Hospital Assessment – Frequently Asked Questions

1. **Q: How much will my hospital have to pay and when are the payments due?**

   A: Your hospital's assessment amount for State Fiscal Year 2009 has been calculated based on 1.2768% of gross patient revenue, modified to exclude certain services, such as physician services. The assessment invoices mailed by DHS on February 27 detailed the methodology for computing the assessment amount. By law, one half of the SFY09 payment is due March 31, 2009, and the second half is due June 30, 2009. The law also provides DHS the discretion to grant payment extensions. **DHS has extended the due date of the first SFY09 payment due April 30, 2009 to align with the proposed rate increase payment schedule.**

2. **Q: Will my Medicaid payments increase as a result of the assessment?**

   A: Yes, for SFY 2009, your fee-for-service payment rates have been calculated to so that they equal 88% of your costs for inpatient services and 99% for outpatient services. You will also be receiving additional payments through any HMOs that you contract with, as explained in Q5 below.

3. **Q: How will my hospital be notified?**

   A: Each hospital should have already received a letter informing it of the rate changes together with the rates.

4. **Q: When will my hospital receive the payment increases?**

   A: The new fee-for-service rates were loaded into the Forward system and new rates began being paid starting on March 1. However, since the new fee-for-service rates apply back to July 1, 2008, and your hospital has already been paid based on the old rates, a lump sum retroactive payment will be made for SFY 2009 claims paid from July 1 2008 through January 31 2009. The lump sum payments will be made by April 10, 2009.

5. **Q: Will there be a difference between fee-for-service payments and payments made through HMOs?**

   A: Yes. As indicated above, fee-for-service payments will be made based on the new cost-based rates. HMO payments, on the other hand, will have two components. To the extent that your Medicaid HMO rate is based on the "fee-for-service rate schedule," the SFY08 (pre-assessment) rate will apply. These payments will be made in usual fashion, based on your hospital submitting a claim to the HMO. The second payment, called an access payment, will be based on your hospital's share of claims paid to the total number of Medicaid claims paid by that HMO to all of its contracted, assessed hospitals. There will be separate inpatient and outpatient access payments, each based on your share of either inpatient discharges or outpatient visits in the claims paid by that HMO.

6. **Q: Will there be assessments after June 2009?**

   A: Yes. The State budget includes two more years of hospital assessments, for SFY 2010 and 2011. The assessment does not sunset after that, but new assessment amounts beyond SFY2011 will be established as part of the 2011-2013 budget.

7. **Q: How will the assessment amounts be computed?**

   A: The Governor proposed total assessments of $310 million in SFY 2010 and $340 million in SFY 2011, so the calculation will involve computing each hospital's share of those totals. Total taxable gross patient revenue aggregated for all 73 participating hospitals will then be computed. A uniform assessment percentage will be derived by dividing the total assessment amounts by the aggregate gross patient revenue. This uniform percentage will then be applied to each hospital's gross patient revenue. The data source for gross patient revenue will continue to be the Hospital Fiscal Survey, with the 2008 survey being used for the 2010 assessment, and the 2009 survey used for 2011. Hospital filed cost reports will be used to adjust the totals to exclude certain services from the computation, consistent with the methodology detailed by DHS in the first assessment invoices mailed 2/27/09.

8. **Q: When will the assessments be due in 2010-2011?**

   A: One-fourth of the annual assessment amount will be due at the end of each calendar quarter: September, December, March, and June.

9. **Q: Will fee-for-service rates change in 2010-2011?**

   A: Yes. In contrast to the 2009 rates, where the increase from the assessment was combined into a single rate, the fee-for-service rates for 2010 and 2011 will be divided into two rates: a "base payment" derived using the pre-assessment rate methodology and an access payment. Fee-for-service access payments will be made using the same HMO methodology outlined above: Inpatient access payments will be made to hospitals based on their share of inpatient discharges, and outpatient access payments based on the share of outpatient visits.

10. **Q: How will HMO payments be made in 2010-2011?**

    A: HMO payments will be made on the same basis as 2009. There will be two components: payments on claims for services as submitted by hospitals, and access payments resulting from each hospital's share of claims volumes. To the extent that Medicaid HMO "base payments" reference the fee-for-service rate schedule, SFY10 and SFY11 fee-for-service rates will apply. The example on the following page will illustrate how the HMO payments are made.

11. **Q: How will I know that my hospital is being paid its appropriate share of access payments?**

    A: By the 15th of each month, HMOs must pay out all of the access payments they had received on the first of the month. The payments will be based on the example below. HMOs must provide each hospital information showing the inpatient and outpatient paid claims volumes for

the previous month, the hospital's share of those volumes, and the resulting payment to the hospital. HMOs will also provide the same information to DHS, so that DHS can validate that the appropriate payments were made.

Month 1

Capitation Payments for Hospital Access Payments Received

Inpatient	$1,200,000
Outpatient	$650,000
Total	$1,850,000

Number of Hospital Claims Paid

	Hospital A	Hospital B	Hospital C	Hospital D	Total
Inpatient	25	53	78	105	261
% of Total	9.6%	20.3%	29.9%	40.2%	100.0%
Outpatient	1,500	1,280	650	4,350	7,780
% of Total	19.3%	16.5%	8.4%	55.9%	100.0%

Access Payments Made to Hospitals Based on Number of Claims Paid Last Month (Month 0)

	Hospital A	Hospital B	Hospital C	Hospital D	Total
Inpatient	$111,628	$251,163	$346,047	$491,163	$1,200,000
% of Total	9.3%	20.9%	28.8%	40.9%	100.0%
Outpatient	$113,842	$98,364	$89,276	$348,517	$650,000
% of Total	17.5%	15.1%	13.7%	53.6%	100.0%

Month 2

Capitation Payments for Hospital Access Payments Received

Inpatient	$1,350,000
Outpatient	$825,000
	$2,175,000

Number of Hospital Claims Paid

	Hospital A	Hospital B	Hospital C	Hospital D	Total
Inpatient	47	65	82	98	292
% of Total	16.1%	22.3%	28.1%	33.6%	100.0%
Outpatient	1,155	1,450	725	2,230	5,560
% of Total	20.8%	26.1%	13.0%	40.1%	100.0%

Access Payments Made to Hospitals Based on Number of Claims Paid Last Month (Month 1)

	Hospital A	Hospital B	Hospital C	Hospital D	Total
Inpatient	$129,310	$274,138	$403,448	$543,103	$1,350,000
% of Total	9.6%	20.3%	29.9%	40.2%	100.0%
Outpatient	$159,062	$135,733	$68,927	$461,279	$825,000
% of Total	19.3%	16.5%	8.4%	55.9%	100.0%

12. **Q: How will the lump-sum interim payment be determined?**

    A: The interim payment covers July 2008 – January 2009 fee-for-service claims. It is based on a claims extract that was run in mid-February. This claims set was re-priced using SFY09 rates and weights. The claims set accounts for most of the normal claims lag. This interim payment is an estimate but cannot duplicate all of the claims edits applied by MMIS during actual claims processing.

13. **Q:How will the reconciliation be done of the retroactive claims?**

    A: Beginning in late April, MMIS will retroactively reprocess SFY09 claims. This process is expected to take six weeks. One-sixth of each hospital's interim payment will be recouped weekly to align with the six-week claims reprocess schedule.

14. **Q: Is there a required or preferred method for accounting for the hospital assessment?**

    A: The assessment should be accounted for as an expense that is eligible for inclusion on the hospital cost report.

15. **Q: Will a calculation be included with the invoice for the assessment as to how each hospital's share was arrived at?**

    A: The assessment methodology is detailed in the invoice. For SFY09, each hospital's assessment is based on 1.2768% of its gross patient revenue.

16. **Q: Who at the hospital receive notice of the hospital assessment?**

    A: Assessment invoices are sent to the chief financial officer.

17. **Q: Is there a required method of payment for the hospital assessment?**

    A: As indicated on the invoice, the required payment method is by check, payable to the State of Wisconsin and should be mailed to Wisconsin Department of Health Services; P.O. Box 1668; Madison, Wisconsin 53701-1668

18. **Q: Will hospitals know the assessment every other hospital is being assessed?**

    A: Each hospital's SFY09 assessment amounts were publicly released in materials distributed by the Governor's Office when the assessment was re-introduced on January 14, 2009.

19. **Q: Will there be a third party (WHA) review the hospital assessment for accuracy before hospitals are notified?**

    A: Assessment amounts use the WHA hospital fiscal survey to assure accuracy.

20. **Q: Will hospital rates for SFY 2010 be out before July 1, 2009?**

    A: It is a goal of DHS to publish SFY10 hospital rates prior to 7/1/09.

21. **Q: How will T-19 HMO Plans account for outpatient series (recurring) claims?**

    A: The access payment method will rely on existing HMO claims payment aggregations and does not create a new process for counting or identifying claims.

22. **Q: When will the state begin to use MS DRGs?**

    A: DHS implemented Version 25 prospectively on 3/1/09. Claims will be re-processed using this Grouper back to 7/1/08. Version 26 will be adopted by WI Medicaid on 7/1/09.

23. **Q: Will hospitals receive access payments from HMOs with which they do not contract if the hospital treats the HMO's patient?**

    A: Yes.

24. **Q: How will DHS/HMOs handle large claims that might be billed several times over the course of a particularly long length of stay (e.g., stay is over a year, currently bill every few months)?**

    A: The access payment will be made only when the stay becomes a discharge.

25. **Q: What about bundled claims? Is it per OP visit or per OP claim? (E.g., multiple PTs on one claim form versus each visit on a separate claims form.) What edits will be in place to prevent unbundling of these claims?**

    A: Access payments are computed per paid visit. Physical therapy has been carved out of OP hospital.

26. **Q: The assessment notice says assessment is due by April 30. Is that postmarked or received by DHS?**

    A: Received by DHS on April 30.

27. **Q: What if a hospital, because of the new Forward system, hasn't been paid for many of its claims. Will the lump sum payment be smaller if based on the paid claim totals from July – January? Since a hospital in this situation won't get most of its increase prior to April 30, can the hospital get a hardship waiver?**

    A: Hospitals experiencing problems with claims payments due to interChange should contact us to work out the payment problems. DHS has established a transitional payment process to assure providers are not harmed from interChange payment problems.

28. **Q: Does DHS have historical HMO encounter data so hospitals can estimate payments – make an accrual on their financial statements?**

A: For purposes of estimating payments, hospitals would have their own historical records of what Medicaid HMOs have paid them. Hospitals can contact DHS if they need additional data.

29. Q: What months will be included in the first HMO access payment expected in April?

A: January through April 2009.

30. Q: What months' paid claims will be used as the basis for the first access payment?

A: December 2008 through March 2009.

31. Q: Will June 2009 paid FFS claims be the basis for the FFS access payments in for July 2009?

A: Yes.