Hospital Rate Setting
Rate Year 2015

Wisconsin Department of Health Services
Division of Health Care Access and Accountability

Bureau of Fiscal Management
July 24, 2014

Agenda

1. Introduction and Welcome
2. SFY2014 Assessment Closeout Plan
3. RY2015 Rate Setting Approach and Timeline
4. RY2015 Policy Requests
5. APR-DRG Transition Feedback
6. Additional Updates
7. Dates of Upcoming MHRAG Meetings
8. Public Comment
9. Adjournment
SFY2014 Assessment Closeout Plan

- DHS finalized the SFY2014 Hospital and Critical Access Hospital Assessment Mid-Year Review for June 2014
  - FFS access payments and utilization are trending lower than originally projected
  - To account for the FFS under spending, DHS will make retroactive rate adjustments for all SFY2014 FFS inpatient and outpatient claims
    - Rate adjustments will occur after the SFY2014 shut off date
    - Rate adjustments will be processed and paid as a cash transaction (not claim adjustments)
    - Below are the projected rate changes; final rates will be calculated after the shut off date

<table>
<thead>
<tr>
<th>IP &amp; OP ACH, Rehab, CAH Rates</th>
<th>Current Rate</th>
<th>Projected Rate</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP FFS PPS Access Payment / Discharge</td>
<td>$3,822</td>
<td>$4,110</td>
<td>$288</td>
</tr>
<tr>
<td>OP FFS PPS Access Payment / Visit</td>
<td>$311</td>
<td>$359</td>
<td>$48</td>
</tr>
<tr>
<td>IP FFS CAH Access Payment / Discharge</td>
<td>$972</td>
<td>$977</td>
<td>$5</td>
</tr>
<tr>
<td>OP FFS CAH Access Payment / Visit</td>
<td>$30</td>
<td>$35</td>
<td>$5</td>
</tr>
</tbody>
</table>

- This retroactive rate adjustment plan assumes that DHS will reconcile the HMO payments for May and June at the full 100%

SFY2014 Assessment Closeout Plan

- DHS will shut off SFY2014 FFS access payments on October 1, 2014
  - This is consistent with prior years and leaves time for the retroactive cash transaction before the Reconciliation Report is due to the Legislature
  - In SFYs 2011-2013, this date has seen 95.57%, 97.32%, and 94.46% claims completion for the fiscal year, respectively
**SFY2014 Assessment Closeout Plan**

- For an overview of the current SFY2014 Assessment Interim Reconciliation projections for acute care & rehab hospitals:
  - **Handout 1: SFY2014 ACH & Rehab Assessment Mid-Year Review**

- For an overview of the SFY2014 Assessment Interim Reconciliation projections for critical access hospitals:
  - **Handout 2: SFY2014 CAH Assessment Mid-Year Review**

- For acute care & rehab hospital-specific payment projections before and after rate adjustments:
  - **Handout 3: SFY2014 ACH & Rehab Assessment Mid-Year Detail**

- For critical access hospital-specific payment projections before and after rate adjustments:
  - **Handout 4: SFY2014 CAH Assessment Mid-Year Detail**

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**RY2015 Rate Setting Approach and Timeline**

**RY2015 Hospital Budget Development**

- DHS uses a methodology for determining the hospital budget based on actual data from the previous state fiscal year

- Methodology for developing the hospital budget for RY2015
  a. Base data: use SFY2014 (July 1, 2013 – June 30, 2014) expenditures, based on date of payment
  b. Utilization: use SFY2014 actual utilization, based on date of payment
  c. Trend adjustment: Calculate and apply an adjustment in order to appropriately account for increases to CAH costs and changes to case mix for acute care hospitals
RY2015 Rate Setting Approach and Timeline

RY2015 Hospital Budget Development

• Methodology for developing the hospital budget (cont.)
  c. Trend adjustment (cont.):
    ▪ CAHs: use the three-year, total cost (from HCRIS) trend for CAHs only
    ▪ In-state acute care and major border status hospitals: use a 50/50 blend between the three-year, total cost (from HCRIS) trend and the national Global Insight Hospital Index trend
    ▪ This is the same methodology that was employed for RY2014
  d. The rates are developed to target this RY2015 budget number based on the above methodology

DRG Weight Recalibration Methodology

• DRG Grouper version: V31 Medicare Grouper
  o Same version as in use for RY2014
  o The earlier rate setting timeline precludes a version change this rate year

• Methodology for calculating Wisconsin-specific DRG weights
  1. Aggregate three most recent state fiscal years of FFS Medicaid claims data (SFY 2012, 2013, 2014) by date of payment and CY2013 HMO Medicaid encounter data by date of service
  2. Assign each ICN to V31 by running claims through the CMS MS-DRG Grouper Software
  3. Reassign relevant DRGs to Wisconsin-specific DRGs for neonatal, psychiatric, and transplant services
DRG Weight Recalibration Methodology

4. Calculate Medicaid cost per claim by ICN
   - Provider specific cost is determined by using Medicare cost report data accessible through the Healthcare Cost Report Information System (HCRIS) maintained and published by CMS
   - Three specific cost to charge ratios (CCRs) are calculated for each provider to determine the Medicaid cost per diem, which include accommodation, ancillary, and transplant service CCRs
   - Revenue codes are cross-walked to determine which CCR should be applied for each claim line to calculate Medicaid cost
   - Adjust Medicaid cost to remove provider-specific differences by applying net equivalent cost factor (adjusts costs to account for differences in wages, capital, and graduate medical education programs)
   - Apply claim specific inflation factor

5. Aggregate claim cost (less any outlier payments) by DRG and ICN

6. Calculate geometric mean and standard deviation for each DRG

7. Remove those claims that are determined to be outliers
   - An outlier is a claim that has a value either above/below 3 standard deviations from the mean

8. Calculate Medicaid DRG weight for each DRG code
   - Cost per DRG (for all claims accepted) / Average Cost for All DRGs (for all claims accepted)
RY2015 Rate Setting Approach and Timeline

DRG Weight Recalibration Methodology

- Methodology for calculating Wisconsin-specific DRG weights (cont.)
  9. Regroup weights to align with Medicare DRG hierarchy within DRG service groups
    - Weights should be properly aligned based upon the acuity of the case: highest weight should be for "services with major complications and comorbidities" then those services "with complications and comorbidities", and "without complications and comorbidities"
  10. Verify statistical significance of claims used to calculate weights for each DRG
    - Default to Medicare weight for DRG if count is less than 30 claims per DRG
- Handout 5: DRG Weight Calculation Example

EAPG Weight Recalibration Methodology

- EAPG Grouper version: 3.9
  - RY2014 used version 3.7
- Methodology for calculating Wisconsin-specific EAPG weights
  1. Aggregate three most recent state fiscal years of FFS Medicaid and Crossover claims data (SFY 2012, 2013, 2014) by date of payment and CY2013 HMO Medicaid encounter data by date of service
  2. Assign each ICN to version 3.9 by running claims through the 3M EAPG Grouper Software
  3. Crosswalk revenue codes from claims to Medicare cost report cost centers
  4. Calculate the CCR from Medicare cost report within HCRIS
RY2015 Rate Setting Approach and Timeline

EAPG Weight Recalibration Methodology

- Methodology for calculating Wisconsin-specific EAPG weights (cont.)

5. Apply hospital-specific, cost center-specific CCR to charges to obtain cost
6. Standardize hospital data across time periods and hospitals statewide
7. Remove those claims that are determined to be outliers
   - An outlier is a claim that has a value either above/below 3 standard deviations from the mean
8. Weight of each EAPG is calculated as follows:

   \[
   \frac{\text{Average Cost of EAPG}}{\text{Average Cost of All EAPGs}}
   \]

- Handout 6: EAPG Weight Calculation Example

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<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Rate Setting Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Access Hospitals</td>
<td>Prospective cost per discharge</td>
</tr>
<tr>
<td>Psychiatric &amp; Rehabilitation Hospitals</td>
<td>Prospective cost per diem rate</td>
</tr>
<tr>
<td>Acute Care Hospitals, including Major Border Status Hospitals</td>
<td>Prospective payment per discharge, incorporating provider-specific attributes</td>
</tr>
<tr>
<td>Minor Border Status Hospitals &amp; Out of State Hospitals</td>
<td>Prospective payment per discharge, no incorporation of provider-specific attributes</td>
</tr>
</tbody>
</table>

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RY2015 Rate Setting Approach and Timeline

Inpatient Hospital Rate Setting Methodology

- High level overview of inpatient rate setting methodology by provider type (each methodology is explained in detail on the following slides)
<table>
<thead>
<tr>
<th>Inpatient Hospital Rate Setting Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Critical Access Hospitals Inpatient Rate Setting Methodology</td>
</tr>
<tr>
<td>• Critical access hospitals are paid a provider-specific cost-based prospective payment per discharge</td>
</tr>
<tr>
<td>• These payments are not cost settled due to the implementation of the provider assessment and CAHs receiving access payments</td>
</tr>
<tr>
<td>• Steps completed to calculate CAH rates:</td>
</tr>
<tr>
<td>1. Determine provider’s most recently audited Medicare cost report</td>
</tr>
<tr>
<td>2. Calculate Medicaid costs based upon provider’s fiscal year end and/or Medicare cost reporting period and Medicaid paid claims data from the Medicaid Management Information System (MMIS)</td>
</tr>
<tr>
<td>3. Limit capital costs to 8%</td>
</tr>
<tr>
<td>4. Account for historical outlier payments</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Inpatient Hospital Rate Setting Methodology (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Steps completed to calculate CAH rates (continued):</td>
</tr>
<tr>
<td>5. Calculate Medicaid cost per discharge which corresponds to the provider’s appropriate Medicare cost reporting period</td>
</tr>
<tr>
<td>6. Inflate cost per discharge by applying inflation factor from Global Insight</td>
</tr>
<tr>
<td>7. Divide cost per discharge by provider’s specific case mix index to remove case mix from the provider’s calculated cost per discharge</td>
</tr>
<tr>
<td>• Case Mix = Aggregated DRG Weights for All Discharges/Total Number of Discharges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculations result in the rate that will be paid to CAHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <strong>Handout 7: Inpatient CAH Rate Calculation Example</strong></td>
</tr>
</tbody>
</table>
Inpatient Hospital Rate Setting Methodology

• Psych & Rehab Hospitals Inpatient Rate Setting Methodology
  • Psych and rehab hospitals are paid a provider-specific prospective cost per day, or per diem, rate
  • Steps completed to calculate psych and rehab rates:
    1. Determine provider's most recently audited Medicare cost report
    2. Calculate Medicaid costs based upon provider's fiscal year end and/or Medicare cost reporting period and Medicaid paid claims data from MMIS
    3. Limit capital costs to 8%

• Psych & Rehab Hospitals Inpatient Rate Setting Methodology (cont.)
  • Steps completed to calculate psych and rehab rates (cont.):
    4. Calculate Medicaid cost per day which corresponds to the provider’s appropriate Medicare cost reporting period
    5. Inflate cost per day by applying inflation factor from Global Insight
    6. Adjust the cost per day to 85% of costs

• Handout 8: Inpatient Psych & Rehab Rate Calculation Example
• Acute Care Hospital Inpatient Rate Setting Methodology
  1. DRG Base Rate (Statewide)
  2. Wage Index Adjustment (Provider-Specific)
  3. Capital Add-On (Provider-Specific)
  4. Graduate Medical Education (Provider-Specific)
  5. Rural Hospital Adjustment (Provider-Specific)

• There are additional factors used to calculate projected acute care hospital payments:
  1. Projected Case Mix Index (Provider-Specific)
  2. Projected Utilization (Provider-Specific)
  3. Projected Outlier Payments (Provider-Specific)

1. DRG Base Rate (Statewide)
   • Represents the average payment per discharge (prior to the application of case mix) that DHS will reimburse providers given historical utilization and projected case mix

2. Wage Index Adjustment (Provider-Specific)
   • Approximately 75% of the DRG base rate is adjusted to recognize difference in wages across Wisconsin hospitals
   • Wage data is obtained through CMS’ most recent fiscal year’s “Final Occupational Mix Factor By Provider” wage index file
   • DHS uses this data to calculate a statewide average wage rate
   • The hospital-specific wage index for each hospital is the hospital-specific average wage divided by statewide average wage
   • This adjustment redistributes funding to providers based upon their wages in relation to the statewide average
Inpatient Hospital Rate Setting Methodology

3. Capital Add-On (Provider-Specific)
   - Provider specific Medicaid capital cost per discharge is calculated to recognize differences in provider capital costs.
   - Capital cost is determined by multiplying the Medicaid inpatient cost by the ratio of hospital capital costs to total hospital costs.
   - Capital cost is limited to no more than 8% of a hospital’s total cost.
   - Capital cost is inflated using the Global Insight’s Hospital and Related Services Individual Price Index.
   - Capital cost is divided by the number of case mix-adjusted discharges.
   - The resulting amount is added to the DRG base rate.

4. Graduate Medical Education Add-On (Provider-Specific)
   - Medicaid graduate medical education cost per discharge is calculated to recognize the cost incurred by teaching hospitals for training future physicians.
   - Graduate medical education cost is determined by multiplying Medicaid inpatient cost by the ratio of hospital GME costs to total hospital costs.
   - GME cost is divided by the number of case mix-adjusted discharges.
   - The resulting amount is added to the DRG base rate.
RY2015 Rate Setting Approach and Timeline

Inpatient Hospital Rate Setting Methodology

• Acute Care Hospital Inpatient Rate Setting Methodology

5. Rural Hospital Adjustment (Provider-Specific)
   • A hospital may qualify for a rural hospital adjustment if it meets the conditions outlined in the Inpatient Medicaid State Plan
   • The adjustment is applied if a provider’s case mix and utilization is less than the median for these measures for urban hospitals
   • The adjustment is applied to the DRG base rate

• The incorporation of the above components results in the hospital-specific DRG rate

• Handout 9: Inpatient ACH Rate Calculation Example

• Acute Care Hospital Inpatient Rate Setting Methodology (cont.)

• Once rates are established, payments are projected to estimate the provider-specific impact
  • In order to estimate this impact, DHS calculates projected case mix
  • The utilization used to develop the case mix is the same as the utilization used for the RY2015 hospital budget
  • This is the utilization from date of payment SFY2014
RY2015 Rate Setting Approach and Timeline

Inpatient Hospital Rate Setting Methodology

- Acute Care Hospital Inpatient Rate Setting Methodology (cont.)
- Once rates are established, payments are projected to estimate the provider-specific impact (cont.)
  - What is case mix index and how is it calculated?

<table>
<thead>
<tr>
<th>ICN</th>
<th>DRG Code</th>
<th>DRG Weight</th>
<th>Count of ICN</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456789</td>
<td>9678</td>
<td>.40</td>
<td>1</td>
</tr>
<tr>
<td>234567891</td>
<td>321</td>
<td>.80</td>
<td>1</td>
</tr>
<tr>
<td>345678912</td>
<td>245</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>456789123</td>
<td>9601</td>
<td>2.1</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>4.8</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Case Mix Index</td>
<td>1.2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outpatient Hospital Rate Setting Methodology

- High level overview of outpatient rate setting methodology by provider type (each methodology is explained in detail on the following slides)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Rate Setting Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Access Hospitals</td>
<td>Prospective cost based on EAPG pricing</td>
</tr>
<tr>
<td>Acute Care Hospitals, Psych and Rehab Hospitals</td>
<td>Prospective payment based on EAPG pricing, incorporating provider specific attributes</td>
</tr>
<tr>
<td>Out of State Hospitals, Major Border Status Hospitals, Minor Border Status Hospitals</td>
<td>Prospective payment based on EAPG pricing, no incorporation of provider specific attributes</td>
</tr>
</tbody>
</table>
RY2015 Rate Setting Approach and Timeline

Outpatient Hospital Rate Setting Methodology

• Critical Access Hospitals Outpatient Rate Setting Methodology
  • Steps completed to calculate CAH rates:
    1. Calculate hospital specific Medicaid costs using the most recently audited Medicare cost report for the provider
    2. Determine net hospital capital costs and net hospital total costs using the most recently audited Medicare cost report for the provider
    3. Calculate capital cost percentage
    4. Calculate Medicaid capital costs
    5. Determine Medicaid capital cost limitation
       • 8% of outpatient Medicaid costs
    6. Limit capital costs to the lesser of Medicaid capital cost or 8% of outpatient Medicaid costs
    7. Determine Medicaid visits from MMIS
    8. Calculate Medicaid cost per visit
    9. Identify IHS Global Insight Factor

Outpatient Hospital Rate Setting Methodology (cont.)

• Critical Access Hospitals Outpatient Rate Setting Methodology (cont.):
  • Steps completed to calculate CAH rates (cont.):
    10. Inflated Medicaid cost per visit to the current rate year
    11. Determine the current rate year projected Medicaid visits from MMIS
    12. Calculate projected current rate year payments
    13. Determine projected adjusted current rate year weights
       • The adjusted weights include all packaging and discounting in the current EAPG reimbursement system
    14. Calculate CAH specific rate

Handout 10: Outpatient CAH Rate Calculation Example
RY2015 Rate Setting Approach and Timeline

Outpatient Hospital Rate Setting Methodology

• Acute Care, Psych, & Rehab Hospital Outpatient Rate Setting Methodology
  • There are several components to acute care hospital rates:
    1. EAPG Base Rate (Statewide)
    2. Direct Graduate Medical Education (Provider-Specific)
  • There are additional factors used to calculate projected acute care hospital payments:
    1. Projected Adjusted Weights (Provider-Specific)
    2. Projected Lab Payments (Provider-Specific)

1. EAPG Base Rate (Statewide)
   • Represents the average payment per adjusted weight that DHS will reimburse providers given historical case mix

2. Graduate Medical Education Add-On (Provider-Specific)
   • Medicaid graduate medical education cost per adjusted weight is calculated to recognize the cost incurred by teaching hospitals for training future physicians
   • Graduate medical education cost is determined by multiplying the projected Medicaid outpatient cost by the ratio of hospital GME costs to total hospital costs
   • Medicaid GME cost is divided by the adjusted weights
   • The resulting amount is added to the EAPG base rate

• Handout 11: Outpatient ACH Rate Calculation Example
RY2015 Rate Setting Approach and Timeline

Outpatient Hospital Rate Setting Methodology

• Acute Care Hospital Outpatient Rate Setting Methodology (cont.)

• Once rates are established, payments are projected to estimate the provider-specific impact
  • In order to estimate this impact, DHS calculates projected adjusted weights
  • The adjusted weights is calculated by aggregating each provider’s claims experience (total weights)

RY2015 Policy Requests

• DHS is currently incorporating the following policy changes for Rate Year (RY) 2015:
  o Encounter data will be modeled and evaluated with the FFS data for both MS-DRG and EAPG weights configuration
  o Weights will be set for all EAPGs other than “inpatient only” and “uncategorized” EAPGs

• DHS received and is currently reviewing the following other policy requests submitted by hospitals for RY2015:
  o Determining outlier trimpoints using criteria other than bed counts
APR-DRG Transition Feedback

- DHS has received multiple responses from hospitals with concerns about the similar timeline for implementing APR-DRGs and ICD-10

- To account for these concerns, DHS can offer an alternate timeline for APR-DRG implementation:
  - DHS will model the fiscal impact of the APR-DRG implementation and prepare the MMIS system in 2015
  - If the ICD-10 implementation date remains October 1, 2015, DHS would go live with APR-DRGs on January 1, 2017
  - If the ICD-10 implementation is further delayed, DHS would go live with APR-DRGs on January 1, 2016

APR-DRG Transition Feedback

- Unlike the APR-DRG grouper, the MS-DRG does not support the transition to ICD-10 well (no internal conversion of codes, etc.)
- Therefore, in order to delay implementation of APR-DRGs until January 1, 2017, DHS would need to take the following steps:
  - Move to an ICD-10 MS-DRG grouper on October 1, 2015 to process claims for the remainder of RY2015, but process those claims using the RY 2015 weights which were based on the ICD-9 grouper
    - Any new DRGs introduced with that grouper would use a national weight
  - Starting for RY 2017, the historical weight-setting data will be a mix of ICD-9 and ICD-10 codes—which is why DHS proposes to implement APR-DRGs no later than January 1, 2017
  - Implementation of APR-DRGs eliminates the need for these actions
APR-DRG Transition Feedback

- Questions for hospitals to consider:
  - How do the interactions between ICD-10 and MS-DRGs (described on the previous slide) impact (if at all) your preferences about the timing of an APR-DRG transition?
  - Is it better to have two transitions spaced out (October 1, 2015 followed by January 1, 2017) or to basically have one bigger transition (October 1, 2015 followed by January 1, 2016 or perhaps even both on October 1, 2015)?

- Please send feedback on these questions to david.hoffert@dhs.wisconsin.gov

Additional Updates

- SFY2015 assessment timeline
  - New acute care/rehabilitation hospital and critical access hospital access payment rates will be effective for July 1, 2014
    - Acute care/rehabilitation hospital access payment rates will be available and installed in mid-summer, with claim adjustments back to July 1, 2014
    - Critical access hospital access payment rates will be available and installed in late summer, with claim adjustments back to July 1, 2014
  - Provider tax amounts will be available in mid-August
    - DHS will send the tax amounts out for provider review
    - First assessment bill will be due September 30, 2014
  - SFY2015 hospital assessment model will be available in September
Additional Updates

- SFY2015 DSH payments timeline
  - Model will be available for review late summer
  - Targeting four quarterly payments this year, first one late September
- FY2007 lab and outpatient non-CAH settlements going out this week
- Childless adults began enrolling in HMOs in July
  - Will continue to be enrolled into HMOs over the next several months
- Budget dashboard will be discussed further at August MHRAG
  - DHS will present all four quarters of SFY2014, trend factor, etc.
  - Opportunity for further discussion of utilization changes at this time
- RY2015 weights and rates will be presented at September MHRAG

Dates of Upcoming MHRAG Meetings

- Wednesday, August 20, 2014, 9:30 AM – 12:00 PM
  - Room B139, State Office Building, 1 W Wilson St, Madison, WI
  - [https://meet.lync.com/widhs-dhs/amy.callender/H5Z31631](https://meet.lync.com/widhs-dhs/amy.callender/H5Z31631)
  - (866) 715-6499, participant passcode 7743838822
  - *Note the change in room from previous communications!*

- Tuesday, September 30, 2014, 1:30 PM – 4:00 PM
  - Room 751, State Office Building, 1 W Wilson St, Madison, WI
  - [https://meet.lync.com/widhs-dhs/amy.callender/GV9PFPJO](https://meet.lync.com/widhs-dhs/amy.callender/GV9PFPJO)
  - (866) 715-6499, participant passcode 7743838822
Request for Public Comment

Questions

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All Questions can be sent by EMAIL to: DHSDHCAABFM@dhs.wisconsin.gov