 ($1,450,000 [$800,000+$0+$650,000] total contributions - $1,300,000 [$0 + $600,000 + $700,000] in wage index pension costs reported for the same period). The annual prefunding installment is $15,000 (1/10th of $150,000).

Example 2 (pension cost for a 12 month wage index cost reporting period):

• Provider’s FY 2017 wage index cost reporting period is 12 months (01/01/2013 - 12/31/2013); the 36 month averaging period is 01/01/2011 to 12/31/2013, which includes the wage index cost reporting year and the prior two cost reporting periods.

• Contributions made during 01/01/2011 - 12/31/2011 = $500,000.

• Contributions made during 01/01/2012 - 12/31/2012 = $300,000.

• Contributions made in wage index cost reporting period 01/01/2013 - 12/31/2013 = $600,000.

• Total contributions made during the 36 month averaging period = $1,400,000.

• The provider has no prefunding balance or prefunding installment.

• The pension cost for the FY 2017 wage index cost reporting period is $466,667 ($1,400,000 total contributions divided by 36 months in the averaging period multiplied by 12 months in the wage index cost reporting period).
Example 3 (pension cost for a 7 month wage index cost reporting period):

- Provider’s FY 2017 wage index cost reporting period is 7 months (01/01/2013 - 07/31/2013); the 36 month averaging period is 08/01/2010 to 07/31/2013 (begins 29 months prior to the Fiscal Year Begin Date of the wage index cost reporting period for a total of 36 months).

- Contributions made during 08/01/2010 - 12/31/2010 = $300,000.
- Contributions made during 01/01/2011 - 12/31/2011 = $500,000.
- Contributions made during 01/01/2012 - 12/31/2012 = $400,000.
- Contributions made in wage index cost reporting period 01/01/2013 - 07/31/2013 = $200,000.

- Total contributions made during the 36 month averaging period = $1,400,000.

- The provider has documented a prefunding balance of $1,000,000; the annual prefunding installment is therefore $100,000 (1/10th of prefunding balance).

- The pension cost for the FY 2017 wage index cost reporting period is $330,555 ($272,222 average pension cost [$1,400,000 total contributions divided by 36 months in the averaging period multiplied by 7 months in the wage index cost reporting period] plus $58,333 pro-rata prefunding installment [$100,000 annual prefunding installment multiplied by 7/12ths to reflect a 7 month wage index cost reporting period]).

Example 4 (pension cost for a new plan):

- Provider’s FY 2017 wage index cost reporting period is 12 months (01/01/2013 - 12/31/2013); the 36 month averaging period is 01/01/2011 to 12/31/2013, which includes the wage index cost reporting year and the prior two cost reporting periods.

- The provider adopted a new pension plan effective 07/01/2012 and had no other pension plan in effect prior to that date; therefore, there is no prefunding balance or prefunding installment.

- Contributions made during 01/01/2011 - 12/31/2011 = $0 (no plan in existence)
- Contributions made during 01/01/2012 - 12/31/2012 = $500,000.
- Contributions made in the wage index cost reporting period 01/01/2013 - 12/31/2013 = $1,200,000.

- Total contributions during the 36 month averaging period = $1,700,000.

- The provider did not report a pension cost attributable to the new plan based on a 36-month averaging period during any prior wage index cost reporting period; therefore it may elect to exclude cost reporting periods ending prior to the 07/01/2012 plan effective date from the averaging period; the 36 month averaging period is, therefore, shortened to 24 months and excludes the period 01/01/2011 to 12/31/2011. The pension cost for the FY 2017 wage index cost reporting period would then be $850,000 ($1,700,000 total contributions divided by 24 months in the averaging period multiplied by 12 months in the wage index reporting period).
Lines 8, 8.01, 8.02, and 8.03—Effective for cost reporting periods beginning prior to October 1, 2015, complete line 8 if the hospital has purchased or self-funded insurance. Effective for cost reporting periods beginning on or after October 1, 2015, complete line 8.01 if the hospital has self-funded insurance without a TPA. Complete line 8.02 if the hospital has self-funded insurance with a TPA. Complete line 8.03 if the hospital purchases health insurance. (See the instructions under Worksheet S-3, Part II, regarding health insurance as a wage-related cost for the wage index).

Line 21—Report costs of executive deferred compensation plans and awards for executives. The policy adopted in the FFY 2012 IPPS final rule; 76 FR 51586 - 51590 (August 18, 2011) does not change the reporting basis for these costs. Examples of executive deferred compensation include special stock option or bonus plans and sum certain postemployment awards that are not available to other employees.

NOTE: Costs reported on line 21 excludes costs of executive deferred compensation that are defined contribution pension plans, tax-sheltered annuity plans, nonqualified defined benefit plans and qualified defined benefit plans that are available to other employees that is reportable on lines 1 through 4, respectively.

Line 25—Enter each wage related cost that is considered an “other” wage related cost separately. Subscript this line for each “other” wage related cost in accordance with the following criteria. For line 25 and subscripts specify the type of each “other” wage related cost. The total of line 25 and its subscripts is reported on Worksheet S-3, Part II, line 18, column 4.

A hospital may report an “other” wage related cost (defined as the value of the benefit) if it meets all of the following criteria:

- The costs are not listed on lines 1 through 23 “Wage Related Costs Core” of this worksheet or included in salaries reported on Worksheet S-3, Part II, column 4, line 17.
- The “other” wage related cost is greater than one (1) percent of total salaries after the direct excluded salaries are removed. Line 25 and each subscript must independently meet this 1 percent test. See below for instructions to calculate the 1 percent test.
- The wage related cost is a fringe benefit as described by the IRS and is reported to the IRS on an employee’s or contractor’s W-2 or 1099 as taxable income.
- The wage related cost is not being furnished for the convenience of the provider or otherwise excludable from income as a fringe benefit (such as a working condition fringe).

NOTE: Direct salaries and wages, including amounts related to paid vacation, holiday, sick leave, etc., reported on line 1 of Worksheet S-3, Part II, must not be included as other wage related costs on this line, nor on line 18 of Worksheet S-3, Part II.

NOTE: Do not include wage related costs applicable to the excluded areas reported on Worksheet S-3, Part II, lines 9 and 10. Instead, these costs are reported on Worksheet S-3, Part II, line 19. Also, do not include on this line the wage related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.
Calculate the 1 percent test by dividing each individual category of the other wage related cost (that is, the numerator) by the sum of Worksheet S-3, Part III, lines 3 and 4, column 4, (that is, the denominator). The other wage related costs associated with contract labor and home office/related organization personnel are included in the numerator because these other wage related costs are allowed in the wage index (in addition to other wage related costs for direct employees), assuming the requirements for inclusion in the wage index are met. For example, if a hospital is including parking garage costs as an other wage related cost that is reported on the W-2 or 1099 form, when running the 1 percent test, include in the numerator all the parking garage other wage related cost for direct salary employees, contracted employees, and home office employees, and divide by the sum of Worksheet S-3, Part III, lines 3 and 4, column 4.

Calculate the 1 percent test only one time for a category of other wage related costs, inclusive of other wage related costs for employees, contracted employees, and home office employees.
4005.5 Part V - Contract Labor and Benefit Costs.--This section identifies the contract labor costs and benefit costs for the entire hospital and hospital healthcare complex including all applicable subproviders and units. This section must be completed by all hospitals (e.g., IPPS hospitals, CAHs, IPFs, IRFs, cancer hospitals, children’s hospitals, LTCHs, and RNHCIs).

Definitions:

Contract Labor Costs--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, as defined in the instructions for Worksheet S-3, Part II, line 11. The amount of contract labor reported on S-3, Part II, line 11, should agree with the amount reported on S-3, Part V, line 2. This is only for the hospital (not including excluded areas). The remainder of Worksheet S-3, Part V, should reflect contract labor as defined on Worksheet S-3, Part II, line 11 (direct patient care for all of the excluded areas), with the aggregate total reported on line 1.

Benefit Costs--Enter the amount of employee benefit costs, also referred to as wage-related costs. Worksheet S-3, Part IV, provides a list of core wage-related costs. The core wage-related costs reported on S-3, Part IV, line 24, which is spread on Worksheet S-3, Part II, lines 17, and 19 through 25, must be reported by component on Worksheet S-3, Part V. The amount reported on Worksheet S-3, Part V, line 1, must agree to the allowable amount reported on Worksheet S-3, Part IV, line 24. Worksheet S-3, Part V, line 2, must agree to the amount reported on Worksheet S-3, Part II, line 17. Each excluded area must contain their share of wage related costs so that lines 19 through 25 on Worksheet S-3, Part II, will agree to Worksheet S-3, Part V, lines 3 through 18.

Identify the contract labor costs and benefit costs for each component on the applicable line.
TO: All Part A and Part B Medicare Administrative Contractors (A/B MACs), and Section 1886(d) Providers (i.e., Providers Paid under Medicare’s Hospital Inpatient Prospective Payment System (IPPS))

SUBJECT: Guidance for Determining Defined Benefit Pension Plan Costs for the Federal Fiscal Year (FY) 2019 Wage Index

This following provides guidance for developing pension cost for the wage index. We have also provided a spreadsheet (that is consistent with these instructions/guidance) to assist hospitals and MACs in developing pension costs for the FY 2019 wage index. Commencing with cost reporting periods used for the FY 2018 wage index, the cost to be included in the wage index for defined benefit pension plans shall be determined in accordance with the policy adopted in the FY 2012 IPPS final rule (CMS-1518-F; 76 FR 51586 – 51590, August 18, 2011), the FY 2016 IPPS final rule (CMS-1632-F; 80 FR 49505 – 49508, August 17, 2015) and as discussed below. The FY 2019 wage index will be computed using wage data from cost reporting periods beginning during FY 2015 (that is, cost reporting periods beginning on or after October 1, 2014 and before October 1, 2015).

Policy

**Defined Benefit Pension Plan:** A defined benefit pension plan is a type of deferred compensation plan, which is established and maintained by the employer primarily to provide systematically for the payment of definitely determinable benefits to its employees usually over a period of years, or for life, after retirement. Pension plan benefits are generally measured by, and based on, such factors as age of employees, years of service, and compensation received by employees. This section applies only to defined benefit pension plans which meet the applicable requirements for a qualified pension plan under Section 401(a) of the Internal Revenue Code. A qualified pension plan is for the exclusive benefit of employees or their beneficiaries and qualifies for special tax benefits, such as tax deferral of employer contributions.

**Pension Contributions:** Pension costs for a defined benefit pension plan are allowable only to the extent that costs are actually incurred by the provider. Such costs are found to have been incurred only if paid directly to participants or beneficiaries under the terms of the plan or paid to a pension fund which meets the applicable tax qualification requirements under Section 401(a) of the Internal Revenue Code. For purposes of the wage index, provider pension payments shall be measured on a cash-basis without regard to §2305 of PRM, Part I. Payment must be made by check or other negotiable instrument, cash, or legal transfer of assets such as stocks, bonds, real property, etc. A contribution payment shall be deemed to occur on the date it is credited to the fund established for the pension plan, or for provider payments made directly to a plan participant or beneficiary, on the date the provider’s account is debited. Contributions made under a pension plan that covers multiple providers or employers shall be allocated on a basis consistent with plan records. If the plan records do not show a separate accounting of the actuarially determined cost estimates, contribution deposits, and/or assets attributable to each participating provider or employer, the allocation basis must represent a reasonable approximation of the funding attributable to each employer.
Source of Documentation for Pension Contributions: Providers are required to obtain contribution data from the pension trustee, insurance carrier, Schedule B or SB of IRS Form 5500, and if applicable, from accounting records showing the allocation of total plan contributions to each participating provider. These records should be maintained as needed for subsequent periods.

Reasonable Compensation: In order for pension costs to be allowable, the benefits payable under the plan (attributable to employer contributions), together with all other compensation paid to the employee, must be reasonable in amount.

Defined Benefit Pension Plan Costs for the Wage Index: The annual pension cost to be included in the wage index shall be the average annual employer contributions made by or on behalf of the provider (on a cash basis) to all defined benefit plans covered under this section during the averaging period. Contribution payments must satisfy the allowability requirements outlined above; see “Pension Contributions” and “Reasonable Compensation” above. A reversion of plan assets shall be treated as a negative contribution payment and a negative pension cost resulting from a reversion of plan assets shall offset a provider’s other wage related costs.

In the FY 2016 IPPS final rule, we changed the averaging period used to compute the average defined benefit pension cost for the wage index. Prior to this change, the averaging period was generally the 36 consecutive calendar month period centered on the midpoint of the cost reporting period used for the wage index (the cost reporting period used for the wage index shall hereafter refered to as the wage index cost reporting period). Beginning with the FY 2017 wage index, the averaging period is the 36 months ending on the last day of the wage index cost reporting period.

A provider who adopts a new defined benefit pension plan and has no other defined benefit plan in existence during the averaging period may elect to exclude from the averaging period all cost reporting periods ending prior to the date the new plan was adopted. No defined benefit pension cost is reportable for a wage index cost reporting period that is excluded from the averaging period in accordance with this paragraph. An election to claim costs for a newly adopted plan based on an averaging period of less than 36 months must be applied on a consistent basis for all wage index cost reporting periods for which the 36 month averaging period contains the plan effective date.

If the wage index cost reporting period does not represent a 12 month period, the annual pension cost otherwise determined in accordance with this section shall be prorated to reflect the number of months in the wage index cost reporting period.

NOTE: For the FY 2013 through FY 2022 wage index only, a provider may include a prefunding installment as a component of pension cost regardless of whether or not the plan(s) which gave rise to the prefunding balance are still in existence. The annual prefunding installment shall equal 1/10th of the prefunding balance. A prefunding installment that is not reflected in the pension cost for a wage index cost reporting period may not be reassigned and added to the pension cost reported for wage index purposes in any subsequent period. The prefunding balance equals the excess, if any, of (i) provider contributions made (on a cash-basis) to its defined benefit pension plans during the look-back period over (ii) the pension costs included in the wage-index for the same look-back period. A provider’s share of the total contributions made under a pension plan that covers multiple providers or employers shall be determined on a basis consistent with the methodology used to determine the wage index pension costs for the cost reporting periods included in the prefunding balance. The look-back period shall consist of consecutive provider cost reporting periods commencing no earlier than October 1, 2002 and ending with the provider’s cost reporting period immediately prior to the FY 2013 wage index cost reporting period. The look-back period may not include any cost reporting period for which the provider is unable to provide documentation of the contributions made or the pension costs included in the
wage index; all prior cost reporting periods must also be excluded in order to satisfy the requirement that the look-back period consist of consecutive cost reporting periods. A provider who establishes a prefunding balance must submit documentation to the Medicare Contractor to support the calculation of the prefunding balance and annual prefunding installment.

**Pension Plan with Multiple Entities:** As discussed in the FY 2016 IPPS final rule, if a hospital participates in a pension plan or retirement system that also covers other entities, the hospital must report its respective 3-year average pension cost (or prefunding balance) reflecting only the hospital’s allocated share of total plan contributions, and not including any share of pension costs of other entities. For each hospital, this is accomplished by first determining the hospital’s allocated portion of pension contribution for each year of the 3-year average, and then computing the 3-year average for that hospital based only on that hospital’s respective allocated pension contributions. This is consistent with the regulations at 42 CFR 413.24(a), which state, in pertinent part, that providers must provide adequate cost data based on their financial and statistical records. Therefore, a provider may not claim as an allowable cost the costs of services associated with another entity. We also note that the allocation of contributions between the various entities participating in a pension plan or pension system should agree with the methodology used for plan reporting purposes and/or financial statement purposes, and the methodology used should be applied consistently over time. Furthermore, if wage index reporting is required for two or more hospitals covered under the same pension plan or retirement system, those hospitals should ensure that the allocation of plan contributions for each reporting period is determined on a consistent basis to avoid duplicate reporting of costs.

**Examples**

**Example 1 (prefunding balance and prefunding installment):**

- Provider’s FY 2019 wage index cost reporting period is 01/01/2015-12/31/2015. The look-back period is subject up until cost reports used for the FY 2013 wage index. Therefore the look back period ends with the cost reporting period ending 12/31/2008 (immediately prior to the FY 2013 wage index cost reporting period.) Assuming the provider has always reported costs on a calendar year basis, the earliest possible cost reporting period in the look-back period is the period commencing 01/01/2003 (first cost reporting period commencing on or after 10/01/2002).

- The provider is able to document its pension contributions (on a cash basis) and the pension costs included in the wage index for all cost reporting periods except for the 2004 year. Therefore, 2004 and all prior cost reporting periods must be excluded from the look-back period. The data for 2005 through 2008 is as follows:

<table>
<thead>
<tr>
<th>Cost Reporting Year</th>
<th>Cash Basis Contributions</th>
<th>Wage-Index Pension Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>$400,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>2006</td>
<td>$800,000</td>
<td>0</td>
</tr>
<tr>
<td>2007</td>
<td>0</td>
<td>$600,000</td>
</tr>
<tr>
<td>2008</td>
<td>$650,000</td>
<td>$700,000</td>
</tr>
</tbody>
</table>
• Because the pension cost reported in the wage index for 2005 was higher than the cash contributions made during that same period, the provider may elect to drop 2005 (and all prior periods) from the look-back period.

• Although the contributions made in 2007 were also less than the pension cost reported for that same period, the provider cannot exclude 2007 without also excluding 2006 (look-back period must consist of consecutive cost reporting periods).

• Although the contributions made in 2008 were less than the pension cost reported in that same period, the provider cannot exclude 2008 since the look-back period must end with 2008 because that is the cost reporting period immediately prior to the FY 2013 wage index cost reporting period.

• The prefunding balance based on a 2006-2008 look-back period is $150,000 ($1,450,000 [$800,000+$0+$650,000] total contributions - $1,300,000 [$0 + $600,000 + $700,000] in wage index pension costs reported for the same period). The annual prefunding installment is $15,000 (1/10th of $150,000).

Example 2 (pension cost for a 12 month wage index cost reporting period):

• Provider’s FY 2019 wage index cost reporting period is 12 months (01/01/2015 – 12/31/2015); the 36 month averaging period is 01/01/2013 to 12/31/2015, which includes the wage index cost reporting year and the prior two cost reporting periods.

• Contributions made in wage index cost reporting period 01/01/2013 – 12/31/2013 = $500,000.

• Contributions made during 01/01/2014 – 12/31/2014 = $300,000.

• Contributions made during 01/01/2015 – 12/31/2015 = $600,000.

• Total contributions made during the 36 month averaging period = $1,400,000.

• The provider has no prefunding balance or prefunding installment.

• The pension cost for the FY 2019 wage index cost reporting period is $466,667 ($1,400,000 total contributions divided by 36 months in the averaging period multiplied by 12 months in the wage index cost reporting period).

Example 3 (pension cost for a 7 month wage index cost reporting period):

• Provider’s FY 2019 wage index cost reporting period is 7 months (01/01/2015 – 07/31/2015); the 36 month averaging period is 8/01/2012 to 7/31/2015 (begins 29 months prior to Fiscal Year Begin Date of the wage index cost reporting period for a total of 36 months).
• Contributions made in wage index cost reporting period 08/01/2012 – 12/31/2012 = $300,000.

• Contributions made during 01/01/2013 – 12/31/2013 = $500,000.

• Contributions made during 01/01/2014 – 12/31/2014 = $400,000.

• Contributions made during 01/01/2015 – 07/31/2015 = $200,000.

• Total contributions made during the 36 month averaging period = $1,400,000.

• The provider has documented a prefunding balance of $1,000,000; the annual prefunding installment is therefore $100,000 (1/10th of prefunding balance).

• The pension cost for the FY 2019 wage index cost reporting period is $330,555 ($272,222 average pension cost [$1,400,000 total contributions divided by 36 months in the averaging period multiplied by 7 months in the in wage index cost reporting period] plus $58,333 pro-rata prefunding installment [$100,000 annual prefunding installment multiplied by 7/12ths to reflect a 7 month wage index cost reporting period]).

Example 4 (pension cost for a new plan):

• Provider’s FY 2019 wage index cost reporting period is 12 months (01/01/2015 – 12/31/2015); the 36 month averaging period is 01/01/2013 to 12/31/2015, which includes the wage index cost reporting year and the prior two cost reporting periods).

• The provider adopted a new pension plan effective 07/01/2014 and had no other pension plan in effect prior to that date; there is therefore no prefunding balance or prefunding installment.

• Contributions made during 01/01/2013 – 12/31/2013 = $0 (no plan in existence)

• Contributions made in the wage index cost reporting period 01/01/2014 – 12/31/2014 = $500,000.

• Contributions made during 01/01/2015 – 12/31/2015 = $1,200,000.

• Total contributions during the 36 month averaging period = $1,700,000.

• The provider did not report a pension cost attributable to the new plan based on a 36 month averaging period during any prior wage index cost reporting period, therefore it may elect to exclude cost reporting periods ending prior to the 07/01/2014 plan effective date from the averaging period; the 36 month averaging period is therefore shortened to 24 months and excludes the period 01/01/2013 to 12/31/2013. The pension cost for the FY 2019 wage index cost reporting period would then be $850,000 ($1,700,000 total contributions divided by 24 months in the averaging period multiplied by 12 months in the wage index reporting period).
NOTE: Fees paid to external organizations (for example, actuarial fees, claim administration fees, IRS form preparation fees) for providing services that are directly associated with a provider’s wage-related costs, including a provider’s defined benefit pension plan(s), maybe included in wage-related costs on Worksheet S-3, Part II for the period in which the expense is incurred (see Form CMS-339, Exhibit 6, Line 6). Such expenses are to be reported as additional costs only if they are paid directly by the provider and NOT out of the plan assets.
intravenous induction therapy was superior to subcutaneous administration and that higher intravenous doses appeared to be more efficacious than lower subcutaneous doses. The applicant noted that IBD experts are generally in agreement that higher doses of biologics are required at the outset to induce remission, while lower and less frequent doses may be adequate to maintain remission in a maintenance setting.

The applicant also submitted comments addressing CMS’ concerns with regards to the lack of head-to-head clinical trials comparing IV induction and maintenance Stelara® therapy with conventional therapy in patients diagnosed with moderate to severe CD that are also primary and secondary nonresponders to treatment using TNF alpha inhibitor therapy. The applicant stated that the UNITI trials were, in fact, head-to-head trials—the placebo group was receiving active treatment and was not truly a placebo group. Those patients continued the conventional therapies they were taking prior to study entry. The applicant noted that the UNITI induction trials covered the breadth of CD patients and that the UNITI–2 population had failed either corticosteroids and/or immunomodulators—these drugs are both recognized as standard conventional therapy for CD according to the applicant. The UNITI–1 population had failed at least one TNF inhibitor; in fact, approximately 50 percent had failed greater than one. This patient population, according to the applicant, is considered to be the most difficult group to treat in that they had, in most cases, already failed not only non-biologic therapy with corticosteroids and/or immunomodulators, but TNF inhibitors as well. The applicant summarized that the trials should be considered head-to-head comparing Stelara® to conventional therapies.

Response: We appreciate the comments submitted by the applicant in response to our concerns. After consideration of the public comments we received, which clarify the placebo group as having received conventional therapies and, therefore, the clinical trials did compare Stelara® to existing therapies, we believe Stelara® meets the substantial clinical improvement criterion because, according to the studies provided by the applicant, Stelara® produced a clinical response and remission in patients with moderate to severe Crohn’s Disease who have failed conventional therapies, including antibiotics, mesalamines, corticosteroids, immunomodulators, and TNFα inhibitors as outlined in their label. Specifically, Stelara® targets cytokines IL–12 and IL–23 which are responsible for inflammation in CD, offering a treatment option, otherwise not available, for a specific patient population. Stelara® provides a treatment option for this difficult-to-treat patient population.

We have determined that Stelara® meets all of the criteria for approval of new technology add-on payments. Therefore, we are approving new technology add-on payments for Stelara® for FY 2018. We expect that Stelara® will be administered for the treatment of adult patients (18 years and older) diagnosed with moderately to severely active CD who have: (1) Failed or were intolerant to treatment using immunomodulators or corticosteroids, but never failed a tumor necrosis factor (TNF) blocker; or (2) failed or were intolerant to treatment using one or more TNF blockers. Cases involving Stelara® that are eligible for new technology add-on payments will be identified by ICD–10–PCS procedure code WX033F3 (Introduction of other New Technology therapeutic substance into peripheral vein, percutaneous approach, New Technology Group 3). In its application, the applicant estimated that the average dose of Stelara® administered through IV infusion is 390 mg which would require 3 vials of Stelara IV at a hospital acquisition cost of $1,600 per vial (for a total of $4,800). Under 42 CFR 412.88(a)(2), we limit new technology add-on payments to the lesser of 50 percent of the average cost of the technology or 50 percent of the costs in excess of the MS–DRG payment for the case. As a result, the maximum new technology add-on payment amount for a case involving the use of STELARATM is $2,400 for FY 2018.

III. Changes to the Hospital Wage Index for Acute Care Hospitals

A. Background

1. Legislative Authority

Section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary adjust the standardized amounts 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. We currently define hospital labor market areas based on the delineations established by the Office of Management and Budget (OMB). A discussion of the FY 2018 hospital wage index based on the statistical areas appears under section III.A.2. of the preamble of this final rule.

Section 1886(d)(3)(E) of the Act requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage-related costs of short-term, acute care hospitals. (CMS collects these data on the Medicare cost report, CMS Form 2552–10, Worksheet S–3, Parts II, III, and IV. The OMB control number for approved collection of this information is 0938–0050.) This provision also requires that any updates or adjustments to the wage index be made in a manner that ensures that aggregate payments to hospitals are not affected by the change in the wage index. The adjustment for FY 2018 is discussed in section IL.B. of the Addendum to this final rule.

As discussed in section III.I. of the preamble of this final rule, we also take into account the geographic reclassification of hospitals in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act by creating hospital wage index 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. We currently define hospital labor market areas based on the delineations established by the Office of Management and Budget (OMB). A discussion of the FY 2018 hospital wage index based on the statistical areas appears under sections III.E.3. and F. of the preamble of this final rule.

Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. A discussion of the occupational mix adjustment that we are applying to the FY 2018 wage index appears under sections III.E.3. and F. of the preamble of this final rule.

2. Core-Based Statistical Areas (CBSAs) for the FY 2018 Hospital Wage Index

The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Under section 1886(d)(3)(E) of the Act, beginning with FY 2005, we delineate hospital labor market areas based on OMB-established Core-Based Statistical Areas (CBSAs). The current statistical areas (which were implemented beginning with FY 2015) and based on revised OMB delineations issued on February 28, 2013, in OMB Bulletin No. 13–01. OMB Bulletin No.
13–01 established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas in the United States and Puerto Rico based on the 2010 Census, and provided guidance on the use of the delineations of these statistical areas using standards published on June 28, 2010 in the Federal Register (75 FR 37246 through 37252). We refer readers to the FY 2015 IPPS/LTCHPPS final rule (79 FR 49951 through 49963) for a full discussion of our implementation of the OMB labor market area delineations beginning with the FY 2015 wage index.

Generally, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses through OMB Bulletins. On July 15, 2015, OMB issued OMB Bulletin No. 15–01, which provides an update to and supersedes OMB Bulletin No. 13–01 that was issued on February 15, 2013. The attachment to OMB Bulletin No. 15–01 provides detailed information on the update to statistical areas since February 28, 2013. The updates provided in OMB Bulletin No. 15–01 are based on the application of the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas to Census Bureau population estimates for July 1, 2012 and July 1, 2013. In the FY 2017 IPPS/LTCHPPS final rule (81 FR 56913), we adopted the updates set forth in OMB Bulletin No. 15–01 effective October 1, 2016, beginning with the FY 2017 wage index. For a complete discussion of the adoption of the updates set forth in OMB Bulletin No. 15–01, we refer readers to the FY 2017 IPPS/LTCHPPS final rule.

For FY 2018, we are continuing to use the OMB delineations that we adopted beginning with FY 2015 to calculate the area wage indexes, with updates as reflected in OMB Bulletin No. 15–01 specified in the FY 2017 IPPS/LTCHPPS final rule.

3. Codes for Constituent Counties in CBSAs

CBSAs are made up of one or more constituent counties. Each CBSA and constituent county has its own unique identifying codes. There are two different lists of codes associated with counties: Social Security Administration (SSA) codes and Federal Information Processing Standard (FIPS) codes. Historically, CMS has listed and used SSA and FIPS county codes to identify and crosswalk counties to CBSA codes for purposes of the hospital wage index. We have learned that SSA county codes are no longer being maintained and updated. However, the FIPS codes continue to be maintained by the U.S. Census Bureau. The Census Bureau’s most current statistical area information is derived from ongoing census data received since 2010; the most recent data are from 2015. For the purposes of crosswalking counties to CBSAs, in the FY 2018 IPPS/LTCHPPS proposed rule (82 FR 19898 through 19899), we proposed to discontinue the use of SSA county codes and begin using only the FIPS county codes.

The Census Bureau maintains a complete list of changes to counties or county equivalent entities on the Web site at: https://www.census.gov/geo/reference/county-changes.html. In our proposed transition to using only FIPS codes for counties for the hospital wage index, we proposed to update the FIPS codes used for crosswalking counties to CBSAs for the hospital wage index to incorporate changes to the counties or county equivalent entities included in the OMB Bulletin No. 13–01 list. Based on information included in the Census Bureau’s Web site, since 2010, the Census Bureau has made the following updates to the FIPS codes for counties or county equivalent entities:

- Petersburg Borough, AK (FIPS State County Code 02–195), CBSA 02, was created from part of former Petersburg Census Area (02–195) and part of Hoonaal-Angoon Census Area (02–105). The CBSA code remains 02.
- The name of La Salle Parish, LA (FIPS State County Code 22–059), CBSA 14, is now LaSalle Parish, LA (FIPS State County Code 22–059). The CBSA code remains as 14.
- The name of Shannon County, SD (FIPS State County Code 46–113), CBSA 43, is now Oglala Lakota County, SD (FIPS State County Code 46–102). The CBSA code remains as 43.

We believe that it is important to use the latest counties or county equivalent entities in order to properly crosswalk hospitals from a county to a CBSA for purposes of the hospital wage index used under the IPPS. In addition, we believe that using the latest FIPS codes will allow us to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. Therefore, in the FY 2018 IPPS/LTCHPPS proposed rule (82 FR 19898 through 19899), we proposed to implement these FIPS code updates, effective October 1, 2017, beginning with the FY 2018 wage indexes. We proposed using FIPS code changes to calculate area wage indexes in a manner that is generally consistent with the CBSA-based methodologies finalized in the FY 2005 IPPS final rule and the FY 2015 IPPS/LTCHPPS final rule. We note that while the county update changes listed earlier changed the county names, the CBSAs to which these counties map did not change from the prior counties. Therefore, there is no impact or change to hospitals in these counties; they continue to be considered rural for the hospital wage index under these changes. We invited public comments on our proposals.

We did not receive any public comments on our proposals. Therefore, for the reasons discussed earlier, we are finalizing our proposal, without modification, to discontinue the use of the SSA county codes and begin using only the FIPS county codes for purposes of crosswalking counties to CBSAs. In addition, we are finalizing our proposal, without modification, to implement the latest FIPS code updates, as discussed earlier, effective October 1, 2017, beginning with the FY 2018 wage indexes. As we proposed, we will use these update changes to calculate the wage indexes in a manner that is generally consistent with the CBSA-based methodologies finalized in the FY 2005 IPPS final rule and the FY 2015 IPPS/LTCHPPS final rule. For FY 2018, Tables 2 and 3 associated with this final rule and the County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File posted on the CMS Web site reflect these county changes.

B. Worksheet S–3 Wage Data for the FY 2018 Wage Index

The FY 2018 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2014 (the FY 2017 wage indexes were based on data from cost reporting periods beginning during FY 2013).

1. Included Categories of Costs

The FY 2018 wage index includes all of the following categories of data associated with costs paid under the IPPS (as well as outpatient costs):

- Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty);
- Home office costs and hours;
- Certain contract labor costs and hours, which include direct patient care, certain top management, pharmacy, laboratory, and nonteaching clinical personnel, and certain contract indirect patient care services (as discussed in the FY 2008 final rule
with comment period (72 FR 47315 through 47317); and

- Wage-related costs, including pension costs (based on policies adopted in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51586 through 51590)) and other deferred compensation costs.

2. Excluded Categories of Costs

Consistent with the wage index methodology for FY 2017, the wage index for FY 2018 also excludes the direct and overhead salaries and hours for services not subject to IPPS payment, such as skilled nursing facility (SNF) services, home health services, costs related to GME (teaching physicians and residents) and certified registered nurse anesthetists (CRNAs), and other subprovider components that are not paid under the IPPS. The FY 2018 wage index also excludes the salaries, hours, and wage-related costs of hospital-based rural health clinics (RHCs), and Federally qualified health centers (FQHCs) because Medicare pays for these costs outside of the IPPS (68 FR 45395). In addition, salaries, hours, and wage-related costs of CAHs are excluded from the wage index for the reasons explained in the FY 2004 IPPS final rule (68 FR 45397 through 45398).

3. Use of Wage Index Data by Suppliers and Providers Other Than Acute Care Hospitals Under the IPPS

Data collected for the IPPS wage index also are currently used to calculate wage indexes applicable to suppliers and other providers, such as SNFs, home health agencies (HHAs), ambulatory surgical centers (ASCs), and hospices. In addition, they are used for prospective payments to IRFs, IPFs, and LTCHs, and for hospital outpatient services. We note that, in the IPPS rules, we do not address comments pertaining to the wage indexes of any supplier or provider except IPPS providers and LTCHs. Such comments should be made in response to separate proposed rules for those suppliers and providers.

C. Verification of Worksheet S–3 Wage Data

The wage data for the FY 2018 wage index were obtained from Worksheet S–3, Parts II and III of the Medicare cost report (Form CMS–2552–10) for cost reporting periods beginning on or after October 1, 2013, and before October 1, 2014. For wage index purposes, we refer to cost reports during this period as the "FY 2014 cost report," the "FY 2014 wage data," or the "FY 2014 data.

Instructions for completing the wage index section of Worksheet S–3 are included in the Provider Reimbursement Manual (PRM), Part 2 (Pub.15–2), Chapter 40, Sections 4005.2 through 4005.4. The data file used to construct the FY 2018 wage index includes FY 2014 data submitted to us as of June 14, 2017. As in past years, we performed an extensive review of the wage data, mostly through the use of edits designed to identify aberrant data. We asked our MACs to revise or verify data elements that result in specific edit failures. For the proposed FY 2018 wage index, we identified and excluded 51 providers with aberrant data that should not be included in the wage index, although we stated in the FY 2018 IPPS/LTCH PPS proposed rule that if data elements for some of these providers are corrected, we intend to include data from those providers in the final FY 2018 wage index (82 FR 19899). We note that of the 51 hospitals that we excluded from the proposed wage index, some hospitals had data that we did not expect to change or improve (for example, among the reasons these providers were excluded are: They are low Medicare utilization providers; they closed and failed edits for reasonableness; or they have extremely high or low average hourly wages that are atypical for their CBSAs). We also adjusted certain aberrant data and included these data in the proposed wage index. For example, in situations where a hospital did not have documentable salaries, wages, and hours for housekeeping and dietary services, we imputed estimates, in accordance with policies established in the FY 2015 IPPS/LTCH PPS final rule (79 FR 49063). We instructed MACs to complete their data verification of questionable data elements and to transmit any changes to the wage data no later than March 24, 2017. In addition, as a result of the April and May appeals processes, and posting of the April 28, 2017 PUF, we have made additional revisions to the FY 2018 wage data, as described further below. The revised data are reflected in this FY 2018 IPPS/LTCH PPS final rule. In constructing the proposed FY 2018 wage index, we included the wage data for facilities that were IPPS hospitals in FY 2014, inclusive of those facilities that have since terminated their participation in the program as hospitals, as long as those data did not fail any of our edits for reasonableness. We believed that including the wage data for these hospitals is, in general, appropriate to reflect the economic conditions in the various labor market areas during the relevant past period and to ensure that the current wage index represents the labor market area’s current wages as compared to the national average of wages. However, we excluded the wage data for CAHs as discussed in the FY 2004 IPPS final rule (68 FR 45397 through 45398). For the proposed rule, we removed 7 hospitals that converted to CAH status on or after January 22, 2016, the cut-off date for CAH exclusion from the FY 2017 wage index, and through and including January 23, 2017, the cut-off date for CAH exclusion from the FY 2018 wage index. After excluding CAHs and hospitals with aberrant data, we calculated the proposed wage index using the Worksheet S–3, Parts II and III wage data of 3,325 hospitals.

Since the development of the FY 2018 proposed wage index, as a result of further review by the MACs and the April and May appeals processes, we received improved data for 15 hospitals and are including the wage data of these 15 hospitals in the final wage index. However, during our review of the wage data in preparation of the April 28, 2017 PUF, we identified and deleted the data of 2 additional hospitals whose data we determined to be aberrant (unusually low average hourly wages) relative to their CBSAs, and there was insufficient documentation provided to explain their wage data. Finally, we learned that in the proposed wage index, we inadvertently deleted the data of one hospital when we should have deleted the data of a different hospital. We have corrected this error, although because we were including one hospital while deleting another, there was no effect on the number of hospitals in the wage index. With regard to CAHs, we have since learned of 2 additional hospitals that converted to CAH status on or after January 22, 2016, the cut-off date for CAH exclusion from the FY 2017 wage index, and through and including January 23, 2017, the cut-off date for CAH exclusion from the FY 2018 wage index. Accordingly, we have removed 9 hospitals that converted to CAH status from the FY 2018 wage index. The final FY 2018 wage index is based on the wage index of 3,336 hospitals (3,325 + 15 – 2 – 1 + 1 – 2 = 3,336).

For the final FY 2018 wage index, we allotted the wages and hours data for a multicampus hospital among the different labor market areas where its campuses are located in the same manner that we allotted such hospitals’ data in the FY 2017 wage index (81 FR 56915). Table 2, which contains the final FY 2018 wage index associated with this final rule (available via the Internet on the CMS Web site), includes separate wage data for the campuses of 9 multicampus hospitals.
### D. Method for Computing the FY 2018 Unadjusted Wage Index

1. Methodology for FY 2018

The method used to compute the FY 2018 wage index without an occupational mix adjustment follows the same methodology that we used to compute the wage indexes without an occupational mix adjustment since FY 2012 (76 FR 51591 through 51593).

**Comment:** One commenter requested that CMS consider developing a process for determining a wage index that would reward hospitals that invest in the workforce and raise the wages of the lowest paid workers, rather than relying primarily on the average hourly wages of the labor market area as a whole.

**Response:** Section 1886(d)(3)(E) of the Act requires the Secretary to adjust for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. The statute does not direct the Secretary to develop a wage index that rewards hospitals for workforce investment or other labor initiatives.

As discussed in the FY 2012 IPPS/LTC PPS final rule, in “Step 5,” for each hospital, we adjust the total salaries plus wage-related costs to a common period to determine total adjusted salaries plus wage-related costs. To make the wage adjustment, we estimate the percentage change in the employment cost index (ECI) for compensation for each 30-day increment from October 14, 2013, through April 15, 2015, for private industry hospital workers from the BLS’ Compensation and Working Conditions. We have consistently used the ECI as the data source for our wages and salaries and other price proxies in the IPPS market basket, and we did not propose any changes to the usage of the ECI for FY 2018. The factors used to adjust the hospital’s data were based on the midpoint of the cost reporting period, as indicated in the following table.

#### MIDPOINT OF COST REPORTING PERIOD

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<th>Adjustment factor</th>
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For example, the midpoint of a cost reporting period beginning January 1, 2014, and ending December 31, 2014, is June 30, 2014. An adjustment factor of 1.011193 would be applied to the wages of a hospital with such a cost reporting period. Using the data as previously described, the FY 2018 national average hourly wage (unadjusted for occupational mix) is $42.1027.

Previously, we also would provide a Puerto Rico overall average hourly wage. As discussed in the FY 2017 IPPS/LTC PPS final rule (81 FR 56915), prior to January 1, 2016, Puerto Rico hospitals were paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As a result, we calculated a Puerto Rico-specific wage index that was applied to the labor share of the Puerto Rico-specific standardized amount. Section 601 of the Consolidated Appropriations Act, 2016 (Pub. L. 114–113) amended section 1886(d)(9)(E) of the Act to specify that the payment calculation with respect to operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges on or after January 1, 2016, shall use 100 percent of the national standardized amount. As we stated in the FY 2017 IPPS/LTC PPS final rule (81 FR 56915 through 56916), because Puerto Rico hospitals are no longer paid with a Puerto Rico-specific standardized amount as of January 1, 2016, under section 1886(d)(9)(E) of the Act, as amended by section 601 of the Consolidated Appropriations Act, 2016, there is no longer a need to calculate a Puerto Rico-specific average hourly wage at a wage index. Hospitals in Puerto Rico are now paid 100 percent of the national standardized amount and, therefore, are subject to the national average hourly wage (unadjusted for occupational mix) which is applied to wages and other wage-related costs. In the September 1, 1994 IPPS final rule (59 FR 45356), we developed a list of “core” wage-related costs that hospitals may report on Worksheet S–3, Part II of the Medicare hospital cost report in order to include those costs in the wage index. Core wage-related costs include categories of retirement cost, plan administrative costs, health and insurance costs, taxes, and other specified costs such as tuition reimbursement. In addition to these categories of core wage-related costs, we allow hospitals to report wage-related costs other than those on the core list if the other wage-related costs meet certain criteria. The criteria for including other wage-related costs in the wage index are discussed in the September 1, 1994 IPPS final rule (59 FR 45357) and also are listed in the Provider Reimbursement Manual (PRM), Part II, Chapter 40, Sections 4005.2 through 4005.4, Line 18 of the Medicare cost report (Form CMS–2552–10, OMB control number 0938–0050). Specifically, “other” wage-related costs are allowable for the wage index if the cost for employees whose services are paid under the IPPS exceeds 1 percent of the total adjusted salaries net of excluded area salaries, is a fringe benefit as defined by the IRS and has been reported to the IRS (as income to the employees or contractors), is not being furnished for the convenience of the provider, and is not listed on Worksheet S–3, Part IV.

We note that other wage-related costs are not to include benefits already included in Line 1 salaries on Worksheet S–3, Part II (refer to the cost report instructions for Worksheet S–3, Part II, Line 18, which state, "‘Other’ wage-related costs do not include wage-related costs reported on line 1 of this worksheet."). We also note that the 1-percent test is conducted by dividing each individual category of the other wage-related cost (that is, the...
We reconsidered allowing other wage-related costs to be included in the wage index because recent internal reviews of the FY 2018 wage data show that only a small minority of hospitals are reporting other wage-related costs that meet the 1-percent test described earlier. In the calculation of the proposed FY 2018 wage index, for each hospital reporting other wage-related costs on Line 18 of Worksheet S–3, we performed the 1-percent test. We then made internal edits removing other wage-related costs on Line 18 where hospitals reported data that failed to meet the mathematical requirement that other wage-related costs must exceed 1 percent of total adjusted salaries net of excluded area salaries. After this review, only approximately 80 hospitals of approximately 3,320 hospitals had other wage-related costs on Line 18 meeting the 1-percent test. We believe that such a limited number of hospitals nationally reporting and meeting the 1-percent test may indicate that other wage-related costs might not constitute an appropriate part of a relative measure of wage costs in a particular labor market area, a longstanding tenet of the wage index. In other words, while other wage-related costs may represent costs that may have an impact on an individual hospital's average hourly wage, we do not believe that costs reported by only a very small minority of hospitals accurately reflect the economic conditions of the labor market areas in which those hospitals are located. Therefore, it is possible that inclusion of other wage-related costs in the wage index in such a limited manner may distort the average hourly wage of a particular labor market area so that its wage index does not accurately represent that labor market area’s current wages relative to national wages.

Furthermore, the open-ended nature of the types of other wage-related costs that may be included on Line 18 of Worksheet S–3, in contrast to the concrete list of other wage-related costs, may hinder consistent and proper reporting of fringe benefits. Our internal review indicates widely divergent types of costs that hospitals are reporting as other wage-related costs on Line 18. We are concerned that inconsistent reporting of other wage-related costs on Line 18 further compromises the accuracy of the wage index as a representation of the relative average hourly wage for each labor market area. Our intent in creating a core list of wage-related costs in the September 1, 1994 IPPS final rule was to promote consistent reporting of fringe benefits, and we are increasingly concerned that inconsistent reporting of wage-related costs on Line 18 of Worksheet S–3 undermines this effort. Specifically, we expressed in the September 1, 1994 IPPS final rule that, since we began including fringe benefits in the wage index, we have been concerned with the inconsistent reporting of fringe benefits, whether because of a lack of provider proficiency in identifying fringe benefit costs or varying interpretations across fiscal intermediaries of the definition for fringe benefits in PRM–I, Section 2144.1 (59 FR 45356).

We believe that the limited and inconsistent use of Line 18 of Worksheet S–3 for reporting other wage-related costs other than the core list might indicate that including other wage-related costs in the wage index compromises the accuracy of the wage index as a relative measure of wages in a given labor market area. Therefore, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19901), we sought public comments on whether we should, in future rulemaking, propose to only include the wage-related costs on the core list in the calculation of the wage index and not to include any other wage-related costs in the calculation of the wage index. Meanwhile, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19901 through 19902), we clarified that, under our current policy, an other wage-related cost (which we define as the value of a benefit) must be a fringe benefit as described by the IRS (refer to IRS Publication 15–B) and must be reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income in order to be considered an other wage-related cost on Line 18 of Worksheet S–3 and for the wage index. That is, other wage-related costs that are not reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income, even if not required to be reported to the IRS according to IRS requirements, will not be included in the wage index. This is consistent with current cost report instructions for Line 18 of Worksheet S–3, Part II of the Medicare cost report. From 2552–10, which states that if an employer is not considered an allowable other wage-related cost, the cost “has been reported to the IRS.” We will apply this policy to the process for calculating the wage index for FY 2019, including the FY 2019 desk reviews beginning in September 2017.

As we stated in the FY 2018 proposed rule, we believe this clarification is necessary because some hospitals have incorrectly interpreted prior manual and existing preamble language to mean that a cost could be considered to other wage-related costs if the provider’s reporting (or not reporting) of the cost...
was in accordance with IRS requirements, rather than if the cost was actually reported on an employee’s or contractor’s W–2 or 1099 form as taxable income. We believe that such an interpretation of our policy would require an analysis of whether the reporting or not reporting of the cost to the IRS was done properly in accordance with IRS regulations and guidance in order to allow the cost as an other wage-related cost. We believe that the determinations regarding the proper or improper reporting of certain other wage-related costs to the IRS for the purpose of inclusion in the Medicare wage index are impractical for CMS and the MACs because we do not have the expertise and fluency in IRS regulations and tax law sufficient to perform such technical reviews of hospital wage-related costs. In contrast, our current policy of including an amount as an other wage-related cost for wage index purposes only if the amount was actually reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income is a straightforward policy that we believe provides clarity to all involved parties. The brightline test of allowing an other wage-related cost to be included in the wage index only if it has been reported on an employee’s or contractor’s W–2 or 1099 form as taxable income helps ensure consistent treatment of other wage-related costs for all hospitals. Considering the variety of types of costs that may be included on Line 18 of Worksheet S–3 of the cost report for other wage-related costs (assuming the 1-percent test is met and other criteria are met), we believe that a straightforward policy that is simple for hospitals and CMS to apply is particularly important. In addition, we believe the policy we are clarifying that an other wage-related cost can be included in the wage index only if it was reported to the IRS as taxable income on the employee’s or contractor’s W–2 or 1099, is consistent with CMS’ longstanding position that a fringe benefit is not furnished for the convenience of the employer or otherwise excludable from income as a fringe benefit (such as a working condition fringe) and that inappropriate types of costs may not be included in the wage index. In response to a comment when we finalized the criteria for other wage-related costs in the September 1, 1994 IPPS final rule (59 FR 45359), we stated that “items such as the unrecovered cost of employee meals, the cost of fuel, rent, and auto allowances will only be allowed as a wage-related cost for purposes of the wage index if properly reported to the IRS on an employee’s W–2 form as a fringe benefit.” (We note that the September 1, 1994 IPPS final rule does not mention the 1099 form for contractors, as contract labor was not allowed at that time in the wage index. Consistent with our treatment of costs for contract labor similar to that of employees for the wage index, we are clarifying that the requirement that a cost be reported to the IRS to be allowed as a wage-related cost for the wage index also applies to contract labor, which must be reported on the contractor’s 1099 to be allowed as a wage-related cost for the wage index.) We believe that requiring other wage-related costs to be reported on employees’ or contractors’ W–2 or 1099 forms to be allowable for Line 18 of Worksheet S–3 of the Medicare cost report is consistent with the requirement that the cost is not being furnished for the convenience of the employer. A cost reported on an employee’s or contractor’s W–2 or 1099 form as taxable income is clearly a wage-related cost that is provided solely for the benefit of the employee. We believe that the requirement that other wage-related costs be a benefit to the employee also guarantees that administrative costs such as overhead and capitalized costs are excluded from other wage-related costs in the wage index. Therefore, for the reasons discussed above, as we discussed in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19901 through 19902), we are clarifying that a cost must be a fringe benefit as described by the IRS and must be reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income in order to be considered an other wage-related cost on Line 18 of Worksheet S–3 and for the wage index. In addition, as discussed earlier, in the proposed rule, we requested public comments on whether we should consider in future rulemaking removing other wage-related costs from the wage index. Because some hospitals have incorrectly interpreted prior manual and existing preamble language, as stated earlier, in the proposed rule we restated the criteria from the September 1, 1994 IPPS final rule (59 FR 45357) for allowing other wage-related costs for the wage index, with clarifications. The criteria follow below, and as stated in the proposed rule, we intend to update the manual with these clarifications: Other Wage-Related Costs. A hospital may be able to report a wage-related cost (defined as the value of the benefit) that does not appear on the core list if it meets all of the following criteria:

- The wage-related cost is provided at a significant financial cost to the employer. To meet this test, the individual wage-related cost must be greater than 1 percent of total salaries after the direct excluded salaries are removed (the sum of Worksheet S–3, Part II, Lines 11, 12, 13, 14, column 4, and Worksheet S–3, Part III, Line 3, Column 4).

- The wage-related cost is a fringe benefit as described by the IRS and is reported to the IRS on an employee’s or contractor’s W–2 or 1099 form as taxable income.

- The wage-related cost is not furnished for the convenience of the provider or otherwise excludable from income as a fringe benefit (such as a working condition fringe).

We note that those wage-related costs reported as salaries on Line 1 (for example, loan forgiveness and sick pay accruals) should not be included as other wage-related costs on Line 18.

Comment: One commenter fully supported CMS proposing in future rulemaking to only include the wage-related costs on the core list in the calculation of the wage index and not to include any other wage-related costs in the calculation of the wage index. The commenter reiterated CMS’ observation that only a small minority of hospitals benefit from the reporting of other wage-related costs, emphasizing that the inclusion of other wage-related costs in the wage index in such a limited manner distorts the average hourly wage of a particular labor market area so that its wage index does not accurately represent that labor market area’s current wages relative to national wages. Several commenters did not oppose CMS proposing in future rulemaking to only include wage-related costs on the core list but requested that CMS first consider convening stakeholders for additional input prior to the removal of the item. Similarly, one commenter requested that CMS be as transparent as possible and provide complete information on the impact on the wage index for all areas of the country in future rulemaking if CMS proposes to exclude other wage-related costs from the wage index calculation.

Response: We appreciate the commenter’s support for our proposing in future rulemaking to consider only including the wage-related costs on the core list in the calculation of the wage index and not to include any other wage-related costs in the calculation of the wage index. In response to the comment that labor market areas with relative few hospitals or small labor market areas might be better served by an additional analytical approach, CMS is considering convening a stakeholder group to provide input on the potential impact of removing other wage-related costs from the wage index calculation.
for additional input prior to the removal of other wage-related costs (on Line 18 of Worksheet S–3) from the wage index, we are reassuring the commenters that we would engage in notice-and-comment rulemaking in order to solicit stakeholder input before removing Line 18 of Worksheet S–3 from the wage index calculation. Similarly, we endeavor to be as transparent as possible and, if appropriate, may consider providing information on the impact on the wage index for all areas of the country in future rulemaking if we propose to exclude other wage-related costs from the wage index calculation.

Comment: Two commenters applauded CMS’ goals of achieving a more equitable and accurate wage index, but suggested that CMS address the inadequacies in the current reporting requirements for noncore other wage-related costs rather than consider eliminating Line 18 of Worksheet S–3 of the Medicare cost report from the wage index. These commenters asserted that all hospitals have noncore benefits. However, the commenters added, the limited guidance and “significant threshold limitations” in the current instructions prevent hospitals from capturing these noncore benefits. Furthermore, the commenters maintained that benefits are rapidly evolving into more nontraditional structures and, therefore, a mechanism to capture these evolving benefits is necessary for CMS to ensure an equitable survey. The commenters submitted several suggestions to ensure open and transparent reporting of other wage-related costs and to remove the onus from CMS and the MAC to make determinations regarding the acceptability of other wage-related costs. The commenters believed that clear and consistent reporting guidelines create an equitable playing field for all providers and stated that addressing the inadequacies in the current reporting requirements for Line 18 is prudent. However, the commenters suggested an approach different than CMS: clarification of current policy to more accurately identify and capture other wage-related costs.

Response: We appreciate the feedback from commenters in favor of our improving the current reporting requirements for noncore other wage-related costs rather than considering eliminating Line 18 of Worksheet S–3 from the wage index calculation. We are not eliminating Line 18 from the wage index calculation at this time. Rather, in line with the commenters’ recommendation, we are clarifying the requirements for Line 18 in this final rule to facilitate consistent and accurate reporting of other wage-related costs for the wage index. We share the commenters’ interests in reporting guidelines that are clear, consistent, and equitable. The commenters’ specific suggestions and our responses follow below:

Comment: Commenters suggested that CMS, with input from providers, define a specific list of noncore benefits commonly shared by a large number of providers for inclusion in the wage index, such as employee parking and transit costs, uniform costs, and meal allowances. The commenters suggested that CMS approach the identification of noncore benefits with the same specificity as it does with core benefits in order to ensure an equitable wage index, more easily address tax issues, and allow more direct application of the employer convenience test.

Response: We appreciate the commenters’ suggestion and agree that defined lists of allowable costs are generally helpful to support consistent and equitable reporting. In fact, our intent in creating a core list of wage-related costs in the September 1, 1994 IPPS final rule was to promote “more equitable and consistent reporting of wage-related costs for all hospitals” (59 FR 45356). When developing the list of core wage-related costs, we stated that one or more of the following criteria must be met to be considered a core wage-related cost: The wage-related cost is provided at a significant financial cost to the employee; the wage-related cost is of a type and nature that would generally be offered as a fringe benefit by most employers; the perceived value of this wage-related cost is of such importance that it would influence an individual’s employment decisions; and the wage-related cost is a mandatory requirement under Federal or State law (for example FICA, Federal and State unemployment, among others) (59 FR 45356).

If there are noncore benefits that are of a type and nature that would generally be offered as a fringe benefit by most employers, as the commenters suggested, we believe that perhaps these costs should be added to the core list rather than defined separately as a list of other wage-related costs. In future rulemaking, we may consider this suggestion in the form of seeking hospitals’ input on expanding the core list of wage-related costs to include common wage-related costs (such as parking) that are currently considered other wage-related costs.

Comment: Commenters suggested that the taxable or nontaxable nature of the benefit should not be a determinant for inclusion as a noncore benefit. In the commenters’ opinion, CMS made too broad a connection between taxable reporting and the employer convenience test; specifically, many employee benefits are not taxable due to dollar threshold exclusions and public policy considerations by Congress and the IRS. Furthermore, the commenters pointed out that evolving tax law could cause volatility in the wage index because what is considered a taxable benefit one year may not be taxable in the next year.

Rather, the commenters suggested that, in order for other wage-related costs to be included in the wage index, CMS require other wage-related costs to be reported to the IRS on the W–2, regardless of whether the benefit is taxable or not (the W–2 allows for reporting of both taxable and nontaxable benefits), and that CMS could then include other wage-related costs in the wage index as long as those costs, whether taxable or nontaxable, are reported on the W–2. The commenters maintained that it should not be the responsibility of CMS or the MACs to prove that the benefit has been handled appropriately for tax purposes, and this requirement to include all taxable and nontaxable costs on the W–2 in order to have those costs included in the wage index would ensure that the benefit has been handled correctly for tax purposes.

Response: In the proposed rule (82 FR 19902), we stated that requiring other wage-related costs to be reported on employees’ or contractors’ W–2 or 1099 forms to be allowable for Line 18 is consistent with the requirement that the cost is not being furnished for the convenience of the employer because, typically, a cost that is for the convenience of the employer is not taxable as income to the employee. This is not to say that all costs that are a benefit to the employee are taxable. Indeed, in our clarification of the criteria for allowing a cost as an other wage-related costs on Line 18 in the wage index, we specifically stated that “The wage-related cost is not furnished for the convenience of the provider or otherwise excludable from income as a fringe benefit (such as a working condition fringe)” (emphasis added). That is, we recognize that being furnished for the convenience of the employer is only one of many reasons that a cost may be excludable from income as a fringe benefit.

While we understand that many employee benefits are not taxable due to dollar threshold exclusions and public policy considerations by Congress and the IRS, and thereby excluded from Line 18, we continue to believe that a brightline test is necessary for consistent
treatment of other wage-related costs for all hospitals. Taken with the commenter’s suggestion that CMS allow taxable and nontaxable other wage-related costs (assuming other criteria are met) as long as the costs are reported on W–2s or 1099s, we understand that the commenter is suggesting a different brightline test: That the cost be listed on the W–2, regardless of whether the cost is taxable or tax-exempt. We continue to believe that our clarification in the proposed rule is a more straightforward policy than the commenter’s suggestion for two reasons. First, all employers report nontaxable costs on an employee’s W–2, nor are they required to do so. Therefore, to allow nontaxable costs so long as those costs are on an employee’s W–2 would create an uneven playing field with inconsistent treatment of nontaxable costs. Second, a taxable benefit is typically income-related and a benefit to the employee. While we understand that there may be benefits to the employee that are tax-exempt due to a variety of public policy considerations, we believe that costs should be taxable in order to be incorporated as part of the wage index because the wage index is a relative measure of salaries and wages.

Furthermore, we agree with the commenter’s assertion that it should not be the responsibility of CMS or the MACs to prove that the benefit has been handled appropriately for tax purposes. Indeed, it is for that reason that we clarified our current policy of allowing an amount as an other wage-related cost for wage index purposes only if the amount was actually reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income. We stated in the proposed rule (82 FR 45358) that other wage-related costs that are not reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income, even if not required to be reported to the IRS according to IRS requirements, will not be included in the wage index. We explained that determinations regarding the proper or improper reporting of certain other wage-related costs to the IRS for the purpose of inclusion in the Medicare wage index are impractical for CMS and the MACs because we do not have the expertise and fluency in IRS regulations and tax law sufficient to perform such technical reviews of hospital wage-related costs.

Comment: Commenters suggested that CMS change the 1-percent test to a test in aggregate for the items on their recommended noncore list. For benefits not specifically listed by CMS as noncore, the commenters suggested that CMS continue using the current methodology, which requires each individual benefit to meet the 1-percent test.

Response: We appreciate the commenters’ suggestion. However, as we stated earlier, if there are noncore benefits that are of a type and nature that would generally be offered as a fringe benefit by most employers, we believe that perhaps these costs should be added to the core list rather than defined separately as a list of other wage-related costs. In future rulemaking, we may consider this suggestion in the form of seeking hospitals’ input on expanding the core list of wage-related costs to include common wage-related costs (such as parking) that are currently considered other wage-related costs.

We continue to believe that it is appropriate for the 1-percent test to be performed on individual, rather than aggregate, other wage-related costs. In response to a public comment, in the September 1, 1994 IPPS final rule (59 FR 45358), we stated that “[t]he provision to include wage-related costs other than those reflected on the core list is intended to recognize only those limited circumstances where a hospital incurs any additional wage-related cost items that truly represent a significant financial burden to the hospital, but that also meet the current definition of a fringe benefit cost. We believe the 1-percent threshold is an appropriate measure of significance, and that the exclusion of any cost representing less than 1 percent of total salaries would not significantly affect the hospital’s overall average hourly wage. We consider the 1-percent test critical in ensuring that providers only include other wage-related costs that contribute significantly to their wage costs and that are not accounted for in the core list.”

We continue to believe that the 1-percent test performed on individual costs ensures that the wage-related cost is provided at a significant financial cost to the employer. Furthermore, we believe that allowing the 1-percent test to be performed on aggregate other wage-related costs (even on a limited list of other wage-related costs, as the commenter suggests) would lead to inequitable treatment of other wage-related costs. Hospitals with other wage-related costs comprising an identical percentage of total adjusted salaries net of excluded area salaries could be treated differently, depending on the presence or absence of additional other wage-related costs to collectively “pass” the 1-percent test. For example, parking costs totaling .08 percent of total salaries for one hospital could be allowed (assuming the other criteria were met) if the hospital also has additional noncore wage-related costs that combine to exceed 1 percent, while another hospital with parking costs totaling the identical .08 percentage of total salaries could have those costs disallowed in absence of additional noncore wage-related costs to add to the parking costs to exceed 1 percent of salaries.

We appreciate all of the comments submitted on this issue. We will take these comments into consideration in determining whether to propose in future rulemaking to remove other wage-related costs from the wage index calculation. Meanwhile, as discussed earlier and in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19900 through 19902), we are again clarifying that a cost must be a fringe benefit as described by the IRS and must be reported to the IRS on employees’ or contractors’ W–2 or 1099 forms as taxable income in order to be considered an other wage-related cost on Line 18 of Worksheet S–3 and for the wage index.

E. Occupational Mix Adjustment to the FY 2018 Wage Index

As stated earlier, section 1886(d)(3)(E) of the Act provides for the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index, for application beginning October 1, 2004 (the FY 2005 wage index). The purpose of the occupational mix adjustment is to control for the effect of hospitals’ employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aids, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.

1. Use of 2013 Occupational Mix Survey for the FY 2018 Wage Index

Section 304(c) of the Consolidated Appropriations Act, 2001 (Pub. L. 106–554) amended section 1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. We collected data in 2013 to compute the occupational mix adjustment for the FY 2016, FY 2017, and FY 2018 wage indexes. A new
measurement of occupational mix is required for FY 2019. The 2013 survey included the same data elements and definitions as the previous 2010 survey and provided for the collection of hospital-specific wages and hours data for nursing employees for calendar year 2013 (that is, payroll periods ending between January 1, 2013 and December 31, 2013). We published the 2013 survey in the Federal Register on February 28, 2013 (78 FR 13679 through 13680). This survey was approved by OMB on May 14, 2013, and is available on the CMS Web site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/Medicare-Wage-Index-Occupational-Mix-Survey2013.html. The 2013 Occupational Mix Survey Hospital Reporting Form CMS–10079 for the Wage Index Beginning FY 2016 (in Excel format) is available on the CMS Web site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/Medicare-Wage-Index-Occupational-Mix-Survey2013.html. Hospitals were required to submit their completed 2013 surveys to their MACs by July 1, 2014. As with the Worksheet S–3, Parts II and III cost report wage data, we asked our MACs to review or verify data elements in hospitals’ occupational mix surveys that result in certain edit failures.

2. Use of the 2016 Medicare Wage Index Occupational Mix Survey for the FY 2019 Wage Index

As stated earlier, a new measurement of occupational mix is required for FY 2019. The FY 2019 occupational mix adjustment will be based on a new calendar year (CY) 2016 survey. The CY 2016 survey (CMS Form CMS–10079) received OMB approval on September 27, 2016. The final CY 2016 Occupational Mix Survey Hospital Reporting Form is available on the CMS Web site: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/2016-Occupational-Mix-Survey-Hospital-Reporting-Form-CMS-10079-for-the-Wage-Index-Beginning-FY-2019.html. Hospitals were required to submit their completed 2016 surveys to their MACs by July 3, 2017. The preliminary, unaudited CY 2016 survey data were posted on the CMS Web site on July 12, 2017. As with the Worksheet S–3, Parts II and III cost report wage data, as part of the FY 2019 desk review process, the MACs will revise or verify data elements in hospitals’ occupational mix surveys that result in certain edit failures.

3. Calculation of the Occupational Mix Adjustment for FY 2018

In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19903), for FY 2018, we proposed to calculate the occupational mix adjustment factor using the same methodology that we have used since the FY 2012 wage index (76 FR 51582 through 51586) and to apply the occupational mix adjustment to 100 percent of the FY 2018 wage index. Because the statute requires that the Secretary measure the earnings and paid hours of employment by occupational category not less than once every 3 years, all hospitals that are subject to payments under the IPPS, or any hospital that would be subject to the IPPS if not granted a waiver, must complete the occupational mix survey, unless the hospital has no associated cost report wage data that are included in the Fiscal Year Index. For the proposed FY 2018 wage index, we used the Worksheet S–3, Parts II and III wage data of 3,325 hospitals, and we used the occupational mix surveys of 3,128 hospitals for which we also have Worksheet S–3 wage data, which represents a “response rate” of 94 percent (3,128/3,325). For the proposed FY 2018 wage index, we applied proxy data for noncompliant hospitals, new hospitals, or hospitals that submitted erroneous or aberrant data in the same manner that we applied proxy data for such hospitals in the FY 2012 wage index occupational mix adjustment (76 FR 51586).

Comment: One commenter stated that all hospitals should be obligated to submit the occupational mix survey because failure to complete the survey jeopardizes the accuracy of the wage index. The commenter suggested that a penalty be instituted for nonsubmitters. This commenter also requested that, pending CMS’ analysis of the Commuting Based Wage Index and given the Institute of Medicine’s study on geographic variation in hospital wage costs, CMS eliminate the occupational mix survey and the significant reporting burden it creates.

Response: We appreciate the commenter’s concern about the accuracy of the wage index. We have continually requested that all hospitals complete and submit the occupational mix surveys. We did not establish a penalty for hospitals that did not submit the 2013 surveys. However, we are considering future rulemaking various options for ensuring full compliance with future occupational mix surveys. Regarding the commenter’s request that CMS eliminate the occupational mix survey, this survey is necessary to meet the provisions of section 1886(d)(3)(E) of the Act, which requires us to measure the earnings and paid hours of employment by occupational category.

After consideration of the public comments we received, for FY 2018, we are adopting as final our proposal to calculate the occupational mix adjustment factor using the same methodology that we have used since the FY 2012 wage index. For the final FY 2018 wage index, we are using the Worksheet S–3, Parts II and III wage data of 3,336 hospitals, and we are using the occupational mix surveys of 3,138 hospitals for which we also have Worksheet S–3 wage data, which represents a “response rate” of 94 percent (3,138/3,336). We note that, in the proposed rule (82 FR 19903), we stated that we used the occupational mix survey of 3,128 hospitals. The reason for the increase in the number of hospitals from 3,128 to 3,138 is that 10 hospitals that had been deleted from the proposed rule wage index and that are now included in the final rule wage index had acceptable occupational mix surveys to use for the final rule. Therefore, we have included the occupational mix surveys of these 10 additional hospitals to calculate the wage index for this final rule. For the final FY 2018 wage index, we applied proxy data for noncompliant hospitals, new hospitals, or hospitals that submitted erroneous or aberrant data in the same manner that we applied proxy data for such hospitals in the FY 2012 wage index occupational mix adjustment (76 FR 51586). As a result of applying this methodology, the FY 2018 occupational mix adjusted national average hourly wage is $42.0564.

F. Analysis and Implementation of the Occupational Mix Adjustment and the FY 2018 Occupational Mix Adjusted Wage Index

As discussed in section III.E. of the preamble of this final rule, for FY 2018, we are applying the occupational mix adjustment to 100 percent of the FY 2018 wage index. We calculated the occupational mix adjustment using data from the 2013 occupational mix survey data, using the methodology described in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51582 through 51586). Using the occupational mix survey data and applying the occupational mix adjustment to 100 percent of the FY 2018 wage index results in a national average hourly wage of $42.0564.
The FY 2018 national average hourly wage for each occupational mix nursing subcategory as calculated in Step 2 of the occupational mix calculation are as follows:

<table>
<thead>
<tr>
<th>Occupational mix nursing subcategory</th>
<th>Average hourly wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>National RN</td>
<td>$38.86637039</td>
</tr>
<tr>
<td>National LPN and Surgical Technician</td>
<td>22.73227683</td>
</tr>
<tr>
<td>National Nurse Aide, Orderly, and Attendant</td>
<td>15.95002569</td>
</tr>
<tr>
<td>National Medical Assistant</td>
<td>17.9579473</td>
</tr>
<tr>
<td>National Nurse Category</td>
<td>32.856948</td>
</tr>
</tbody>
</table>

The national average hourly wage for the entire nurse category as computed in Step 5 of the occupational mix calculation is $32.856948. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of greater than the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of greater than 1.0. Hospitals with a nurse category average hourly wage (as calculated in Step 4) of less than or equal to the national nurse category average hourly wage receive an occupational mix adjustment factor (as calculated in Step 6) of less than 1.0.

Based on the 2013 occupational mix survey data, we determined (in Step 7 of the occupational mix calculation) that the national percentage of hospital employees in the nurse category is 42.6 percent, and the national percentage of hospital employees in the all other occupations category is 57.4 percent. At the CBSA level, the percentage of hospital employees in the nurse category ranged from a low of 25.7 percent in one CBSA to a high of 73.5 percent in another CBSA.

We compared the FY 2018 occupational mix adjusted wage indexes for each CBSA to the unadjusted wage indexes for each CBSA. As a result of applying the occupational mix adjustment to the wage data, the final wage index values for 222 (54.4 percent) urban areas and 23 (48.9 percent) rural areas will increase. The final wage index values for 110 (27.0 percent) urban areas will increase by greater than or equal to 1 percent but less than 5 percent, and the final wage index values for 6 (1.5 percent) urban areas will increase by 5 percent or more. The final wage index values for 10 (21.3 percent) rural areas will increase by greater than or equal to 1 percent but less than 5 percent, and the final wage index values for 6 (1.5 percent) rural areas will increase by 5 percent or more. However, the final wage index values for 184 (45.1 percent) urban areas and 24 (51.1 percent) rural areas will decrease. The final wage index values for 85 (20.8 percent) urban areas will decrease by greater than or equal to 1 percent but less than 5 percent, and no urban areas’ final wage index value will decrease by 5 percent or more. The final wage index values of 8 (17.0 percent) rural areas will decrease by greater than or equal to 1 percent and less than 5 percent, and no rural areas’ final wage index values will decrease by 5 percent or more. The largest final positive impacts will be 17.4 percent for an urban area and 2.9 percent for a rural area. The largest final negative impacts will be 4.9 percent for an urban area and 2.4 percent for a rural area. Two urban areas’ final wage index, but no rural area wage indexes will remain unchanged by application of the occupational mix adjustment. These results indicate that a larger percentage of urban areas (54.4 percent) will benefit from the occupational mix adjustment than will rural areas (48.9 percent).

G. Application of the Rural, Imputed, and Frontier Floors

1. Rural Floor

Section 4410(a) of Public Law 105–33 provides that, for discharges on or after October 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. This provision is referred to as the "rural floor." Section 3141 of Public Law 111–144 also requires that the national budget neutrality adjustment be applied in implementing the rural floor. Based on the FY 2018 wage index associated with this final rule (which is available via the Internet on the CMS Web site), we estimate that 366 hospitals will receive an increase in their FY 2018 wage index due to the application of the rural floor.

2. Expiration of the Imputed Floor Policy

In the FY 2005 IPPS final rule (69 FR 49109 through 49111), we adopted the “imputed floor” policy as a temporary 3-year regulatory measure to address concerns from hospitals in all-urban States that have argued that they are disadvantaged by the absence of rural hospitals to set a wage index floor for those States. Since its initial implementation, we have extended the imputed floor policy seven times, the last of which was adopted in the FY 2017 IPPS/LTCH PPS final rule and is set to expire on September 30, 2017. (We refer readers to further discussions of the imputed floor in the FY 2014, FY 2015, FY 2016, and FY 2017 IPPS/LTCH PPS final rules (78 FR 50589 through 50590, 79 FR 49969 through 49970, 80 FR 49497 through 49498, and 81 FR 56921 through 56922, respectively) and to the regulations at 42 CFR 412.64(h)(4).) Currently, there are three all-urban States—Delaware, New Jersey, and Rhode Island—with a range of wage indexes assigned to hospitals in these States, including through reclassification or redesignation. (We refer readers to discussions of geographic reclassifications and redesignations in section III.I. of the preamble of this final rule.) In computing the imputed floor for an all-urban State under the original methodology, which was established beginning in FY 2005, we calculated the ratio of the lowest-to-highest CBSA wage index for each all-urban State as well as the average of the ratios of lowest-to-highest CBSA wage indexes of those all-urban States. We then compared the State’s own ratio to the average ratio for all-urban States and whichever is higher is multiplied by the highest CBSA wage index value in the State—the product of which established the imputed floor for the State. As of FY 2012, there were only two all-urban States—New Jersey and Rhode Island—and only New Jersey benefitted under this methodology. Under the previous OMB labor market area delineations, Rhode Island had only one CBSA (Providence-New Bedford-Fall River, RI–MA) and New Jersey had 10 CBSAs. Therefore, under the original methodology, Rhode Island’s own ratio equaled 1.0, and its imputed floor was equal to its original CBSA wage index value. However, because the average ratio of New Jersey and Rhode Island was higher than New Jersey’s own ratio, this methodology provided a benefit for New Jersey, but not for Rhode Island.

In the FY 2013 IPPS/LTCH PPS final rule (77 FR 53368 through 53369), we retained the imputed floor calculated under the original methodology as discussed above, and established an alternative methodology for computing the imputed floor wage index to address the concern that the original imputed floor methodology guaranteed a benefit for one all-urban State with multiple wage indexes (New Jersey) but could not benefit the other all-urban State (Rhode Island). The alternative methodology for calculating the imputed floor was established using data from the application of the rural floor policy for FY 2013. Under the alternative methodology, we first determined the average percentage difference between the pre-reclassified floor area wage index and the post-reclassified, rural floor wage index (without rural floor
budget neutrality applied) for all CBSAs receiving the rural floor. (Table 4D associated with the FY 2013 IPPS/LTCH PPS final rule (which is available via the Internet on the CMS Web site) included the CBSAs receiving a State’s rural floor wage index.) The lowest post-reclassified wage index assigned to a hospital in an all-urban State having a range of such values then is increased by this factor, the result of which establishes the State’s alternative imputed floor. We amended §412.64(h)(4) of the regulations to add new paragraphs to incorporate the finalized alternative methodology, and to make reference and date changes. In summary, for the FY 2013 wage index, we did not make any changes to the original imputed floor methodology at §412.64(h)(4) and, therefore, made no changes to the New Jersey imputed floor computation for FY 2013. Instead, for FY 2013, we adopted a second, alternative methodology for use in cases where an all-urban State has a range of wage indexes assigned to its hospitals, but the State cannot benefit under the original methodology.

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50589 through 50590), we extended the imputed floor policy (both the original methodology and the alternative methodology) for 1 additional year, through September 30, 2014, while we continued to explore potential wage index reforms.

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 49969 through 49970), for FY 2015, we adopted a policy to extend the imputed floor policy (both the original methodology and alternative methodology) for another year, through September 30, 2015, as we continued to explore potential wage index reforms. In that final rule, we revised the regulations at §412.64(h)(4) and (h)(4)(vi) to reflect the 1-year extension of the imputed floor. As discussed in section III.B. of the preamble of that FY 2015 final rule, we adopted the new OMB labor market area delineations beginning in FY 2015. Under the new OMB delineations, Delaware became an all-urban State and was subject to an all-urban floor as well for FY 2015.

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49497 through 49498), for FY 2016, we extended the imputed floor policy (under both the original methodology and the alternative methodology) for 1 additional year, through September 30, 2016. In that final rule, we revised the regulations at §412.64(h)(4) and (h)(4)(vi) to reflect this additional 1-year extension. Similarly, in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56921 through 56922), for FY 2017, we extended the imputed floor policy (under both the original methodology and the alternative methodology) for 1 additional year, through September 30, 2017. In that final rule, we revised the regulations at §412.64(h)(4) and (h)(4)(vi) to reflect this additional 1-year extension.

The imputed floor is set to expire effective October 1, 2017, and in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19905), we proposed to extend the imputed floor policy. In the FY 2005 IPPS final rule (69 FR 49110), we adopted the imputed floor policy for all-urban States under the authority of section 1886(d)(3)(E) of the Act, which gives the Secretary broad authority to adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels by a factor (established by the Secretary).

However, we have expressed reservations about establishment of an imputed floor, considering that the imputed rural floor methodology creates a disadvantage in the application of the wage index to hospitals in States with rural hospitals but no urban hospitals receiving the rural floor (72 FR 24786 and 72 FR 47322). As we discussed in the FY 2008 IPPS final rule (72 FR 47322), the application of the rural and imputed floors requires transfer of payments from hospitals in States with rural hospitals but where the rural floor is not applied to hospitals in States where the rural or imputed floor is applied. For this reason, in the FY 2018 IPPS/LTCH PPS proposed rule, we proposed not to apply an imputed floor to wage index calculations and payments for hospitals in all-urban States for FY 2018 and subsequent years. That is, we proposed that hospitals in New Jersey, Delaware, and Rhode Island (and in any other all-urban State) would receive a wage index that is calculated without applying an imputed floor for FY 2018 and subsequent years. Therefore, under our proposal, only States containing both rural areas and hospitals located in such areas (including any hospital reclassified as rural under the provisions of §412.103 of the regulations) would benefit from the rural floor, in accordance with section 4410 of Public Law 105–33. In addition, we proposed to no longer include the imputed floor as a factor in the national budget neutrality adjustment. Therefore, the proposed wage index and impact tables associated with the FY 2018 IPPS/LTCH PPS proposed rule (which are available via the Internet on the CMS Web site) did not reflect the imputed floor policy, and there was no proposed national budget neutrality adjustment for the imputed floor for FY 2018. We invited public comments on our proposal not to extend the imputed floor for FY 2018 and subsequent years. We are presenting below summaries of the public comments we received and our responses.

Response: We appreciate the positions of commenters that support the proposal not to extend the imputed floor. In the FY 2005 IPPS final rule (69 FR 49110), we adopted the imputed floor policy for all-urban States under the authority of section 1886(d)(3)(E) of the Act, which gives the Secretary broad authority to adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the DRG prospective payment rates for area differences in hospital wage levels by a factor (established by the Secretary). Therefore, we believe that we have the discretion to adopt a policy that would adjust wage indexes in the stated manner. We adopted the imputed floor policy to address concerns from hospitals in all-urban States and subsequently extended it through notice-and-comment rulemaking. While we understand the commenters’ concerns that the application of the imputed floors requires transfer of payments from hospitals in States with rural hospitals but where the rural floor is not applied to hospitals in States where the rural or imputed floor is applied, we also received many comments expressing concern about discontinuing the imputed floor (as further discussed below). As explained further below, we have decided to
temporarily extend the imputed floor for 1 year while we continue to consider the comments we received and assess whether to continue or discontinue the imputed floor policy for the long term.

Comment: Several commenters disagreed with the proposal to allow the imputed floor to expire, and stated that CMS should maintain the status quo and continue to extend the imputed floor in 1-year increments until the entirety of Medicare wage index reform is complete. The commenters stated that, by eliminating the imputed floor, CMS is eliminating only a fraction of the combined payment transfer from the application of the rural and imputed floors. The commenters pointed out that, combined, hospitals in the three all-urban States (New Jersey, Rhode Island, and Delaware) accounted for less than 10 percent of the 397 hospitals nationally that received either the rural or imputed floor last year. The commenters conveyed that CMS indicated in the FY 2014 and FY 2015 IPPS/LTCH PPS final rules, both of which extended the imputed floor for an additional year, that CMS would continue to explore potential wage index reform, and that, as of the FY 2018 IPPS/LTCH PPS proposed rule, such reform has not occurred.

Multiple commenters indicated that eliminating the imputed floor would create the same uneven playing field that existed prior to 2005, in response to which CMS initially established the policy. The commenters stated that the anomaly originally cited by CMS (that is, the all-urban States with predominant labor market areas do not have any type of protection, or “floor,” from declines in their wage index) would exist again if the imputed floor policy were discontinued.

One commenter indicated that the imputed floor is an equitable measure established by CMS which provides relief to hospitals in all-urban States. The commenter stated that this longstanding policy has reduced volatility and increased the equitability of the wage index system. The commenter believed that CMS should not remove the imputed floor from all-urban States. Regarding CMS’ concern with the payment impact of the existing imputed floor policy on States with rural hospitals that do not have urban hospitals that benefit from a rural floor, the commenter believed this should be reviewed as part of a comprehensive Medicare wage index reform. The commenter suggested that CMS consider all recommended changes to the imputed floor as opposed to wage index reform, and that the public have a chance to provide input to CMS prior to finalizing any decisions regarding elimination of the imputed rural floor. The commenter further suggested that if there is a decision made to eliminate the imputed rural floor, the decision should include a 2-year notification period to allow impacted hospitals appropriate planning time. The commenter stated that CMS has extended such advance notice, including changes concerning the wage index, for this purpose in the past.

Several commenters stated they would like to make the imputed floor wage index provision permanent in the FY 2018 IPPS/LTCH PPS final rule. The commenters pointed out that CMS has upheld the imputed floor for the past 12 years as a valuable method of maintaining equitable wage index protections for all-urban States, consistent with those that exist for States with rural areas. The commenters referenced CMS’ explanation from the FY 2005 IPPS final rule (69 FR 49110) for adopting the imputed floor, such as: “because there is no ‘floor’ to protect those hospitals not located in the predominant labor market area from facing continued declines in their wage index, it becomes increasingly difficult for those hospitals to continue to compete for labor.” The commenters stated it is imperative that the imputed floor policy be made permanent to ensure that its State’s hospitals are not artificially disadvantaged simply because of geography and population.

In addition, the commenters stated that there are many Medicare payment programs that redirect scarce Medicare funding to a class of unique hospitals. Not all States have hospitals that benefit from these programs. For example, the commenters stated that CMS makes payments to CAHs at a rate of 101 percent of their cost. The commenters noted that some States do not have any hospitals that qualify as a CAH and do not benefit from this program. The commenters further stated that while CAHs are paid outside the IPPS program, the dollars continue to come from a finite Medicare trust fund. The commenters believed that this represents a transfer of payments from hospitals in States without any CAHs, such as all-urban States, into States with CAHs, similar to the transfer of payments CMS cites as its rationale to discontinue the imputed floor. The commenters indicated that there is precedent for CMS to restore, in the final rule, policies or provisions that were scheduled for elimination or discontinuation in the proposed rule. The commenters pointed out that, in the FY 2012 IPPS/LTCH PPS proposed rule, CMS stated that the imputed floor provision was extended for 2 additional years, through FY 2013 (September 30, 2013).

One commenter supported the alternative methodology for calculating the imputed rural floor in Rhode Island. According to the commenter, the methodology has been used since FY 2013 and has been key for the State’s hospitals and maintaining access to care for residents of Rhode Island. The commenter stated that the alternative methodology for calculating the imputed floor appropriately addresses a hospital wage index reclassification system that does not reflect Rhode Island’s characteristics. The commenter further expressed that the alternative methodology for calculating the imputed rural floor protects its hospitals from falling to some of the lowest reimbursement rates in the country, at the same time while competing with some of the most highly reimbursed urban hospitals. The commenter referenced FY 2013, where a majority of hospitals in Rhode Island reported operating losses and a cumulative operating margin of negative 2.0 percent. The commenter pointed out that since implementing the alternative methodology for calculating the imputed floor, there has been improvement in the overall fiscal condition of Rhode Island’s health care system. According to the commenter, the alternative methodology provided nearly $30 million that hospitals in Rhode Island last year. The commenter was concerned that any discontinuation of this policy would be devastating for a State still facing challenging economic conditions.

Response: While the commenters raised concerns that, if the imputed floor were discontinued, hospitals in all-urban States would again be disadvantaged by the absence of rural hospitals to set a wage index floor for those States, as well as concerns about the fiscal impacts of discontinuing the imputed rural floor, we also have expressed concerns about continuing the imputed floor policy. As we discussed in the FY 2008 IPPS/LTCH PPS final rule (72 FR 47322), the FY 2012 IPPS/LTCH PPS final rule (76 FR 51593), and the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19905), the application of the rural and imputed floors requires transfer of payments from hospitals in States with rural hospitals but where the rural floor is not applied to hospitals in States where the rural or imputed floor is applied. While the three all-urban States may count for a fraction of all States that...
received the rural and imputed floor last year, the imputed rural floor methodology still creates a disadvantage in the application of the wage index to hospitals in States with rural hospitals but no urban hospitals receiving the rural floor. As discussed below, given the many comments we received both in support of and against our proposal to discontinue the imputed floor, we believe it would be appropriate to temporarily extend the imputed floor for an additional year, while we continue to consider these comments and further assess the effects of this policy and whether to continue or discontinue the policy for the long term.

In response to the comment suggesting that we maintain the status quo and continue to extend the imputed floor until wage index reform is complete, we note that section 3137(b) of the Affordable Care Act required the Secretary to submit to Congress a report that includes a plan to reform the Medicare wage index applied under the IPPS. We submitted the report to Congress on April 11, 2012, and have posted the report and other information regarding wage index reform on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html. While in past years we have stated that we continue to explore wage index reforms while extending the imputed floor in increments (for example, 78 FR 50589 through 50590 and 79 FR 49969 through 49970), we note that it has already been many years since our Report to Congress was issued with no new legislation from Congress to comprehensively reform the wage index. Therefore, we do not agree with the commenter that the imputed floor should continue until such time as comprehensive wage index reform may be implemented.

In addition, we note that the imputed floor was originally authorized for only 3 years. In the FY 2005 IPPS final rule (60 FR 49110), we indicated that during the 3 years that the policy is in effect, we would determine whether to make additional changes to the policy or eliminate it. Given that we had indicated in the FY 2005 IPPS final rule that the provision was set to expire after 3 years, and that we have temporarily extended the provision in increments for several subsequent years due to the reasons discussed earlier, we believe that hospitals in all-urban States should not rely on the policy to continue permanently or until wage index reform is implemented. Furthermore, because the policy has been temporarily extended in increments for several years, we believe that hospitals have had ample notice that the policy could ultimately expire, and thus should not rely on a notification period as requested by the commenter. However, we would provide the public a chance to provide input to CMS through the rulemaking process prior to finalizing any decisions regarding elimination of the imputed rural floor.

Finally, regarding the comparison made by commenters between the CAH payment methodology and the imputed floor methodology with respect to the transfer of payments, we disagree with this comparison. Because there is no national budget neutrality requirement relating to CAH payments (as there is with the imputed floor methodology), there is no transfer of payments from hospitals in States without any CAHs to hospitals in States with CAHs, similar to that which exists as a result of the application of the imputed floor. Under sections 1814(l) and 1834(g) of the Act, payments made to CAHs for inpatient and outpatient services are generally based on 101 percent of the reasonable costs of the CAH in providing such services. Reasonable cost is defined in section 1861(v)(1)(A) of the Act and determined in accordance with the regulations under 42 CFR part 413.

Comment: One commenter stated that, in more recent years, the rural floor wage index adjustment has been a cause for concern nationally because urban hospitals in certain States have had their wage indexes set equal to the highest wage index of any rural hospital in their respective State. As a result, the commenter pointed out, hospitals in such States draw Medicare money away from hospitals in other States. The commenter emphasized its previous recommendations, which were also included in the MedPAC’s 2007 Report to Congress, that Congress repeal the existing hospital wage index. The commenter appeared to be requesting support for legislation which would include: Removing the more than 900 individual hospital reclassifications, and other exceptions that occur each year, which are either stipulated in law or implemented through regulation, and also giving the Secretary authority to determine in accordance with the regulations under 42 CFR part 413.

Response: We thank the commenter for its comments and its recommendations regarding modifications to the hospital wage index. However, we note that we do not have authority to repeal or revise the existing wage index statutory provisions, including the rural floor statutory provisions at section 4410(b) of the BBA and section 3141 of the Affordable Care Act.

Comment: One commenter opposed the continued application of the nationwide rural floor budget neutrality adjustment as described in the proposed rule. The commenter recognized that the impetus for the policy is a Federal statute, not regulation. The commenter discussed section 3141 of the Affordable Care Act which established a policy of national budget neutrality for the application of the rural and imputed floors to the Medicare wage index. The commenter conveyed that, coupled with the orchestrated conversion of a single facility in Massachusetts—Nantucket Cottage Hospital—from a CAH to an IPPS hospital, section 3141 of the Affordable Care Act allows hospitals to unfairly manipulate the Medicare payment system and reward hospitals in Massachusetts and a few other States at the expense of most other hospitals across the nation. The commenter stated that the adverse consequences of nationwide rural floor budget neutrality have been recognized and commented upon by CMS, MedPAC, and many others over the past several years. Until this policy is corrected, the commenter stated that the Medicare wage index system cannot possibly accomplish its objective of ensuring that payments for the wage component of labor accurately reflect actual wage costs.

Other commenters stated “that the current application of the rural floor is broken” and referenced how a single hospital can shift such a large amount of payments and have it paid for by many other States in the nation. The commenters explained that section 4410 of the BBA established a rural floor. The commenters noted that, by careful selection of specific hospitals converting from CAHs to hospitals paid under the IPPS, States could game the system and exploit this provision, shifting millions of dollars into that State. These commenters stated that the most notable example of such gaming is a hospital located on Nantucket Island off the coast of Massachusetts. This single hospital sets the wage index for all hospitals in Massachusetts. The commenters stated that, according to
rural floor impact statements provided by CMS in the annual IPPS final rule from FY 2012 through FY 2017, this one hospital will bring a projected $1.3 billion into the commonwealth of Massachusetts. The commenter pointed out that the inequity of this provision recently was highlighted in a March 2017 Office of Inspector General (OIG) report showing how a single hospital overreported dollars and underreported hours, driving up the average hourly wage. According to the commenter, the OIG estimated that this error resulted in more than $133 million in Medicare overpayments to be paid to Massachusetts hospitals. The commenters “urged CMS to establish a national wage index ceiling (for example, 1.33) that can be used to increase the national wage index floor to a reasonable level (for example, .874)”. In addition, the commenters opposed the application of a nationwide rural floor budget neutrality adjustment and requested that CMS overturn section 3141 of the Affordable Care Act and restore integrity to the hospital wage index system.

Response: We thank the commenters for their comments and suggestions. Because there is no national wage index floor, we are not clear what the commenter meant with respect to its request to establish a national wage index ceiling that can be used to increase the national wage index floor to a reasonable level. Therefore, we are unable to respond to this suggestion made by the commenter. As we stated earlier in section 4410 of the BBA requires the application of the rural floor and section 3141 of the Affordable Care Act requires a uniform, national budget neutrality adjustment for the rural floor. We do not have authority to repeal or revise these laws.

Comment: One commenter suggested that CMS use its authority to establish a temporary wage index floor for Puerto Rico in the interest of preventing a decrease in Medicare payments due to Puerto Rico’s lower than national average wages.

Response: We appreciate the suggestions provided by the commenter regarding a temporary wage index floor for Puerto Rico. However, this comment is outside the scope of the proposed rule.

We appreciate the positions of commenters that both supported and opposed the proposal to allow the imputed floor policy to expire. After consideration of public comments we received, we believe extending the imputed floor policy for 1 more year through FY 2018 is appropriate while we continue to consider the many comments we received and whether to continue or discontinue the imputed floor for the long term. Therefore, we are extending the imputed floor policy under both the original methodology and the alternative methodology for an additional year, through September 30, 2018, and will address this issue again in our FY 2019 rulemaking. We also are revising the regulations at §§ 412.64(h)(4) and (h)(4)(vi) to reflect the 1-year extension of the imputed floor, through September 30, 2018.

The wage index and impact tables associated with this FY 2018 IPPS/LTCH PPS final rule (which are available on the Internet via the CMS Web site) reflect the continued application of the imputed floor policy at § 412.64(h)(4) and a national budget neutrality adjustment for the imputed floor for FY 2018. There are 17 hospitals in New Jersey that will receive an increase in their FY 2018 wage index due to the continued application of the imputed floor policy under the original methodology, and 10 hospitals in Rhode Island and 6 hospitals in Delaware that will benefit under the alternative methodology.

3. State Frontier Floor for FY 2018

Section 10324 of Public Law 111–148 requires that hospitals in frontier States cannot be assigned a wage index of less than 1.0000. (We refer readers to the regulations at 42 CFR 412.64(m) and to a discussion of the implementation of this provision in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50160 through 50161).) In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19005), we did not propose any changes to the frontier floor policy for FY 2018. We stated in the proposed rule that 52 hospitals would receive the frontier floor value of 1.0000 for their FY 2018 wage index. These hospitals are located in Montana, Nevada, North Dakota, South Dakota, and Wyoming.

We did not receive any public comments on the application of the State frontier floor for FY 2018. In this final rule, 49 hospitals will receive the frontier floor value of 1.0000 for their FY 2018 wage index. These hospitals are located in Montana, Nevada, North Dakota, South Dakota, and Wyoming.

The areas affected by the final rural and frontier floor policies for the FY 2018 wage index are identified in Table 2 associated with this final rule, which is available via the Internet on the CMS Web site.

H. FY 2018 Wage Index Tables

In the FY 2016 IPPS/LTCH PPS final rule (80 FR 49498 and 49807 through 49808), we finalized a proposal to streamline and consolidate the wage index tables associated with the IPPS proposed and final rules for FY 2016 and subsequent fiscal years. Prior to FY 2016, the wage index tables had consisted of 12 tables (Tables 2, 3A, 3B, 4A, 4B, 4C, 4D, 4E, 4F, 4J, 9A, and 9C) that were made available via the Internet on the CMS Web site. Effective beginning FY 2016, with the exception of Table 4E, we streamlined and consolidated 11 tables (Tables 2, 3A, 3B, 4A, 4B, 4C, 4D, 4F, 4J, 9A, and 9C) into 2 tables (Tables 2 and 3). We refer readers to section VI. of the Addendum to this final rule for a discussion of the final wage index tables for FY 2018.

1. Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications

1. General Policies and Effects of Reclassification and Redesignation

Under section 1886(d)(10) of the Act, the Medicare Geographic Classification Review Board (MGCRB) considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. Hospitals must apply to the MGCRB to reclassify not later than 13 months prior to the start of the fiscal year for which reclassification is sought (usually by September 1). Generally, hospitals must be proximate to the labor market area to which they are seeking reclassification and must demonstrate characteristics similar to hospitals located in that area. The MGCRB issues its decisions by the end of February for reclassifications that become effective for the following fiscal year (beginning October 1). The regulations applicable to reclassifications by the MGCRB are located in 42 CFR 412.230 through 412.280. (We refer readers to a discussion in the FY 2002 IPPS final rule (66 FR 39874 and 39875) regarding how the MGCRB defines mileage for purposes of the proximity requirements.) The general policies for reclassifications and redesignations and the policies for the effects of hospitals’ reclassifications and redesignations on the wage index are discussed in the FY 2012 IPPS/LTCH PPS final rule for the FY 2012 final wage index (76 FR 51595 and 51596). In addition, in the FY 2012 IPPS/LTCH PPS final rule, we discussed the effects on the wage index of urban hospitals reclassifying to rural areas under 42 CFR 412.103. Hospitals that are geographically located in States without any rural areas are ineligible to apply for rural reclassification in accordance with the provisions of 42 CFR 412.103.

On April 21, 2016, we published an interim final rule with comment period
are 374 hospitals approved for wage index calculations. We refer readers to § 412.273, hospitals that have been redesignated/reclassified may be considered rural under section 1886(d) of the Act and for other purposes. We discussed that when there is both a § 412.103 redesignation and an MGCRB reclassification, the MGCRB reclassification controls for wage index calculation and payment purposes. We exclude hospitals with § 412.103 redesignations from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area. That is, if an application for urban reclassification through the MGCRB is approved, and is not withdrawn or terminated by the hospital within the established timelines, we consider the hospital’s geographic CBSA and the urban CBSA to which the hospital is reclassified under the MGCRB for the wage index calculation. We refer readers to the April 21, 2016 IFC (81 FR 23428 through 23438) and the FY 2017 IPPS/ LTCH PPS final rule (81 FR 56922 through 56930) for a full discussion of the effect of simultaneous reclassifications under both the § 412.103 and the MGCRB processes on wage index calculations.

2. MGCRB Reclassification and Redesignation Issues for FY 2018

a. FY 2018 Reclassification Requirements and Approvals

As previously stated, under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in regulations under 42 CFR 412.230 through 412.280.

At the time this final rule was constructed, the MGCRB had completed its review of FY 2018 reclassification requests. Based on such reviews, there are 374 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2018. Because MGCRB wage index reclassifications are effective for 3 years, for FY 2018, hospitals reclassified beginning in FY 2016 or FY 2017 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 245 hospitals approved for wage index reclassifications in FY 2016 that will continue for FY 2018, and 246 hospitals approved for wage index reclassifications in FY 2017 that will continue for FY 2018. Of all the hospitals approved for reclassification for FY 2016, FY 2017, and FY 2018, based upon the review at the time of this final rule, 865 hospitals are in a MGCRB reclassification status for FY 2018.

Under the regulations at 42 CFR 412.273, hospitals that have been reclassified by the MGCRB are permitted to withdraw their applications if the request for withdrawal is received by the MGCRB within 45 days of the publication of CMS’ annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates for the fiscal year for which the application has been filed. (We note that in section III.I.4. of the preamble of this final rule, we did not finalize our proposal to revise the above described regulation text to specify that written notice to the MGCRB must be provided within 45 days from the date of public display of the proposed rule at the Office of the Federal Register.) For information about withdrawing, terminating, or canceling a previous withdrawal or termination of a 3-year reclassification for wage index purposes, we refer readers to § 412.273, as well as the FY 2002 IPPS final rule (66 FR 39887 through 39888) and the FY 2003 IPPS final rule (67 FR 50065 through 50066). Additional discussion on withdrawals and terminations, and clarifications regarding reinstating reclassifications and “fallback” reclassifications were included in the FY 2008 IPPS final rule (72 FR 47333).

Changes to the wage index that result from withdrawals of requests for reclassification, terminations, wage index corrections, appeals, and the Administrator’s review process for FY 2018 are incorporated into the wage index values published in this FY 2018 IPPS/LTCH PPS final rule. These changes affect not only the wage index value for specific geographic areas, but also the wage index value for redesignated/reclassified hospitals receive; that is, whether they receive the wage index that includes the data for both the hospitals already in the area and the redesignated/reclassified hospitals. Further, the wage index value for the area from which the hospitals are redesignated/reclassified may be affected.

Comment: MedPAC and other commenters stated that the increasing number of wage index reclassifications, along with other wage index exceptions, raises questions regarding whether the current wage index is equitably adjusting payments for local input costs of providing patient care. One commenter stated that the increasing number of hospitals that reclassify is a “clear indication of the broken system” that needs to be replaced; another commenter requested general wage index reform. MedPAC reiterated that recommendations included in the Commission’s 2007 Report to Congress and similar recommendations made by the Institute of Medicine would eliminate the need for the system of geographic reclassification and exceptions that is currently in place. Specifically, MedPAC recommended that the Congress repeal the existing hospital wage index, remove the more than 900 individual hospital reclassifications and other exceptions that occur each year, and give the Secretary the authority to establish a new wage index system.

Response: We understand the commenters’ concerns regarding the high volume of MGCRB reclassifications. We appreciate MedPAC’s recommendation to repeal the current wage index statute. However, repealing the wage index statute would require legislative action by Congress. Specifically, section 1886(d)(3)(E) of the Act requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts 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. We also appreciate the other commenters’ requests for wage index reform. We will take the requests into consideration and may address this issue again in future rulemaking.

Applications for FY 2019 reclassifications are due to the MGCRB by September 1, 2017 (the first working day of September 2017). We note that this is also the deadline for canceling a previous wage index reclassification, withdrawal, or termination under 42 CFR 412.273(d). Applications and other information about MGCRB

Under previous regulations at 42 CFR 412.256(a)(1), applications for reclassification were required to be mailed or delivered to the MGCRB, with a copy to CMS, and were not allowed to be submitted through the facsimile (FAX) process or by other electronic means. Because we believed this previous policy was outdated and overly restrictive and to promote ease of application for FY 2018 and subsequent years, in the FY 2017 IPPS/LTCH PPS final rule (81 FR 59628), we revised this policy to require applications and supporting documentation to be submitted via the method prescribed in instructions by the MGCRB, with an electronic copy to CMS. We revised § 412.256(a)(1) to specify that an application must be submitted to the MGCRB according to the method prescribed by the MGCRB, with an electronic copy of the application sent to CMS. We specified that CMS copies should be sent via email to wageindex@cms.hhs.gov.

In the FY 2017 IPPS/LTCH PPS final rule (81 FR 59628), we reiterated that MGCRB application requirements will be published separately from the rulemaking process, and paper applications will likely still be required. The MGCRB makes all initial determinations for geographic reclassification requests, but CMS requests copies of all applications to assist in verifying a reclassification status during the wage index development process. We stated that we believed that requiring electronic versions would better aid CMS in this process, and would reduce the overall burden upon hospitals. We did not receive any public comments on the requirements for applications for FY 2019 reclassifications.

b. Extension of PRA Information Collection Requirement Approval for MGCRB Applications

As stated earlier, under section 1886(d)(10) of the Act, the MGCRB considers applications by hospitals for geographic reclassification for purposes of payment under the IPPS. The specific procedures and rules that apply to the geographic reclassification process are outlined in the regulations under 42 CFR 412.230 through 412.280. The information collection requirements for the MGCRB procedures and criteria and supporting regulations in 42 CFR 412.256 subject to the Paperwork Reduction Act provisions were approved under OMB Control Number 0938–0573 and expired on February 28, 2017. As discussed in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19906 and 19907), an extension of the collection was required in time for applications due to the MGCRB by September 1, 2017 for FY 2019 reclassifications. A request for an extension of the information collection requirements for the MGCRB procedures and criteria and supporting regulations received approval by OMB on June 30, 2017, and can be accessed at: https://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201612-0938-023.

c. Deadline for Submittal of Documentation of Sole Community Hospital (SCH) and Rural Referral Center (RRC) Classification Status to the MGCRB

The regulations at 42 CFR 412.230(a)(3), consist with section 1886(d)(10)(I)(III) of the Act, set special rules for SCHs and RRCs reclassifying under the MGCRB. Specifically, a hospital that is an SCH or an RRC, or both, does not have to demonstrate a close proximity to the area to which it seeks redesignation. If a hospital that is an RRC or an SCH, or both, qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital. If the hospital is closer to another urban area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area.

In addition, section 1886(d)(10)(D)(iii) of the Act, as implemented in the regulations at § 412.230(d)(3)(i), provides an exception to certain wage comparison criteria for RRCs and former RRCs reclassifying under the MGCRB. Under § 412.230(d)(3)(i), if a hospital was ever an RRC, it does not have to demonstrate that it meets the average hourly wage criterion at § 412.230(d)(1)(iii), which would require that the hospital’s average hourly wage be at least 106 percent for rural hospitals and at least 108 percent for urban hospitals of the average hourly wage of all other hospitals in the area in which the hospital is located. Rather, as codified at § 412.230(d)(3)(ii), consistent with our authority under section 1886(d)(10)(D)(ii) of the Act, if a hospital was ever an RRC, it is required to meet only the criterion for rural hospitals at § 412.230(d)(1)(iv), which requires that the hospital’s average hourly wage is equal to at least 82 percent of the average hourly wage of hospitals in the area to which it seeks redesignation. The regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify as an RRC.

For a hospital to use the special rules at § 412.230(a)(3) for SCHs and RRCs, the existing regulation at § 412.230(a)(3) requires that the hospital be an active SCH or an RRC as of the date of the MGCRB’s review. In addition, for a hospital to use the RRC exceptions at § 412.230(d)(3), a hospital must either be an RRC at the time of the MGCRB’s review or have previously been classified as an RRC in the past. In other words, under the existing regulations, if a hospital is approved by CMS as an SCH or an RRC but the approval is not yet effective at the time of the MGCRB’s review, the hospital’s status as an SCH or an RRC would not be considered in the MGCRB’s decision, unless the hospital was a former RRC, in which case it would be allowed to use the RRC exceptions at § 412.230(d)(3).

The MGCRB currently accepts supporting documentation of SCH and RRC classification (including, but not limited to, the CMS approval letter) up until the date of MGCRB’s review, which varies annually. A hospital may apply at any time for classification as an SCH or an RRC and the classification is effective 30 days after the date of CMS’ written notification of approval, in accordance with § 412.92. Considering that the MGCRB usually meets in early February, hospitals typically seek to obtain SCH approval letters no later than early January (30 days prior to the date of MGCRB review) for the SCH status to be effective as of the date of the MGCRB’s review. However, consistent with section 1886(d)(5)(C)(I) of the Act, a hospital must submit its application for RRC status during the quarter before the first quarter of the hospital’s cost reporting period, to be effective at the beginning of the next cost reporting period. The existing regulation at § 412.230(a)(3), combined with the statutory timeframe for RRC classification, require that a hospital’s cost reporting period as an RRC begin on or before the date of the MGCRB’s review in order to be considered an RRC by the MGCRB for purposes of the special rules under § 412.230(a)(3). Similarly, in order to use the RRC exceptions under § 412.230(d)(3), a hospital’s RRC status must be effective on the date of the MGCRB’s review, or (unlike the case of the MGCRB) the hospital must have had RRC status in the past. For example, a hospital with a cost
reporting period beginning in March would obtain RRC approval, in accordance with the statutory timeframe, during the December through February quarter (potentially before the MGCRB’s decision), but would not be considered an RRC by the MGCRB because the approval would not be effective until the next cost reporting period begins in March, after the MGCRB’s decision (unless, for purposes of § 412.230(d)(3), the hospital had previously been classified as an RRC in the past).

As discussed in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19907 through 19908), the current practice of accepting documentation of SCH and RRC approvals up until the date of MGCRB review does not ensure adequate time for the MGCRB to include SCH and RRC approvals in its review.

We noted in the proposed rule that many hospitals now obtain SCH or RRC status based on a § 412.103 reclassification in order to reclassify using the special rules and exceptions under the MGCRB following the April 21, 2016 IFC (81 FR 23428), which revised the regulations to allow hospitals nationwide to reclassify based on acquired rural status. We stated in the proposed rule that we believe the additional volume of SCH and RRC approvals submitted to the MGCRB increases the need for an earlier deadline for documentation of SCH and RRC classifications to be submitted to the MGCRB for purposes of the special rules at § 412.230(a)(3) and the exception at § 412.230(d)(3). In addition, because the date of the MGCRB’s review varies annually, we stated in the proposed rule that we believe hospitals would benefit from the certainty of a set date by which documentation of RRC or SCH status must be submitted in order to have that status considered by the MGCRB under § 412.230(a)(3) and § 412.230(d)(3).

Therefore, to ensure sufficient time for the MGCRB to include SCH and RRC status approvals in its review and increase clarity for hospitals, we are allowing as much time and flexibility as possible for hospitals applying for RRC status to be considered RRCs by the MGCRB, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19907 through 19908), we proposed to revise the regulations at § 412.230(a)(3) and § 412.230(d)(3). We proposed to revise the regulations at § 412.230(a)(3) in two ways. First, we proposed to establish a deadline of the first business day after January 1 for hospitals to submit to the MGCRB documentation of SCH or RRC status approval (the CMS approval letter) in order to take advantage of the special rules under § 412.230(a)(3) when reclassifying under the MGCRB. We stated that we believe that this date of the first business day after January 1 would provide sufficient time for the MGCRB to consider documentation of SCH or RRC status approval in its review, without negatively affecting hospitals seeking to obtain SCH or RRC status, as explained below. Second, we proposed to revise § 412.230(a)(3) to require hospitals to submit documentation of SCH or RRC status approval (the CMS approval letter) by the deadline above, rather than to have SCH or RRC classification that is effective as of the date of MGCRB review, in order to use the special rules for SCHs and RRCs under § 412.230(a)(3). Likewise, we proposed to revise the regulations at § 412.230(d)(3) so that a hospital qualifies for these RRC exceptions if it was ever approved as a RRC. In other words, the exceptions at § 412.230(d)(3) would continue to apply to hospitals that were ever classified as RRCs, but consistent with our authority under section 1886(d)(10)(D)(i) of the Act to publish guidelines to be utilized by the MGCRB, we proposed to also extend these exceptions to hospitals that were ever approved as RRCs. Similar to § 412.230(a)(3), we also proposed to establish a deadline of the first business day after January 1 for hospitals to submit documentation of RRC status approval (the CMS approval letter) in order to take advantage of the exception under § 412.230(d)(3) when reclassifying under the MGCRB.

We stated in the proposed rule that these proposed revisions would more appropriately allow the MGCRB to prepare for its review and would allow hospitals obtaining SCH or RRC status approval as late as the first business day after January 1 to have these classifications considered by the MGCRB under § 412.230(a)(3) and (d)(3), irrespective of the effective date of these classifications. We stated that these proposals would not substantially affect hospitals seeking SCH classification for purposes of reclassifying under the MGCRB because a hospital must obtain SCH status approval by early January under the existing regulation in order to have that classification effective 30 days later by the time the Board usually meets in early February. For hospitals seeking RRC classification for purposes of reclassifying under the MGCRB, however, the proposed deadline of no later than the first business day after January 1, in concert with our proposal to accept documentation of approval (the CMS approval letter) instead of requiring the hospital to be an active RRC at the time of the MGCRB review in order to take advantage of the special rules and exceptions under § 412.230(a)(3) and (d)(3), is beneficial. We stated that the proposed revisions to the regulations at § 412.230(a)(3) and (d)(3) would accommodate more hospitals with various cost reporting year ends by allowing hospitals with cost reporting periods beginning soon after the MGCRB’s decision to have RRC status approvals included in the MGCRB’s review. Under the proposals, the MGCRB would consider an RRC status approval obtained as late as the first business day after January 1 instead of requiring the RRC classification to be effective by the time the Board meets, which has been in February in past years. For example, under our proposal, a hospital with a cost reporting period beginning as late as March, which could apply for RRC status approval in accordance with the statutory timeframe starting in December, would be considered an RRC by the MGCRB if it submits documentation of approval of RRC status no later than the first business day after January 1, even though the approval would not be effective until after the MGCRB’s decision.

For the reasons discussed earlier, consistent with our authority under section 1886(d)(10)(D)(i) of the Act to publish guidelines to be utilized by the MGCRB, we proposed to revise the regulations at § 412.230(a)(3) to specify that, to be redesignated under the special rules in that paragraph, the hospital must submit documentation of the approval of SCH or RRC status to the MGCRB no later than the first business day after January 1. In addition, we proposed conforming revisions to paragraphs (a)(3)(i) and (ii) of § 412.230 to reflect that these paragraphs apply to hospitals with SCH and RRC approval as specified above (and not only effective status). Specifically, we proposed to revise § 412.230(a)(3)(i) to specify that a hospital that is approved as an RRC or SCH, or both, does not have to demonstrate a close proximity to the area to which it seeks redesignation; and to revise § 412.230(a)(3)(ii) to specify that this paragraph applies if a hospital that is approved as an RRC or SCH, or both, qualifies for urban redesignation. We note that we proposed additional revisions to § 412.230(a)(3)(ii) as discussed in section III.I.2.d. of the preamble of the proposed rule and this final rule.
Act to publish guidelines to be utilized by the MGCRB, we proposed to revise the regulations at § 412.230(d)(3). Specifically, we proposed to add introductory language to § 412.230(d)(3) to specify that for the exceptions in this paragraph to apply, the hospital must submit documentation of the approval of RRC status (current or past) to the MGCRB no later than the first business day after January 1. In addition, we proposed to revise § 412.230(d)(3)(i) to specify that if a hospital was ever approved as an RRC, it does not have to demonstrate that it meets the average hourly wage criterion set forth in § 412.230(d)(1)(iii); and to revise § 412.230(d)(3)(ii) to specify that if a hospital was ever approved as an RRC, it is required to meet only the criterion that applies to rural hospitals under § 412.230(d)(1)(iv), regardless of its actual location in an urban or rural area.

We invited public comments on these proposals.

Comment: One commenter did not disagree with the establishment of a deadline for submitting documentation of SCH and RRC status to the MGCRB because the commenter believed that the proposed deadline will provide clarity to hospitals, the MGCRB, and CMS in this process and will ensure adequate time for the MGCRB to include SCH and RRC approvals in its review. However, the commenter urged CMS to also establish a deadline of 30 days from receipt of request for SCH or RRC status for CMS to respond. The commenter pointed out that while the regulations specify effective dates for SCH and RRC status, the regulations do not set a timeframe by which CMS must rule on an SCH or RRC request. Therefore, the commenter stated, a hospital may face uncertainty that CMS will respond to its request for SCH or RRC status by the first business day in January, in time to submit to the MGCRB. According to the commenter, absent a defined timeframe within which CMS must respond to hospitals’ requests for SCH and RRC status, hospitals face a disadvantage in complying with the deadline of the first business day after January 1 for submitting documentation of SCH and RRC status to the MGCRB.

Response: We appreciate the commenter’s support for our effort to provide clarity to all parties. The commenter is correct that the regulations do not set a timeframe by which CMS must rule on an SCH or RRC request. However, under section 1886(d)(5)(C)(i) of the Act, CMS must make a final determination on a request for SCH status within 60 days after the date the request was submitted. We agree with the commenter that, depending on the timeframe within which SCH and RRC status approvals are issued, hospitals may face a disadvantage in complying with the proposed deadline to submit SCH and RRC documentation to the MGCRB. Thus, we believe that further consideration is needed regarding the appropriate timeframe for such approvals to avoid the disadvantage cited by the commenter. Accordingly, for FY 2018, we are not finalizing the proposed deadline of the first business day after January 1 for hospitals to submit documentation of SCH and RRC status to the MGCRB. We may revisit the deadline for submitting documentation to the MGCRB in future rulemaking to give us the opportunity to further consider the timeframe for CMS to respond to applications for SCH and RRC status.

However, we believe that the proposal to require that a hospital must be approved for SCH or RRC status, rather than have active RRC or SCH status, in order to use the special rules for SCHs and RRCs and exceptions for RRCs under §§ 412.230(a)(3) and (d)(3), remains beneficial for hospitals. While we are still concerned with providing the MGCRB sufficient time to include SCH and RRC status approval in its review, we believe finalizing our proposal to require that a hospital be approved for SCH or RRC status, rather than have active RRC or SCH status, in order to use the special rules for SCHs and RRCs and exceptions for RRCs under §§ 412.230(a)(3) and (d)(3), is appropriate because it provides flexibility and accommodates more hospitals. Therefore, as discussed further below, we are finalizing our proposed changes to the regulations to specify that a hospital must be approved as an SCH or RRC at the date of the MGCRB’s review, irrespective of effective date of SCH or RRC status. While documentation of SCH and RRC status approval may include the CMS approval letter, we are clarifying that other documents could also serve this purpose as determined by the MGCRB, and that documentation in addition to the CMS approval letter may be required. Questions about acceptable supporting documentation should be directed to the MGCRB at 410–766–1174.

After consideration of the public comment we received, for the reasons discussed earlier, we are not finalizing our proposed revisions to the regulations at §§ 412.230(a)(3) and (d)(3) to establish a deadline of the first business day after January 1 for hospitals to submit documentation of SCH and RRC status approval to the MGCRB. However, consistent with our authority under section 1886(d)(10)(D)(i) to publish guidelines to be used by the MGCRB, for the reasons discussed earlier and in the FY 2018 IPPS/LTCH PPS proposed rule, we are finalizing our proposal that a hospital must be approved for SCH or RRC status, rather than have active SCH or RRC status in order to use the special rules for SCHs and RRCs and exceptions for RRCs under §§ 412.230(a)(3) and (d)(3). Specifically, we are revising the regulation at § 412.230(a)(3) to specify that, to be redesignated under the special rules in this paragraph, a hospital must be approved as an SCH or RRC as of the date of the MGCRB’s review. In addition, we are finalizing, without modification, our proposed revisions to paragraphs (a)(3)(i) and (ii) of § 412.230 to reflect that these paragraphs apply to hospitals with SCH and RRC approval (and not only effective status). Specifically, we are revising § 412.230(a)(3)(i) to specify that a hospital that is approved as an RRC or SCH, or both, qualifies for urban redesignation. We note that we are making additional revisions to § 412.230(a)(3)(ii) as discussed in section III.L.2.d. of the preamble of this final rule.

In addition, for the reasons discussed earlier, while we are not finalizing our proposed introductory language to § 412.230(d)(3), we are finalizing our proposed revisions to paragraphs (d)(3)(i) and (ii) of § 412.230, without modification, to reflect that these paragraphs apply to hospitals with RRC approval (and not only effective status). Specifically, we are revising § 412.230(d)(3)(i) to specify that if a hospital was ever approved as an RRC, it does not have to demonstrate that it meets the average hourly wage criterion set forth in § 412.230(d)(1)(iii); and revising § 412.230(d)(3)(ii) to specify that, if a hospital was ever approved as an RRC, it is required to meet only the criterion that applies to rural hospitals under § 412.230(d)(1)(iv), regardless of its actual location in an urban or rural area.

d. Clarification of Special Rules for SCHs and RRCs Reclassifying to Geographic Home Area

Following issuance of the April 21, 2016 IFC (81 FR 23428), hospitals may simultaneously be redesignated as rural under § 412.103 and reclassified under the MGCRB. An urban hospital seeking
benefits of rural status, such as rural payments for disproportionate share hospitals (DSH) and eligibility for the 340B Drug Pricing Program administered by HRSA, without the associated rural wage index may be redesignated as rural under §412.103 (if it meets the applicable requirements) and also reclassify under the MGCRB to an urban area (again, if it meets the applicable requirements). As discussed earlier and in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56922 through 56927), a hospital with simultaneous §412.103 redesignation and MGCRB reclassification receives the wage index of the CBSA to which it is reclassified under the MGCRB while still maintaining §412.103 reclassified rural status for other purposes.

Hospitals that are redesignated under §412.103 may seek MGCRB reclassification to their geographic home area. Such hospitals automatically meet the criteria for proximity, but must still demonstrate that they meet the wage comparison requirements using the criteria for rural hospitals at §412.230(d). Specifically, a hospital with a §412.103 redesignation seeking reclassification under the MGCRB must demonstrate that its average hourly wage is at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located in accordance with §412.230(d)(1)(iii), and the hospital’s average hourly wage is equal to at least 82 percent of the average hourly wage of hospitals in the area to which it seeks redesignation, in accordance with §412.230(d)(1)(iv). In this case, both the area in which the hospital is located and the area to which it seeks redesignation are the geographic home area. If a hospital with a §412.103 rural redesignation also has SCH or RRC status based on its acquired rural status, the hospital may use the exception at §412.230(d)(3) for SCHs and RRCs seeking reclassification under the MGCRB and the special reclassification rules at §412.230(a)(3) for SCHs and RRCs. Specifically, under §412.230(d)(3)(iii), an RRC or former RRC must only demonstrate that its average hourly wage is equal to at least 82 percent of the geographic home area or to the closest area outside of its geographic home area. The proximity requirement is waived under §412.230(a)(3) for SCHs and RRCs, and SCHs and RRCs are redesignated to the urban area that is closest to the hospital (or if the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural area or the closest urban area).

As discussed in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19908 through 19909), the existing regulation at §412.230(a)(3)(ii) states that if an SCH or RRC qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital. As currently worded, we believe it is unclear how this provision would apply to a hospital with a §412.103 rural redesignation and SCH or RRC status. If the urban area that is closest to the hospital is interpreted to mean the hospital’s geographic home area, a hospital with a §412.103 rural redesignation and SCH or RRC status would not be able to reclassify to any closer urban area outside of the hospital’s geographic home area, but would only be allowed to reclassify to the geographic home area. Alternatively, if the urban area that is closest to the hospital is interpreted to mean the closest urban area to the hospital’s geographic home area, the hospital would seem to be precluded from reclassifying under the MGCRB to its geographic home area. In other words, under the existing language of this regulation, the urban area that is closest to the hospital can either be interpreted to mean the hospital’s geographic home area, or the closest area outside of the hospital’s geographic home area. In the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19909), we stated that we believe it would be appropriate to revise §412.230(a)(3)(ii) to clarify that it allows for redesignation to either the hospital’s geographic home area or to the closest area outside of the hospital’s geographic home area. Prior to the April 21, 2016 interim final rule with comment period (IFC) (81 FR 23428), it was not possible for a hospital with a §412.103 rural redesignation to seek reclassification to its geographic home area or to the closest area outside its geographic home area under the MGCRB because dual reclassification under §412.103 and under the MGCRB was not permitted. However, the IFC allowed dual §412.103 and MGCRB reclassifications, so a hospital may now reclassify to a rural area under §412.103 and then reclassify back to its geographic home area or another area under the MGCRB for wage index purposes (if it meets all criteria). Thus, depending on the circumstances, a hospital may seek to reclassify to either its geographic home area or the closest area outside of its geographic home area.

Therefore, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19909), we proposed to revise the regulations at §412.230(a)(3)(ii) to clarify that a hospital with a §412.103 rural redesignation and SCH or RRC approval may reclassify under the MGCRB to its geographic home area or to the closest area outside of its geographic home area. Specifically, we proposed to revise §412.230(a)(3)(ii) to state that if a hospital that is approved as an RRC or SCH, or both, qualifies for urban redesignation, it is redesignated to the urban area that is closest to the hospital or to the hospital’s geographic home area. If the hospital is closer to another rural area than to any urban area, it may seek redesignation to either the closest rural or the closest urban area.

Comment: Two commenters supported the clarification in the proposed rule and stated that it provides clarity with respect to SCHs and RRCs with §412.103 rural redesignation and MGCRB approval applying for MGCRB reclassification based on special access rules. In addition, the commenters stated that the proposed regulatory revision is consistent with the regulations, past administrative decisions, and CMS’ policy of allowing a hospital with §412.103 rural redesignation to reclassify under the MGCRB.

Response: We appreciate the commenters’ support.

After consideration of the public comments we received, for the reasons discussed earlier and in the FY 2018 IPPS/LTCH PPS proposed rule, we are finalizing, without modification, our proposed revision of §412.230(a)(3)(ii) to clarify that a hospital with a §412.103 rural redesignation and SCH or RRC approval may reclassify under the MGCRB to its geographic home area or to the closest area outside of its geographic home area.

3. Redesignations Under Section 1886(d)(8)(B) of the Act

In the FY 2012 IPPS/LTCH PPS final rule (76 FR 51599 through 51600), we adopted the policy that, beginning with FY 2012, an eligible hospital that waives its Lugar status in order to receive the out-migration adjustment has effectively waived its deemed urban status and, thus, is rural for all purposes under the IPPS effective for the fiscal year in which the hospital receives the out-migration adjustment. In addition, we adopted a minor procedural change that would allow a Lugar hospital that qualifies for and accepts the out-migration adjustment (through written notification to CMS within 45 days from
the publication of the proposed rule) to
to waive its urban status for the full 3-year
period for which its out-migration
adjustment is effective. (We note that, in
section III.14. of the preamble of this
final rule, we finalized a policy revision
to require a Lugar hospital that qualifies
for and accepts the out-migration
adjustment, or that no longer wishes to
accept the out-migration adjustment and
instead elects to return to its deemed
urban status, to notify CMS within 45
days from the date of public display of
the proposed rule at the Office of the
Federal Register.) By doing so, such a
Lugar hospital would no longer be
required during the second and third
years of eligibility for the out-migration
adjustment to advise us annually that it
prefers to continue being treated as rural
and receive the out-migration
adjustment. In the FY 2017 IPPS/LTCH
PPS final rule (81 FR 56930), we again
clarified that such a request to waive
Lugar status, received within 45 days of
the publication of the proposed rule, is
valid for the full 3-year period for which
the hospital’s out-migration adjustment
is effective. We further clarified that if
a hospital wishes to reinstate its urban
status for any fiscal year within this 3-
year period, it must send a request to
CMS within 45 days of publication of
the proposed rule for that particular
fiscal year. We indicated that such
reinstatement requests may be sent
electronically to wageindex@
cms.hhs.gov. We wish to further clarify
that both requests to waive and to
reinstate “Lugar” status may be sent to
this mailbox. To ensure proper
accounting, we request hospitals to
include their CCN, and either “waive
Lugar” or “reinstate Lugar”, in the
subject line of these requests. As noted
earlier, and discussed further in section
III.14. of this final rule, we are finalizing
our proposal to revise these notification
timeframes, effective October 1, 2017, to
45 days from the date of public display
of the annual proposed rule.
We did not receive any public
comments on this subject area in the
proposed rule.

4. Changes to the 45-Day Notification
Rules

Certain Medicare regulations specify
that hospitals have 45 days from the
publication of the annual proposed rule
for the hospital inpatient prospective
payment system to inform CMS or the
MCRB of certain requested
reclassification/redesignation and out-
migration adjustment changes relating
to the development of the hospital wage
index. Specifically, 42 CFR
412.64(i)(3)(iii), which provides for
adjusting the wage index to account for
commuting patterns of hospital workers,
and 42 CFR 412.211f(3)(i)(ii), which
provides for the same adjustment for
hospitals in Puerto Rico, state that a
hospital may waive the application of
this wage index adjustment by notifying
CMS in writing within 45 days after the
publication of the annual notice of
proposed rulemaking for the hospital
inpatient prospective payment system.

In the FY 2018 IPPS/LTCH
PPS proposed rule (82 FR 19010), we
proposed to revise the above described
regulation text and policies as follows to
specify that written notification to CMS
or the MCRB (as applicable) must be
provided within 45 days from the date
of public display of the annual proposed
rule for the hospital inpatient
prospective payment system at the
Office of the Federal Register. We stated
that we believe that the public has
access to the necessary information from
the date of public display of the
proposed rule at the Office of the
Federal Register and on its Web site in
order to make the decisions at issue.
Specifically, we proposed to revise the
regulations at §412.64(i)(3)(iii) and
§412.211f(3)(iii) to provide that a
hospital may waive the application of
the wage index adjustment by notifying
CMS within 45 days of the date of
public display of the annual notice of
proposed rulemaking for the hospital
inpatient prospective payment system at
the Office of the Federal Register.
In addition, we proposed to revise the
regulations at §412.273(c)(1)(ii) and
(c)(2) to provide that a request for
withdrawal or termination of an MCRB
reclassification must be received by the
MCRB within 45 days of the date of
public display at the Office of the
Federal Register of the annual notice of
proposed rulemaking concerning
changes to the inpatient hospital
prospective payment system and
proposed payment rates for the fiscal
year for which the application has been
filed (in the case of a withdrawal under
§412.273(c)(1)(ii), or for the fiscal year
for which the termination is to apply
(under §412.273(c)(2)). We also
proposed to revise our policy outlined
in the FY 2012 IPPS/LTCH PPS final
rule (76 FR 51599 through 51600) (as
described above) to require a Lugar
hospital that qualifies for and accepts
the out-migration adjustment, and that no
longer wishes to accept the out-
migration adjustment and instead elects
to return to its deemed urban status to
notify CMS within 45 days from the
date of public display of the IPPS
proposed rule at the Office of the
Federal Register. We invited public
comments on these proposals.
We did not receive any public
comments on the proposed revisions to
§412.64(i)(3)(iii) or §412.211f(3)(iii)
with regard to the time period for
hospitals to notify CMS of decisions
about the out-migration adjustment, or
with regard to the proposed revision to
the policy outlined in the FY 2012 IPPS/
LTCH PPS final rule (76 FR 51599
through 51600) concerning the time
period for notifications by Lugar
hospitals regarding acceptance or
nonacceptance of the out-migration
adjustment. However, we did receive
public comments on our proposed
revisions to §412.273(c)(1)(ii) and (c)(2)
regarding the time period to request
withdrawal or termination of an MCRB
reclassification. These comments are
summarized below.

Comment: Several commenters
disagreed with the proposal to change
the 45-day notification requirement for
MCRB withdrawals and terminations.
They stated that 45 days from the date
of public display at the Office of the
Federal Register would not give
hospitals adequate time to review the
applicable data. The commenters
pointed out that the proposal would
decrease the time period for providers to
act by approximately 14 days, which
they claimed would “unnecessarily
disadvantage” hospitals in making the
most beneficial reclassification
determinations for their wage index. In
addition, a few commenters presented
scenarios whereby the proposal may
require hospitals to submit withdrawal
or termination requests to the MCRB
prior to the Administrator’s decisions
on MCRB appeals. The commenters
recommended that CMS maintain its
existing policy of 45 days after the
proposed rule is issued in the Federal
Register for hospitals to request
withdrawal and termination of MGCRB reclassifications. One commenter suggested that CMS also allow for an extension of the current deadline to ensure providers have at least 15 days from the issuance of a CMS Administrator decision to make withdrawal and termination requests.

Response: While the commenters are correct that requiring hospitals to submit withdrawal or termination requests to the MGCRB within 45 days from the date of public display, rather than the date the proposed rule is issued in the Federal Register, reduces the time for hospitals to make such determinations, we do not agree that hospitals generally would have inadequate time to review the applicable data. As discussed in the proposed rule (82 FR 19910), we believe that the public has access to the necessary information from the date of public display of the proposed rule at the Office of the Federal Register and on its Web site in order to make the decisions at issue under our proposals. However, while we believe that hospitals generally would have adequate time to make reclassification determinations under the proposal, we acknowledge that hospitals may be disadvantaged if the Administrator’s decision on a hospital’s appeal of an MGCRB decision has not been issued prior to the proposed deadline for submitting withdrawal or termination requests to the MGCRB. Specifically, the regulations at §§ 412.278(a) and (b)(1) provide that a hospital may request the Administrator to review the MGCRB decision, and that such request must be received by the Administrator within 15 days after the date the MGCRB issues its decision. Under § 412.278(f)(2)(i), the Administrator issues a decision not later than 90 days following receipt of the party’s request for review (except that the Administrator may, at his or her discretion, for good cause shown, toll such 90 days). Considering the usual dates of the MGCRB’s decisions (generally early February) and of the public display of the IPPS proposed rule, the maximum amount of time for an Administrator’s decision to be issued may potentially extend beyond the proposed deadline of 45 days from the date of public display. Therefore, in order to further consider whether our proposed revisions to § 412.273(c) may require hospitals to submit withdrawal or termination requests to the MGCRB before the Administrator’s decision on an appeal is issued, we are not finalizing our proposed change to the 45-day notification rule at § 412.273(c)(1)(ii) and (c)(2) for requesting withdrawals and terminations of MGCRB reclassifications. However, after consideration of these comments, we are revising our regulations at §§ 412.273(c)(1)(ii) and (c)(2) to ensure that our current policy under those regulations is clear. Specifically, we are revising §§ 412.273(c)(1)(ii) and (c)(2) to clarify that, under these regulations, a hospital’s request to withdraw or terminate an MGCRB reclassification must be received by the MGCRB within 45 days of the date the annual notice of proposed rulemaking is issued in the Federal Register. We believe that these revisions will provide for greater clarification regarding how these provisions are applied. We note that we are not providing for an extension of the current deadline as one commenter suggested to allow providers to have at least 15 days from the issuance of a CMS Administrator decision to withdraw or terminate an MGCRB reclassification because we do not believe that an extension is necessary under the current deadline. Under §§ 412.273(c)(1)(ii) and (c)(2). Under the current deadline, a hospital can plan its withdrawal or termination decisions for both potential alternatives of the Administrator’s decision on its appeal, and then act immediately within the current 45-day timeframe as soon as the Administrator’s decision either to affirm or reverse the MGCRB’s decision is issued.

Comment: One commenter stated that CMS’ policy that hospitals must request to withdraw or terminate MGCRB reclassifications within 45 days of the proposed rule is problematic because a hospital could terminate a reclassification based on information in the proposed rule and, with the publication of the final rule, discover that its original reclassified status was more desirable. The commenter stated that hospitals cannot make informed decisions concerning their reclassification status based on values in a proposed rule that are likely to change and, therefore, recommended that CMS revise its policy to permit hospitals to withdraw or terminate their reclassification status within 45 days after the publication of the final rule.

Response: We maintain that information provided in the proposed rule constitutes the best available data to assist hospitals in making reclassification decisions. In addition, section 1886(d)(8)(D) of the Act requires the Secretary to adjust the standardized amounts to ensure that aggregate payments under the IPPS after implementation of the provisions of certain sections of the Act, including section 1886(d)(10) of the Act for geographic reclassifications by the MGCRB, are equal to the aggregate prospective payments that would have been made absent these provisions. If hospitals were to withdraw or terminate reclassification statuses after the final rule, as the commenter suggested CMS permit, any resulting changes in the wage index would not have been taken into account when calculating the IPPS standardized amounts in the final rule in accordance with the statutory budget neutrality requirement. Therefore, the values published in the final rule represent the final wage index values reflective of reclassification decisions.

While we are not finalizing, for the reasons discussed earlier, the proposed changes to § 412.273(c)(1)(ii) and (c)(2) concerning the time period for requesting withdrawals and terminations of MGCRB reclassifications, we are finalizing, without modification, our proposed changes to § 412.64(i)(3)(iii) and § 412.211(f)(3)(iii) regarding the 45-day requirement for notifying CMS of decisions to waive application of the out-migration adjustment, and our proposed change to the policy outlined in the FY 2012 IPPS/LTCP PPS final rule (76 FR 51599 through 51600) concerning the time period for notifications by Lugar hospitals regarding acceptance or nonacceptance of the out-migration adjustment. Unlike MGCRB decisions under § 412.278, out-migration adjustment and Lugar status decisions are not subject to Administrator’s review. Therefore, hospitals deciding to waive the out-migration adjustment under § 412.64(i)(3)(iii) or § 412.211(f)(3)(iii) or Lugar hospitals deciding to accept or decline the out-migration adjustment would not experience the same potential disadvantage from implementation of the proposed revisions to the 45-day notification rules. For decisions regarding the out-migration adjustment and Lugar status, we continue to believe that the public has access to the necessary information from the date of public display of the proposed rule at the Office of the Federal Register and on its Web site in order to make decisions. Therefore, we believe that it is appropriate to finalize without modification our proposed changes to § 412.64(i)(3)(iii) and § 412.211(f)(3)(iii) and our proposed change to the policy outlined in the FY 2012 IPPS/LTCP PPS final rule (76 FR 51599 through 51600) as discussed earlier.

In addition, as a courtesy, we will post on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-
for Service-Payment/Acute Inpatient PPS/wageindex.html the calendar closing dates of the 45-day notification deadlines for waiving the out-migration adjustment, for Lugar hospitals to notify CMS regarding acceptance or nonacceptance of the out-migration adjustment, and for requesting withdrawal or termination of an MGCRB reclassification. We note that the MGCRB is independent of CMS and that the deadline for withdrawals and terminations of MGCRB reclassifications posted on CMS’ Web site will be posted as a courtesy only. The MGCRB makes the final decision regarding the date of the deadline and whether a request for withdrawal or termination is timely. The public should confirm the deadline for withdrawals and terminations of MGCRB reclassifications with the MGCRB.

After consideration of the public comments we received, for the reasons discussed earlier and in the FY 2018 IPPS/LTCH PPS proposed rule, we are finalizing, without modification, the proposed changes to the regulations at §412.64(i)(3)(iii) and §412.211(f)(3)(iii) to provide that hospitals may waive the application of the out-migration wage index adjustment within 45 days of the date of public display of the annual notice of proposed rulemaking for the hospital inpatient prospective payment system at the Office of the Federal Register. We also are finalizing, without modification, the proposed changes to the policy outlined in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51599 through 51600), so that a Lugar hospital that qualifies for and accepts the out-migration adjustment, or that no longer wishes to accept the out-migration adjustment and instead elects to return to its deemed urban status, must notify CMS within 45 days from the date of public display of the IPPS proposed rule at the Office of the Federal Register. For the reasons discussed earlier, we are not finalizing, as proposed, the changes to the regulations at §412.273(c)(1)(i) and (c)(2) concerning the timeframe for submitting a request to the MGCRB to withdraw or terminate an MGCRB reclassification. Rather, we are revising the regulations at §412.273(c)(1)(ii) and §412.273(c)(2) to clarify our current policy under these regulations that a request for withdrawal or termination of an MGCRB reclassification must be received by the MGCRB within 45 days of the date the annual notice of proposed rulemaking concerning changes to the inpatient hospital prospective payment system and proposed payment rates. Finally, as discussed earlier, as a courtesy (and independent of the MGCRB), we will begin posting on the CMS Web site the annual calendar dates of the 45-day notification deadlines for (1) hospitals to notify CMS that they are waiving the out-migration adjustment; (2) Lugar hospitals to notify CMS that they qualify for and accept the out-migration adjustment or no longer wish to accept the out-migration adjustment and elect instead to return to deemed urban status; and (3) hospitals to request from the MGCRB withdrawal or termination of an MGCRB reclassification.

J. Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees

In accordance with section 1886(d)(13) of the Act, as added by section 505 of Public Law 108–173, beginning with FY 2005, we established a process to make adjustments to the hospital wage index based on commuting patterns of hospital employees (the “out-migration” adjustment). The process, outlined in the FY 2005 IPPS final rule (69 FR 49061), provides for an increase in the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. Section 1886(d)(13)(B) of the Act requires the Secretary to use data the Secretary determines to be appropriate to establish the qualifying counties. When the provision of section 1886(d)(13) of the Act was implemented for the FY 2005 wage index, we analyzed commuting data compiled by the U.S. Census Bureau that were derived from a special tabulation of the 2000 Census journey-to-work data for all industries (CMS extracted data available to hospitals). These data were compiled from responses to the “long-form” survey, which the Census Bureau used at the time and which contained questions on where residents in each county worked (69 FR 49062). However, the 2010 Census was “short form” only; information on where residents in each county worked was not collected as part of the 2010 Census. The Census Bureau worked with CMS to provide an alternative dataset based on the latest available data on where residents in each county worked in 2010, for use in developing a new out-migration adjustment based on new commuting patterns developed from the 2010 Census data beginning with FY 2016. To determine the out-migration adjustments and applicable counties for FY 2016, we analyzed commuting data compiled by the Census Bureau that were derived from a custom tabulation of the American Community Survey (ACS), an official Census Bureau survey, using 2008 through 2012 (5-Year) Microdata. The data were compiled from responses to the ACS questions regarding the county where workers reside and the county to which workers commute. As we discussed in the FY 2016 and FY 2017 IPPS/LTCH PPS final rules (80 FR 49501 and 81 FR 56930, respectively), the same policies, procedures, and computation that were used for the FY 2012 out-migration adjustment were applicable for FY 2016 and FY 2017, and in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19910), we proposed to use them again for FY 2018. We have applied the same policies, procedures, and computations since FY 2012, and we believe they continue to be appropriate for FY 2018. We refer readers to the FY 2016 IPPS/LTCH PPS final rule (80 FR 49501 through 49502) for a full explanation of the revised data source.

For FY 2018, until such time that CMS finalizes out-migration adjustments based on the next Census, the out-migration adjustment continues to be based on the data derived from the custom tabulation of the ACS utilizing 2008 through 2012 (5-Year) Microdata. For FY 2018, we did not propose any changes to the methodology or data source that we used for FY 2016 (81 FR 25071). (We refer readers to a full discussion of the out-migration adjustment, including rules on deeming hospitals reclassified under section 1886(d)(8) or section 1886(d)(10) of the Act to have waived the out-migration adjustment, in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51601 through 51602).) We did not receive any public comments regarding the FY 2018 out-migration adjustment. Thus, for the reasons discussed earlier and in the FY 2018 IPPS/LTCH PPS proposed rule, we are finalizing, without modification, our proposed policies, procedures, methodology, and computation for the out-migration adjustment. Table 2 associated with this final rule (which is available via the Internet on the CMS Web site) includes the final out-migration adjustments for the FY 2018 wage index.
K. Reclassification From Urban to Rural Under Section 1886(d)(8)(E) of the Act, Implemented at 42 CFR 412.103

Under section 1886(d)(8)(E) of the Act, a qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MCCRB. Specifically, section 1886(d)(8)(E) of the Act provides that, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital that satisfies certain criteria, the Secretary shall treat the hospital as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located. We refer readers to the regulations at 42 CFR 412.103 for the general criteria and application requirements for a subsection (d) hospital to reclassify from urban to rural status in accordance with section 1886(d)(8)(E) of the Act. The FY 2012 IPPS/LTCH PPS final rule (76 FR 51595 through 51596) includes our policies regarding the effect of wage data from reclassified or redesignated hospitals.

Hospitals must meet the criteria to be reclassified from urban to rural status under § 412.103, as well as fulfill the requirements for the application process. There may be one or more reasons that a hospital applies for urban to rural reclassification, and the timeframe that a hospital submits an application is often dependent on those reason(s). Because the wage index is part of the methodology for determining the prospective payments to hospitals for each fiscal year, we believe there should be a definitive timeframe within which a hospital should apply for rural status in order for the reclassification to be reflected in the next Federal fiscal year’s wage data used for setting payment rates.

Therefore, after notice of proposed rulemaking and consideration of public comments, in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56931 through 56932), we revised § 412.103(b) by adding paragraph (6) to specify that, in order for a hospital to be treated as rural in the wage index and budget neutrality calculations under §§ 412.64(e)(1)(ii), (e)(2), (e)(4), and (h) for payment rates for the next Federal fiscal year, the hospital’s filing date must be no later than 70 days prior to the second Monday in June of the current Federal fiscal year and the application must be approved by the CMS Regional Office in accordance with the requirements of § 412.103. We refer readers to the FY 2017 IPPS/LTCH PPS final rule for a full discussion of this policy. We clarified that the lock-in date does not affect the timing of payment changes occurring at the hospital-specific level as a result of reclassification from urban to rural under § 412.103. This lock-in date also does not change the current regulation that allows hospitals that qualify under § 412.103(a) to request, at any time during a cost reporting period, to reclassify from urban to rural. A hospital’s rural status and claims payment reflecting its rural status continue to be effective on the filing date of its reclassification application, which is the date the CMS Regional Office receives the application, in accordance with § 412.103(d). The hospital’s IPPS claims will be paid reflecting its rural status on the filing date (the effective date) of the reclassification, regardless of when the hospital applies.

Comment: One commenter suggested that CMS’ current policy that the effective date of an urban to rural reclassification under § 412.103 is the date the application is received by CMS should be revised to allow flexibility for a later date. Specifically, the commenter requested that CMS allow hospitals to ask for an effective date anytime from the date the application is received until up to 60 days after the receipt of the application, to help hospitals that experience a short-term reduction in payment from obtaining rural status before becoming eligible for increased payment at a later time. The commenter stated that amending the regulation in this way would accommodate the various reasons why hospitals request rural status and will be more consistent with the statutory language at section 1886(d)(8)(E) of the Act which provides that the Secretary shall treat a hospital as rural “not later than 60 days after the receipt of an application.”

Response: We did not propose any such revisions to the policy at § 412.103 in the FY 2018 IPPS/LTCH PPS proposed rule, but instead explained and clarified our existing policy. We appreciate the comments and may consider the commenter’s request in future rulemaking.

L. Clarification of Application Deadline for Rural Referral Center (RRC) Classification

Section 1886(d)(5)(C)(i) of the Act, implemented at 42 CFR 412.96, provides for the classification and special treatment of rural referral centers (RRCs). The regulations at § 412.96 set forth the criteria that a hospital must meet in order to qualify as an RRC. Under § 412.96(b)(1)(ii), a hospital may qualify as an RRC if it is located in a rural area and has 275 or more beds during its most recently completed cost reporting period. The hospital also can obtain RRC status by showing that at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the staff of the hospital, and at least 60 percent of the hospital’s Medicare patients live more than 25 miles from the hospital, and at least 60 percent of all the services that the hospital furnishes to Medicare beneficiaries are furnished to beneficiaries who live more than 25 miles from the hospital (§ 412.96(b)(2)), or by showing that the hospital meets the alternative criteria at § 412.96(c). We refer readers to 42 CFR 412.96 for a full description of the criteria for classification as an RRC.

Consistent with section 1886(d)(5)(C)(i) of the Act, the hospital must submit its application for RRC status during the last quarter of the hospital’s cost reporting period, to be effective with the beginning of the next cost reporting period. Specifically, section 1886(d)(5)(C)(i) of the Act provides that an appeal allowed under this paragraph must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital’s cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by reclassification based upon the appeal will be effective at the beginning of such cost reporting period. Therefore, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19911), we clarified that applications for RRC status must be submitted during this timeframe. That is, applications for RRC status must be submitted during the last quarter of the cost reporting period before the first quarter of a hospital’s cost reporting year. If approved, the RRC status is effective with the beginning of the hospital’s cost reporting period occurring after the last quarter of the cost reporting period in which the hospital submits an application.

We also clarified in the proposed rule that, while RRC applications must be submitted only within the timeframe described above, applications for urban-to-rural reclassification under § 412.103 may be submitted at any time for the hospital to be approved for rural reclassification. This includes hospitals seeking rural classification under § 412.103(a)(3), which states that a hospital meets criteria for urban-to-rural
reclassification if the hospital would qualify as a RRC as set forth in § 412.96, or as an SCH as set forth in § 412.92, if the hospital were located in a rural area. A hospital seeking RRC status based on a rural reclassification under § 412.103, including § 412.103(a)(3), must still submit an application for RRC status during the last quarter of its cost reporting year before the next cost reporting period in accordance with section 1886(d)(5)(C)(i) of the Act. While the § 412.103 rural redesignation would be effective as of the date of filing the application, in accordance with § 412.103(d), the RRC status would be effective beginning with the hospital’s cost reporting period occurring after the last quarter of the cost reporting period in which the hospital submits an application. Because a hospital may only apply for RRC status during the last quarter of its cost reporting year in accordance with section 1886(d)(5)(C)(i) of the Act, hospitals seeking RRC status, in order to reclassify through the MGCRB using the special rules for SCHs and RRCs at § 412.230(a)(3) and the exceptions at § 412.230(d)(3) for RRCs, may be disadvantaged due to their cost reporting year end. As discussed in section III.1.2 of the preamble of the proposed rule, we proposed to revise the regulations at § 412.230(a)(3) and (d)(3) to allow hospitals to submit documentation of the approval of SCH or RRC status (as applicable) to the MGCRB no later than the first business day after January 1. We stated in the proposed rule that we believe our proposal to accept documentation of approval of RRC classification, instead of requiring that the hospital be classified as a RRC at the time of Board review, would accommodate more hospitals with various cost reporting period endings. We refer readers to section III.1.2 of the preamble of the proposed rule for further discussion of this proposal. We note that, as discussed in section III.1.2. of the preamble of this final rule, while we are finalizing our proposal that a hospital must be approved for SCH or RRC status, rather than have active SCH or RRC status, in order to use the special rules for SCHs and RRCs and the exceptions for RRCs under § 412.230(a)(3) and (d)(3), we are not finalizing our proposal to establish a deadline of the first business day after January 1 for hospitals to submit documentation of SCH and RRC status approval to the MGCRB.

Comment: One commenter agreed that the specific timing is required by the statutory language, but argued that CMS is applying a “restrictive interpretation” of the RRC application timing requirements so that there is not a level playing field based solely on cost report year-ends. The commenter suggested an interpretation of the statute that it believes could allow hospitals seeking to obtain RRC status for the purposes of an MGCRB application to be considered RRCs even outside of the statutory timeframe. Specifically, the commenter pointed to section 1886(d)(10)(D)(iii) of the Act, which states that, in the case of a hospital that has ever been classified by the Secretary as rural referral center, the MGCRB may not reject the application on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located. According to the commenter, CMS’ determination that a hospital meets the rural redesignation requirements under § 412.103(a)(3) (that is, the hospital would qualify as an RRC if it were located in a rural area) could be considered sufficient classification to trigger the exemption from the home area wage test and application of the special access rules.

Response: As discussed earlier, and as noted by the commenter, the timeframe for applying for RRC status is set forth in the statute. We recognize that certain hospitals may be disadvantaged due to their cost reporting year end, and for that reason we propose, and are finalizing (as discussed in section III.1.2, of the preamble of this final rule) revisions to the regulations at § 412.230(a)(3) and (d)(3) to reflect that these paragraphs apply to hospitals with RRC approval (and not only effective status).

We do not agree with the commenter that CMS’ determination under § 412.103(a)(3) that a hospital would qualify for RRC status if the hospital were located in a rural area (which is one condition under which a hospital can qualify for § 412.103 rural redesignation) is considered RRC classification. In fact, hospitals may obtain rural reclassification under § 412.103(a)(3), but not subsequently obtain RRC status. Therefore, we do not believe that such a determination under § 412.103(a)(3) is sufficient to satisfy the requirements at section 1886(d)(10)(D)(iii) of the Act.

M. Process for Requests for Wage Index Data Corrections

1. Process for Hospitals To Request Wage Index Data Corrections

The preliminary, unaudited Worksheet S–3 wage data files for the proposed FY 2018 wage index were made available on May 16, 2016, and the preliminary CY 2013 occupational mix data files on May 16, 2016, through the Internet on the CMS Web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html.

On January 30, 2017, we posted a public use file (PUF) at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html containing FY 2018 wage index data available as of January 29, 2017. This PUF contains a tab with the Worksheet S–3 wage data (which includes Worksheet S–3, Parts II and III wage data from cost reporting periods beginning on or after October 1, 2013 through September 30, 2014; that is, FY 2014 wage data), a tab with the occupational mix data (which includes data from the CY 2013 occupational mix survey, Form CMS–10079), a tab containing the Worksheet S–3 wage data of hospitals deleted from the January 30, 2017 wage data PUF, and a tab containing the CY 2013 occupational mix data (if any) of the hospitals deleted from the January 30, 2017 wage data PUF.

In a memorandum dated January 27, 2017, we instructed all MACs to inform the IPPS hospitals that they service of the availability of the January 30, 2017 wage index data PUFs, and the process and timeframe for requesting revisions in accordance with the FY 2018 Wage Index Timetable.

In the interest of meeting the data needs of the public, beginning with the proposed FY 2009 wage index, we post an additional PUF on our Web site that reflects the actual data that are used in computing the proposed wage index. The release of this file does not alter the current wage index process or schedule. We notify the hospital community of the availability of these data as we do with the current public use wage data files through our Hospital Open Door Forum. We encourage hospitals to sign up for automatic notifications of information about hospital issues and about the dates of the Hospital Open Door Forums at the CMS Web site at: http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/index.html.

In a memorandum dated May 16, 2016, we instructed all MACs to inform the IPPS hospitals that they service of the availability of the wage index data files and the process and timeframe for requesting revisions. We also instructed the MACs to advise hospitals that these data were also made available directly through their representative hospital organizations.

If a hospital wished to request a change to its data as shown in the May
16. 2016 wage data files and the May 16, 2016 occupational mix data files, the hospital had to submit corrections along with complete, detailed supporting documentation to its MAC by September 2, 2016. Hospitals were notified of this deadline and of all other deadlines and requirements, including the requirement to review and verify their data as posted in the preliminary wage index data files on the Internet, through the letters sent to them by their MACs.

November 4, 2016 was the date by when MACs notified State hospital associations regarding hospitals that failed to respond to issues raised during the desk reviews. The MACs notified the hospitals by mid-January 2017 of any changes to the wage index data as a result of the desk reviews and the resolution of the hospitals’ revision requests. The MACs also submitted the revised data to CMS by January 20, 2017. CMS published the wage index PUFs that included hospitals’ revised wage index data on January 30, 2017. Hospitals had until February 17, 2017, to submit requests to the MACs for reconsideration of adjustments made by the MACs as a result of the desk review, and to correct errors due to CMS’ or the MAC’s mishandling of the wage index data. Hospitals also were required to submit sufficient documentation to support their requests.

After reviewing requested changes submitted by hospitals, MACs were required to transmit to CMS any additional revisions resulting from the hospitals’ reconsideration requests by March 24, 2017. Under our current policy, the deadline for a hospital to request CMS intervention in cases in which a hospital disagreed with a MAC’s policy interpretation was April 5, 2017. As discussed in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 9912), beginning next year (that is, April 2018 for wage data revisions for the FY 2019 wage index), we proposed to require that a hospital that seeks to challenge the MAC’s handling of wage data on any basis (including a policy, factual, or any other dispute) must request CMS to intervene by the date in April that is specified as the deadline for hospitals to appeal MAC determinations and request CMS’ intervention in cases where the hospital disagrees with the MAC’s determination (as we stated above and in the proposed rule, the wage index timetable will be updated to reflect the specified date). Hospitals were given the opportunity to examine Table 2, which was listed in section VI. of the Addendum to the proposed rule and available via the Internet on the CMS Web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html. Table 2 associated with the proposed rule contained each hospital’s proposed adjusted average hourly wage used to construct the wage index values for the past 3 years, including the FY 2014 data used to construct the proposed FY 2018 wage index. We noted in the proposed rule (82 FR 9912) that the proposed hospital average hourly wages shown in Table 2 only reflect changes made to a hospital’s data that were transmitted to CMS by early February 2017.

We posted the final wage index data PUFs on April 28, 2017 on the Internet at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html. The April 2017 PUFs were made available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry or tabulation of the final data. The hospital was given the opportunity to notify both the MAC and CMS regarding why it believed an error exists and provide all supporting information, including relevant dates (for example, when it first became aware of the error). The hospital was required to send its request to CMS and to the MAC no later than May 30, 2017. Similar to the April appeals, beginning with the FY 2015 wage index, in accordance with the FY 2018 wage index timeline posted on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY2018-Wage-Index-Home-Page.html, the May appeals were required to be sent via mail and email to CMS and the MACs. We refer readers to the wage index timeline for complete details.

Verified corrections to the wage index data received timely by CMS and the MACs (that is, by May 30, 2017) were incorporated into the final FY 2018 wage index in this FY 2018 IPPS/LTCH PPS final rule, which is effective October 1, 2017.

We created the processes previously described to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2018 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage index data corrections or to dispute the MAC’s decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth earlier (requiring requests to MACs by the specified date in February and, where such requests are unsuccessful,
requests for intervention by CMS by the specified date in April) will not be permitted to challenge later, before the PRRB, the failure of CMS to make a requested data revision. We refer readers also to the FY 2000 IPPS final rule (64 FR 41513) for a discussion of the parameters for appeals to the PRRB for wage index data corrections.

Again, we believe the wage index data correction process described earlier provides hospitals with sufficient opportunity to bring errors in their wage and occupational mix data to the MAC’s attention. Moreover, because hospitals had access to the final wage index data PUFs by late April 2017, they had the opportunity to detect any data entry or tabulation errors made by the MAC or CMS before the development and publication of the final FY 2018 wage index by August 2017, and the implementation of the FY 2018 wage index on October 1, 2017. Given these processes, the wage index implemented on October 1 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to our attention after May 30, 2017, we retain the right to make midyear changes to the wage index under very limited circumstances.

Specifically, in accordance with 42 CFR 412.64(k)(1) of our regulations, we make midyear corrections to the wage index for an area only if a hospital can show that: (1) The MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, “before the beginning of the fiscal year” means by the May deadline for making corrections to the wage data for the following fiscal year’s wage index (for example, May 30, 2017 for the FY 2018 wage index). This provision is not available to a hospital seeking to revise another hospital’s data that may be affecting the requesting hospital’s wage index for the labor market area. As indicated earlier, because CMS makes the wage index data available to hospitals on the CMS Web site prior to publishing both the proposed and final IPPS rules, and the MACs notify hospitals directly of any wage index data changes after completing their desk reviews, we do not expect that midyear corrections will be necessary. However, under our current policy, if the correction of a data error changes the wage index value for an area, the revised value will be effective prospectively from the date the correction is made.

In the FY 2006 IPPS final rule (70 FR 47385 through 47387 and 47485), we revised 42 CFR 412.64(k)(2) to specify that, effective on October 1, 2005, that is, beginning with the FY 2006 wage index, a change to the wage index can be made retroactive to the beginning of the Federal fiscal year only when CMS determines all of the following: (1) The MAC or CMS made an error in tabulating data used for the wage index calculation; (2) the hospital knew about the error and requested that the MAC and CMS correct the error using the established process and within the established schedule for requesting corrections to the wage index data, before the beginning of the fiscal year for the applicable IPPS update (that is, by the May 30, 2017 deadline for the FY 2018 wage index); and (3) CMS agreed before October 1 that the MAC or CMS made an error in tabulating the hospital’s wage index data and the wage index should be corrected.

In those circumstances where a hospital requested a correction to its wage index data before CMS calculated the final wage index (that is, by the May 30, 2017 deadline for the FY 2018 wage index), and CMS acknowledges that the error in the hospital’s wage index data was caused by CMS’ or the MAC’s mishandling of the data, we believe that the hospital should not be penalized by our delay in publishing or implementing the correction. As with our current policy, we indicated that the provision is not available to a hospital seeking to revise another hospital’s data. In addition, the provision cannot be used to correct prior years’ wage index data; and it can only be used for the current Federal fiscal year. In situations where our policies would allow midyear corrections other than those specified in 42 CFR 412.64(k)(2)(ii), we continue to believe that it is appropriate to make prospective-only corrections to the wage index.

We note that, as with prospective changes to the wage index, the final retroactive correction will be made irrespective of whether the change increases or decreases a hospital’s payment rate. In addition, we note that the policy of retroactive adjustment will still apply in those instances where a final judicial decision reverses a CMS denial of a hospital’s wage index data revision request.

2. Process for Data Corrections by CMS After the January Public Use File (PUF)

The process set forth with the wage index timeline discussed in section III.D.1 of the preamble of this final rule allows hospitals to request corrections to their wage index data within prescribed timeframes. In addition to hospitals’ opportunity to request corrections of wage index data errors or MACs’ mishandling of data, CMS has the authority under section 1886(d)(3)(E) of the Act to make corrections to hospital wage index and occupational mix data in order to ensure the accuracy of the wage index. As we explained in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49490 through 49491) and the FY 2017 IPPS/LTCH PPS final rule (81 FR 56914), section 1886(d)(3)(E) of the Act requires the Secretary to adjust the proportion of hospitals’ costs attributable to wages and wage-related costs for area differences reflecting the relative hospital wage level in the geographic areas of the hospital compared to the national average hospital wage level. As discussed in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19913 through 19915), we believe that, under section 1886(d)(3)(E) of the Act, we have discretion to make corrections to hospitals’ data to help ensure that the costs attributable to wages and wage-related costs in fact accurately reflect the relative hospital wage level in the hospitals’ geographic areas.

We have an established multistep, 15-month process for the review and correction of the hospital wage data that is used to create the IPPS wage index for the upcoming fiscal year. Since the origin of the IPPS, the wage index has been subject to its own annual review process, first by the MACs, and then by CMS. As a standard practice, after each annual desk review, CMS reviews the results of the MACs’ desk reviews and focuses on items flagged during the desk review, requiring that, if necessary, hospitals provide additional documentation, adjustments, or corrections to the data. This ongoing communication with hospitals about their wage data may result in the discovery by CMS of additional items that were reported incorrectly or other data errors, even after the posting of the January PUF, and throughout the remainder of the wage index development process. In addition, the fact that CMS analyzes the data from a regional and even national level, unlike the review performed by the MACs that review a limited subset of hospitals, can facilitate additional editing of the data that may not be readily apparent to the MACs. In these occasional instances, an error may be of sufficient magnitude that the wage index of an entire CBSA is affected. Accordingly, CMS uses its authority to ensure that the wage index accurately reflects the relative hospital wage level in the geographic area of the
would provide opportunities for hospital wage data as appropriate, regardless of whether that correction will raise or lower a hospital’s average hourly wage. For example, as discussed in section III.D.2. of the preamble of the proposed rule (82 FR 19900 through 19902), in the calculation of the proposed FY 2018 wage index, upon discovering that hospitals reported other wage-related costs on Line 18 bf Worksheet S–3, despite those other wage-related costs failing to meet the requirement that other wage related costs must exceed 1 percent of total adjusted salaries net of excluded area salaries, CMS made internal edits to remove those other wage-related costs from Line 18. Conversely, if CMS discovers after conclusion of the desk review, for example, that a MAC inadvertently failed to incorporate positive adjustments resulting from a prior year’s wage index appeal to a hospital’s wage related costs such as pension, CMS would correct that data error and the hospital’s average hourly wage would likely increase as a result.

We maintain CMS’ authority to conduct additional review and make resulting corrections at any time during the wage index development process, in the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19914), we proposed a process for hospitals to request further review of a correction made by CMS starting with the FY 2019 wage index. In order to allow opportunity for input from hospitals concerning corrections made by CMS after the posting of the January PUF, we proposed a process similar to the existing process in which hospitals may request corrections to wage index data displayed in the January PUF. We stated in the proposed rule that instances where CMS makes a correction to a hospital’s data after the January PUF based on a different understanding than the hospital about certain reported costs, for example, could potentially be resolved using this proposed process before the final wage index is calculated. We stated that we believe this proposed process and timeline (as described below) would bring additional transparency to instances where CMS makes data corrections after the January PUF, and would provide opportunities for hospitals to request further review of CMS changes in time for the most accurate data to be reflected in the final wage index calculations.

Effective beginning with the FY 2019 wage index development cycle, we proposed to use existing appeal deadlines (in place for hospitals to appeal determinations made by the MAC during the desk review process) for hospitals to dispute corrections made by CMS after posting of the January PUF that do not arise from a hospital request for a wage data revision. Starting with the April appeal deadline, hospitals would use the soonest approaching appeal deadline to dispute any adjustments made by CMS. However, if a hospital was notified of an adjustment within 14 days of an appeal deadline, the hospital would have until the next appeal deadline to dispute any adjustments. We believe this would give hospitals sufficient time to prepare an appeal of adjustments made by CMS after the January PUF. Specifically, for any adjustments made by CMS between the date the January PUF is posted and at least 14 calendar days before the April appeals deadline, we proposed that hospitals would have until the April appeals deadline (which, for example, is April 5 in the FY 2018 Wage Index Timetable) to dispute the adjustments. For any adjustments made by CMS between 13 calendar days before the April appeals deadline and 14 calendar days before the May appeals deadline, we proposed that hospitals would have until the May appeals deadline (which, for example, is May 30 in the FY 2018 Wage Index Timetable) to dispute the adjustments. In cases where hospitals disagree with CMS adjustments of which they were notified 13 calendar days before the May appeals deadline or later, the hospitals could appeal to the PRRB with no need for further review by CMS before such appeal.

We are using dates from the FY 2018 Wage Index Timetable in the following example which was included in the proposed rule at 82 FR 19914 (we reiterate that this appeals process would be effective beginning with the FY 2019 wage index cycle, but for illustrative purposes, we are using dates from the FY 2018 Wage Index Timetable, the most recently published wage index timetable): A hospital that is notified by the MAC or CMS of an adjustment to its wage data after the release of the January 30, 2017 PUF could use the April 5, 2017 appeals deadline to dispute the adjustment. If the hospital is notified of an adjustment by CMS or the MAC to its wage data after March 22, 2017 (that is, less than 14 days prior to the April 5 appeals deadline), it could use the May 30, 2017 appeals deadline to dispute the adjustment. If the hospital is first notified about the adjustment after May 16, 2017 (that is, less than 14 days prior to the May 30 deadline), and disagrees with the adjustment, the hospital could appeal directly to the PRRB.

As with the existing process for requesting wage data corrections, we proposed that a hospital disputing an adjustment made by CMS after the posting of the January PUF would be required to request a correction by the first applicable deadline. For example, using the FY 2018 Wage Index Timetable for illustrative purposes only, if a hospital was notified on March 20 of an adjustment to its data by CMS and did not appeal by April 5, the hospital would not be able to appeal by May 30 or bring the case before the PRRB. That is, hospitals that do not meet the procedural deadlines set forth earlier would not be afforded a later opportunity to submit wage index data corrections or to dispute CMS’ decision with respect to requested changes. As with the existing process for hospitals to request wage data corrections, our policy is that hospitals that do not meet the procedural deadlines set forth earlier would not be permitted to challenge later, before the PRRB, the failure of CMS to make a requested data revision.

In summary, under the statute, CMS has discretion to make corrections and revisions to hospitals’ wage data throughout the multistep wage index development process, and we proposed a pathway for hospitals to request additional review of corrections to their wage data made by CMS. Beginning with the development of the FY 2019 wage index, we proposed a process whereby CMS could continue to correct data after the posting of the January PUF, while allowing hospitals to appeal changes made by CMS using existing deadlines from the process for hospitals to request wage data corrections. As with the existing process, a hospital would be required to appeal by the first applicable deadline, if relevant, to maintain the right to appeal to the PRRB to dispute a correction to its wage data made by CMS.

We invited public comments on our proposals.

Comment: Several commenters stated that CMS is proposing to limit the time a provider has to dispute an adjustment once the January PUF is posted. The commenters stated that, currently, hospitals have 1 month to request corrections for errors in the April 28 PUF. They maintained that the revised timelines will require hospitals to review the posted PUF immediately to
ensure that the data are correct and take any necessary action to correct. The
commenters also noted that CMS has taken a more active role in recent years in
performing additional data analysis that results in follow-up questions or
requests to hospitals for supporting data, which require time for hospitals to
develop a response. One commenter stated that, by reducing time, CMS will
be placing an administrative hardship on hospitals while they attempt to
respond to detailed audit requests. Some of the commenters were "deeply concerned'' that the short timeline CMS proposed to respond to detailed requests
will not allow for comprehensive analysis and a thorough response. One
commenter specifically requested that the dispute process be expanded to 28
days prior to the appeal deadline, instead of the proposed 14 days, to give
hospitals enough time to collect data and respond in a timely manner.

Response: We believe that the commenters misunderstood our proposal as a change to the current
process for hospitals to request wage data corrections, rather than an
additional process for disputing corrections made by CMS after the
January PUF that do not arise from a hospital's request for wage data
revisions. Under our proposal, hospitals would still have approximately 1 month
to request corrections for errors in the April 28 PUF, in accordance with the
Wage Index Timeline. Our proposal would create an additional process for hospitals to appeal adjustments or
corrections made by CMS or the MAC after the normal desk review timeframe
that do not arise from a hospital's request for wage data revisions. Therefore, we do not agree that this
proposal requires hospitals to review the posted PUF any earlier than hospitals would do so under the current
policy, or that it constitutes administrative hardship. Furthermore, we believe that, rather than limiting
hospitals, our proposal would provide additional transparency and
opportunities for hospitals to request further review of CMS changes made after the January PUF where there is
currently no such established process.

Regarding the concerns that the proposed timeline is too short and the
suggestion that CMS expand the 14-day timeline to 28 days, we continue to
believe that our proposed timeline would give hospitals sufficient time to
prepare an appeal of adjustments made by CMS after the January PUF. We
believe that a hospital that was notified of an adjustment at least 2 weeks before the
upcoming deadline has enough time to prepare an appeal by the upcoming
deadline. Specifically, starting with the April appeal deadline, hospitals would
use the soonest approaching appeal deadline to dispute any adjustments
made by CMS. However, if a hospital was notified of an adjustment within 14
days of an appeal deadline, the hospital would have until the next appeal
deadline to dispute any adjustments.

Comment: One commenter did not state a position on the proposal but
expressed the following concerns: First, that CMS should add the particulars of
this appeal process to the existing FY 2019 Wage Index Timeline that is
published and made available online each year by CMS; second, that most
adjustments to the wage data made by CMS on a routine basis be performed
much earlier in the process than these April and May appeal deadlines, so that
the proposed appeal process would be reserved for "rare and unusual
circumstances requiring CMS' intervention and adjustment to the
data."

Specifically, this commenter stated that it would oppose a policy that
gives CMS the latitude to indiscriminately make adjustments to the
hospital wage data this late in the process where that adjustment was
known of far ahead of time and/or could have easily been made earlier in the
process.

Response: We appreciate the commenter's concerns and suggestions. In response to the commenter's first
suggestion, we intend to add the particulars of this appeal process to the
existing Wage Index Timeline that is published and made available online
each year by CMS. Second, while we maintain CMS' authority under section
1886(d)(3)(E) of the Act to make corrections to hospitals' data to help
ensure the accuracy of the wage index, we note that routine adjustments to the
wage data that are known of far ahead of time and/or could easily be made
earlier in the process will continue to be performed earlier in the process than
these April and May appeal deadlines.

After consideration of the public comments we received, for the reasons
discussed earlier and in the FY 2018 IPPS/LTCF PPS proposed rule, we are
finalizing, without modification, our proposed process for hospitals to
dispute data corrections made by CMS after the January PUF that do not arise
from a hospital's request for wage data revisions. Effective beginning with the
FY 2019 wage index development cycle, we will use existing appeal deadlines
(in place for hospitals to appeal determinations made by the MAC
during a desk review process) for hospitals to dispute corrections made by
CMS after posting of the January PUF that do not arise from a hospital request
for a wage data revisions. Starting with the April appeal deadline, hospitals
must use the soonest approaching appeal deadline to dispute any
adjustments made by CMS. However, if a hospital is notified of an adjustment
within 14 days of an appeal deadline, the hospital has until the next appeal
deadline to dispute any adjustments, as discussed earlier. As with the existing
process for requesting wage data corrections, a hospital disputing an
adjustment made by CMS after the posting of the January PUF will be
required to request a correction by the first applicable deadline. For example,
using the FY 2018 Wage Index Timetable for illustrative purposes only,
if a hospital was notified on March 20
of an adjustment to its data by CMS and did not appeal by April 5, the hospital
would not be able to appeal by May 30 or bring the case before the PRRB. That
is, hospitals that do not meet the procedural deadlines set forth above
will not be afforded a later opportunity to submit wage index data corrections or
do not appeal by April 5, the hospital
to dispute CMS' decision with respect to
requested changes. Our policy is that
hospitals that do not meet the
procedural deadlines set forth earlier
will not be permitted to challenge later,
before the PRRB, the failure of CMS to
make a requested data revision.

N. Labor-Market Share for the FY 2018 Wage Index

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the
proportion of the national prospective payment system base payment rates that
are attributable to wages and wage-related costs by a factor that reflects the
relative differences in labor costs among geographic areas. It also directs the
Secretary to estimate from time to time the proportion of hospital costs that are
labor-related and to adjust the proportion (as estimated by the
Secretary from time to time) of
hospitals' costs which are attributable to wages and wage-related costs of the
DRG prospective payment rates. We refer to the portion of hospital costs attributable to wages and wage-related costs as the labor-related share. The
labor-related share of the prospective payment rate is adjusted by an index of
relative labor costs, which is referred to as the wage index.

Section 403 of Public Law 108–173 amended section 1886(d)(3)(E) of the
Act to provide that the Secretary must employ 62 percent as the labor-related
share unless this would result in lower payments to a hospital than would
otherwise be made. However, this provision of Public Law 108–173 did
not change the legal requirement that the Secretary estimate from time to time the proportion of hospitals’ costs that are attributable to wages and wage-related costs. Thus, hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

In the FY 2014 IPPS/LTCH PPS final rule (78 FR 50596 through 50607), we rebased and revised the hospital market basket. We established a FY 2010-based IPPS hospital market basket to replace the FY 2006-based IPPS hospital market basket, effective October 1, 2013. In that final rule, we presented our analysis and conclusions regarding the frequency and methodology for updating the labor-related share for FY 2014. Using the FY 2010-based IPPS market basket, we finalized a labor-related share for FY 2014, FY 2015, FY 2016, and FY 2017 of 69.6 percent. In addition, in FY 2014, we implemented this rebased and revised labor-related share in a budget neutral manner (78 FR 51016). However, consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0000 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0000.

For FY 2018, as described in section IV. of the preamble of the FY 2018 IPPS/LTCH PPS proposed rule (82 FR 19916 through 19929), we proposed to rebase and revise the IPPS market basket reflecting 2014 data. We also proposed to recalculate the labor-related share for discharges occurring on or after October 1, 2017 using the proposed 2014-based IPPS market basket. As discussed in Appendix A of the proposed rule, we proposed this rebased and revised labor-related share in a budget neutral manner. However, consistent with section 1886(d)(3)(E) of the Act, we did not take into account the additional payments that would be made as a result of hospitals with a wage index less than or equal to 1.0000 being paid using a labor-related share lower than the labor-related share of hospitals with a wage index greater than 1.0000. We refer readers to section IV. of the preamble of this final rule and Appendix A for our finalized policies for the 2014-based IPPS market basket.

The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. We include a cost category in the labor-related share if the costs are labor intensive and vary with the local labor market. As described in section IV. of the preamble of the proposed rule, we proposed to include in the labor-related share the national average proportion of operating costs that are attributable to Wages and Salaries, Employee Benefits, Professional Fees: Labor-Related, Administrative and Facilities Support Services, Installation, Maintenance, and Repair Services, and All Other: Labor-Related Services as measured in the proposed 2014-based IPPS market basket.

For FY 2018, we proposed to use a labor-related share of 68.3 percent for discharges occurring on or after October 1, 2017. We refer readers to section IV.B.3. of the preamble of this final rule for a discussion of our recalculation of the labor-related share for discharges occurring on or after October 1, 2017 using the 2014-based IPPS market basket.

Prior to January 1, 2016, Puerto Rico hospitals were paid based on 75 percent of the national standardized amount and 25 percent of the Puerto Rico-specific standardized amount. As a result, we applied the Puerto Rico-specific labor-related share percentage and nonlabor-related share percentage to the Puerto Rico-specific standardized amount. Because Puerto Rico hospitals are no longer paid with a Puerto Rico-specific standardized amount as of January 1, 2016, they shall use 100 percent of the national standardized amount. Because Puerto Rico hospitals are no longer paid with a Puerto Rico-specific standardized amount as of January 1, 2016, they shall use 100 percent of the national standardized amount. Hospitals in Puerto Rico are now paid 100 percent of the national standardized amount and, therefore, are subject to the national labor-related share and nonlabor-related share percentages that are applied to the national standardized amount. Accordingly, for FY 2018, we did not propose a Puerto Rico-specific labor-related share percentage or a nonlabor-related share percentage.

Comment: Commenters suggested that CMS consider an approach that will mitigate significant decreases in inpatient payments to hospitals as a result of the proposed decrease in the labor-related share for FY 2018.

Response: As noted earlier, section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national prospective payment system base payment rates that are attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. It also directs the Secretary to estimate from time to time the proportion of hospital costs that are labor-related and to adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs of the DRG prospective payment rates. In section IV.B.3. of the preamble of this final rule, we discuss our recalculation of the labor-related share for discharges occurring on or after October 1, 2017, using the 2014-based IPPS market basket. We believe that the labor-related share calculated for FY 2018 accurately and appropriately reflects the proportion of hospitals’ costs that are attributable to wages and wage-related costs. Therefore, we do not believe it is necessary or appropriate to mitigate the effects of the labor-related share percentage finalized in this rule.

After consideration of the public comments we received, for the reasons discussed in section IV.B.3. of the preamble of this final rule and in the FY 2018 IPPS/LTCH PPS proposed rule, we are finalizing our proposal to use a labor-related share of 68.3 percent for discharges occurring on or after October 1, 2017, for all hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.0000.

Table 1A and Table 1B, which are published in section VI. of the Addendum to this FY 2018 IPPS/LTCH PPS final rule and available via the Internet on the CMS Web site, reflect the national labor-related share, which is also applicable to Puerto Rico hospitals. For FY 2018, all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are less than or equal to 1.0000, we are applying the wage index to a labor-related share of 62 percent of the national standardized amount. For all hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.0000, for FY 2018, we are applying the wage index to a labor-related share of 68.3 percent of the national standardized amount.
MEDICARE WAGE INDEX
OCCUPATIONAL MIX SURVEY

Date:  /  /  

Provider CCN: ______________________
Provider Contact Name: ______________________
Provider Contact Phone Number: ______________________
Reporting Period: 01/01/2016 – 12/31/2016*

Introduction

Section 304(c) of Public Law 106-554 amended section 1886(d)(3)(E) of the Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program, in order to construct an occupational mix adjustment to the wage index. The law also requires the application of the occupational mix adjustment to the wage index beginning October 1, 2004.

This survey provides for the collection of occupational mix data for a 12-month period, that is, *from pay periods ending between January 1, 2016 and December 31, 2016 to be applied to the FY 2019 wage index. Specifically, the survey’s begin date cannot be earlier than December 17, 2015, and the survey’s end date cannot end later than December 31, 2016. Complete the survey for any hospital that is subject to the inpatient prospective payment system (IPPS), or any hospital that would be subject to IPPS if not granted a waiver[^1]. [Note: Do not complete this survey if you are a no/low Medicare utilization provider. Check with your Medicare

[^1]: Critical Access Hospitals (CAHs) are not paid under the IPPS, therefore, CAHs are not required to complete the survey. Also, hospitals that terminated participation in the Medicare program before January 1, 2016, or terminated after January 1, 2016, but before December 2016, resulting in less than 11 months of data from CY 2016, are not required to complete the survey.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0907. The time required to complete this information collection is estimated to average 480 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Tehila Lipschutz/ Noel Manlove, (410) 786-1344 / (410) 786-5161, tehila.lipschutz@cms.hhs.gov / noel.manlove@cms.hhs.gov.
Administrative Contractors (MAC) to confirm your status. It is important for hospitals to ensure that the data reported on the survey are accurate and verifiable through supporting documentation.

Completed occupational mix surveys must be submitted to MACs, on the Excel hospital reporting form, by July 1, 2017, via email attachment or overnight delivery. The Excel version of the occupational mix survey may be obtained from MACs or downloaded from CMS’s website at:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files.html

Instructions and definitions for the data elements and the occupational categories are attached.
MEDICARE WAGE INDEX
OCCUPATIONAL MIX SURVEY

Instructions and Definitions

Instructions

Complete this survey for employees who are full-time and part-time, directly hired, and acquired under contract. Do not include employees in areas excluded from IPPS via Worksheet S-3, Part II, Lines 9 and 10, such as skilled-nursing facilities, psychiatric, or rehabilitation units or facilities. This exclusion applies to directly-hired and contract employees who provide either direct or indirect patient care services in IPPS excluded areas. Also, do not include employees or contract labor whose services are excluded from the IPPS, such as physician Part B, and interns and residents. Include employees who are allocated from the home office or related organizations to IPPS reimbursable cost centers and outpatient departments of the hospital that are included in the wage index (e.g., outpatient clinic, emergency room).

Employees in the home office, related organizations, or general services costs centers (Worksheet S-3, Part II, Lines 26 through 43) typically provide services throughout the hospital, including the IPPS-excluded areas (Lines 9 and 10). In completing the survey, a hospital should apply the same methodology it uses for allocating home office and related organization costs on Worksheet S-3, Part II, and exclude from the survey such costs associated with excluded areas. If home office or related organization personnel provide only administrative services, report their wages and hours in the “All Other Occupations” category. To the extent that there are home office or related organization personnel that are engaged in nursing activities, they must be reported in the appropriate nursing subcategory.

Additionally, hospitals should apply the methodology that is used in the wage index calculation for allocating general service salaries and hours to excluded areas. (See Step 4 of the wage index calculation in 76 FR 51592, August 18, 2011, or in the Wage Index Calculator at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/FY-2016-Wage-Index-Home-Page.html.) Note that, although wage-related costs are included in the general service allocation methodology for Worksheet S-3, wage-related costs should be excluded from the general service allocation methodology for the occupational mix survey because the occupational mix survey excludes wage-related costs.

Nursing personnel working in the following cost centers as used for Medicare cost reporting purposes must be included in the appropriate nursing subcategory. These cost centers reflect where the majority of nursing employees are assigned in hospitals and are selected to ensure consistent reporting among hospitals. The wages and hours for nursing personnel working in other areas of the hospital that are reimbursable under the IPPS or OPPS, or nurses who are performing solely administrative functions, would be included in the “All Other Occupations” category.
COST CENTER DESCRIPTIONS

<table>
<thead>
<tr>
<th>Cost Centers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Administration</td>
<td>13</td>
</tr>
<tr>
<td>Adults and Pediatrics (General Routine Care)</td>
<td>30</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>31</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>32</td>
</tr>
<tr>
<td>Burn Intensive Care Unit</td>
<td>33</td>
</tr>
<tr>
<td>Surgical Intensive Care Unit</td>
<td>34</td>
</tr>
<tr>
<td>Other Special Care (specify)</td>
<td>35</td>
</tr>
<tr>
<td>Nursery</td>
<td>43</td>
</tr>
<tr>
<td>Operating Room</td>
<td>50</td>
</tr>
<tr>
<td>Recovery Room</td>
<td>51</td>
</tr>
<tr>
<td>Delivery Room and Labor Room</td>
<td>52</td>
</tr>
<tr>
<td>Electrocardiology</td>
<td>69</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>74</td>
</tr>
<tr>
<td>Ambulatory Surgical Center (Non-Distinct Part)</td>
<td>75</td>
</tr>
<tr>
<td>Other Ancillary</td>
<td>76</td>
</tr>
<tr>
<td>Clinics</td>
<td>90</td>
</tr>
<tr>
<td>Emergency</td>
<td>91</td>
</tr>
<tr>
<td>Observation Beds</td>
<td>92</td>
</tr>
</tbody>
</table>

Note: Subscripted cost centers that would normally fall into one of these cost centers should be included on the survey.

Definitions

Paid Salaries and Paid Hours:

**Paid Salaries** – Include the total of **paid** wages and salaries for the specified category of hospital employees including overtime, vacation, holiday, sick, lunch, and other paid-time-off, severance, and bonuses. Do not include fringe benefits or wage-related costs as defined in Provider Reimbursement Manual, Part II, Section 4005.2.

**Paid Hours** – Include the total **paid** hours for the specified category of hospital employees. Paid hours include regular hours, overtime hours, paid holiday, vacation, sick, and other paid-time-off hours, and hours associated with severance pay. Do not include non-paid lunch periods and on-call hours in the total paid hours. (Note: On-call hours for the occupational mix survey must be treated the same as on-call hours for Worksheet S-3 wage data; see Provider Reimbursement Manual, Part II, section 4005.2, column 5 instructions). Overtime hours must be
calculated as one hour when an employee is paid time and a half. No hours are
required for bonus pay. The hours reported for salaried employees who are paid a
fixed rate must be recorded based on 40 hours per week or the number of hours in
the hospital’s standard workweek.

Occupational Categories:

[The occupational categories and definitions included in this survey derive directly from the U.S.
http://www.bls.gov/oes/current/oes_stru.htm. The numbers in parentheses are the BLS standard
occupational categories (SOCs). As with the BLS survey, workers should be classified in the
occupation that requires their highest level of skill. If there is no measurable difference in skills,
workers are to be included in the occupation in which they spend the most time.]

Registered Nurses (RNs, SOC 29-1141) - Assess patient health problems and
needs, develop and implement nursing care plans, and maintain medical records.
Administer nursing care to ill, injured, convalescent, or disabled patients. May
advise patients on health maintenance and disease prevention or provide case
management. Licensing or registration required. RNs who have specialized
formal, post-basic education and who function in highly autonomous and
specialized roles, may be assigned a variety of roles such as staff nurse, advanced
practice nurse, case manager, nursing educator, infection control nurse,
performance improvement nurse, and community health nurse. Advanced
practice nurses (APNs) (that is, nurse practitioners, clinical nurse specialists,
certified nurse midwives, and certified registered nurse anesthetists) are usually
paid by Medicare under a Part B fee schedule and are not included in the IPPS.
APNs must be excluded from the survey if they are excluded from Worksheet S-3,
Part II, but should be included on the survey if they are included in one of the
cost centers for the survey and are included on Worksheet S-3, Part II.

Licensed Practical Nurses (LPNs, SOC 29-2061) and Surgical
Technologists** (SOC 29-2055) – LPNs: Care for ill, injured, convalescent, or
disabled persons in hospitals, nursing homes, clinics, private homes, group homes,
and similar institutions. May work under the supervision of a registered
nurse. Licensing is required. Surgical Technologists: Assist in operations, under
the supervision of surgeons, registered nurses, or other surgical personnel. May
help set up operating room, prepare and transport patients for surgery, adjust
lights and equipment, pass instruments and other supplies to surgeons and
surgeon's assistants, hold retractors, cut sutures, and help count sponges, needles,
supplies, and instruments.

Nursing Assistants (SOC 31-1014) and Orderlies** (31-1015) - Nursing
Assistants: Provide basic patient care under direction of nursing staff. Perform
duties, such as feed, bathe, dress, groom, or move patients, or change linens. May
transfer or transport patients. Includes nursing care attendants, nursing aides, and
nursing attendants. Orderlies**: Transport patients to areas such as operating
rooms or x-ray rooms using wheelchairs, stretchers, or moveable beds. May
maintain stocks of supplies, or clean and transport equipment.
**Medical Assistants** (SOC 31-9092) - Performs administrative and certain clinical duties under the direction of a physician. Administrative duties may include scheduling appointments, maintaining medical records, billing, and coding for insurance purposes. Clinical duties may include taking and recording vital signs and medical histories, preparing patients for examination, drawing blood, and administering medications as directed by physician. Exclude “Physician Assistants” (29-1071). Include only those employees who perform administrative and certain clinical functions under the direction of a physician in the IPPS cost centers and outpatient areas of the hospital that are listed above. Do not include phlebotomists, information technology personnel, health information management personnel, medical secretaries, ward clerks, and general business office personnel.

**Note:** Medical Assistants, Orderlies, and Surgical Technologists are “nursing” employees for purposes of the occupational mix survey. Whenever the terms “nursing staff”, “nursing personnel”, “nursing occupations”, “nursing employees”, or “nursing categories” are used with regard to the occupational mix survey, they are deemed to include medical assistants, orderlies, and surgical technologists.

Note: Only nurses, surgical technologists, nursing aides/assistants/orderlies, and medical assistants, as defined on the survey, can be included in the respective RNs, LPNs, Surgical Technologists, Aides/Assistants/Orderlies, and MAs categories. Do not include other occupations that may provide similar services as nursing personnel. Instead, those occupations (if assigned to IPPS/OPPS areas of the hospital) must be included in the All Other Occupations category. For example, hospital-based paramedics may provide services that are similar to those provided by nursing personnel; however, on the occupational mix survey, these non-nursing occupations must be included in All Other Occupations. This is to ensure consistent reporting among hospitals.

**All Other Occupations** – Non-nursing employees (directly hired and under contract) in IPPS reimbursable cost centers and outpatient departments that are included in the wage index (e.g., outpatient clinic, emergency room) must be included in the “All Other Occupations” category. In addition, this category would include the wages and hours of nurses (including APNs) that function solely in administrative or leadership roles, that do not directly supervise staff nurses who provide patient care, and do not provide any direct patient care themselves. This category must not include occupations that are excluded from the wage index (such as physician Part B services, interns, residents, and the services of APNs - nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists – that are excluded from the wage index because their services are billable under a Part B fee schedule). Also, the “All Other Occupations” category must not include employees in areas of the hospital that are excluded from the wage index via Worksheet S-3, Part II, Lines 9 and 10, such as skilled nursing, psychiatric, and rehabilitation units and facilities. Therapists and therapy assistants, equipment technologists and technicians, medical and clinical laboratory staff, pharmacists and pharmacy technicians, administrators (other than nursing), computer specialists, dietary, and housekeeping staff are examples of employees who should be reported in the “All Other Occupations” category. Also include the wages and hours of personnel from the home office or related organizations if they perform solely
administrative functions and work in IPPS cost centers and outpatient departments that are included in the wage index.

Note: Do not include salaries and hours for APNs (nurse practitioners, clinical nurse specialists, nurse midwives, or certified registered nurse anesthetists) in any of the Nursing or All Other Occupations categories if their services are billable under Medicare Part B. The services of these nurses are generally billable under a Part B fee schedule and excluded from the wage index because they are not paid under the hospital inpatient prospective payment system (IPPS).
Date:  /  /  

Provider CCN:  
Provider Contact Name:  
Provider Contact Phone Number:  
Reporting Period:  Pay Periods Ending Between 01/01/2016 and 12/31/2016 

Report Paid Salaries and Paid Hours in whole numbers. Round Average Hourly Wage to 2 decimal places.

<table>
<thead>
<tr>
<th>Occupational Category</th>
<th>Paid Salaries</th>
<th>Paid Hours</th>
<th>Average Hourly Wage (Salaries/Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Occupations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>RNs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPNs and Surgical Technologists</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nursing Assistants and Orderlies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Assistants</td>
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<tr>
<td>Total Nursing</td>
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<td></td>
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<tr>
<td>All Other Occupations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (Nursing and All Other)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Do not mark in shaded areas.