WISCONSIN DEPARTMENT of HEALTH SERVICES

State of Wisconsin Medicaid Health Information Technology (HIT) Plan

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Appendix B – Hospital Payment Calculation Methodology

CONTENTS

1 OVERVIEW

This document describes the logic and methodology of the Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS) for participating hospitals' Medicaid Promoting Interoperability (PI) Program payment calculation. This methodology was developed by using the federal mandated formula and discretionary state decisions pertaining to hospitals' sources of data, their reporting of data, and the disbursement of incentive payments to qualifying hospitals.

1.1 Hospital Payment Calculation Formula

To calculate the Medicaid PI Program hospital incentive payments, DMS uses the formula outlined in the Medicare and Medicaid PI Programs' final rule published July 28, 2010:

Aggregate Medicaid Hospital PI Payment = (Overall PI Amount) × (Medicaid Share)

- **Aggregate Medicaid Hospital PI Payment Amount** is the total amount the hospital is eligible to receive in Medicaid PI payments over the duration of the program
- **Overall EHR Amount** = {Sum Over Four Years [(Base Amount + Discharge-Related Amount Applicable for Each Year) × Transition Factor Applicable for Each Year]}
- **Medicaid Share** = {(Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days) / [(Total Inpatient Bed Days) × (Estimated Total Charges – Charity Care Charges) / (Estimated Total Charges)]}

The following section provides a description of the data inputs used in the formula to complete the hospital payment calculation.

1.2 Hospital Payment Calculation Data Inputs

DMS calculates hospital incentive payments using data from two sources: the Medicare cost reports and the DMS Data Warehouse/Decision Support System (DW/DSS). The Medicare cost report data used is based upon the first year the hospital participates in the Medicaid PI Program and the hospital's fiscal year. Eligible Hospitals that received their first Wisconsin Medicaid PI Program payment in either Program Year 2011, 2012, or 2013 used data inputs based on the hospital fiscal year (a 12-month period) that ended in the federal fiscal year (FFY) before the hospital's fiscal year that serves as the first payment year. For Eligible Hospitals initiating program participation in Program Year 2014 or later, all data inputs are or will be based on the most recent, continuous 12-month period prior to the payment year that Medicare cost report data is available.

DMS elected to use Medicare cost reports as a source of data to be consistent with data used in other federal reporting programs pertaining to hospitals, such as the Medicare PI Program. Most hospitals are dually eligible for both PI programs. DMS will work closely with hospitals that do not submit Medicare cost reports (i.e., children's hospitals) to ensure the proper reporting of information for the payment calculation.

The sections that follow provide detail on the data inputs and data sources used to calculate the hospital payments.

1.2.1 Overall EHR Amount

To calculate the overall incentive amount, the table below describes the data inputs used. Two of the data inputs are statutorily defined and do not change, while the third is based on the number of discharges in the hospitals' fiscal year.

Data Input Name	Description	Source of Data
Base Amount	$2,000,000	Statutorily Defined
Discharge-Related Amount	$200× (the 1,150th through the 23,000th discharge for year one) For subsequent years, use discharges adjusted for the hospital's average annual growth rate for the most recent three years for which data are available per year.	Discharges from historical years (prior to 2010) come from the Medicare cost report CMS 2552-96 Worksheet S-3 Part I, column 15, line 12. Discharges from current years (2010 and beyond) come from the Medicare cost report CMS 2552-10 Worksheet S-3 Part I, column 15, line 14.
Transition Factor	Year 1 = 1 Year 2 = 0.75 Year 3 = 0.50 Year 4 = 0.25	Statutorily Defined

Figure B.01: Hospital Payment Calculation Factors

1.2.2 Medicaid Share

The Medicaid share is calculated using the data inputs described in the table below. These data inputs are variable and depend upon the hospitals' operations data for the fiscal year. Most of these data inputs are reported in the Medicare cost report; however, some information is provided by DMS due to limitations in the hospitals' ability to identify Title XIX data.

Data Input Name	Description	Source of Data
Medicaid Inpatient Bed Days*	Medicaid (Title XIX) fee-for-service inpatient bed days for the hospital's cost reporting period	DW/DSS
Medicaid Managed Care Inpatient Bed Days*	Medicaid (Title XIX) managed care inpatient bed days for the hospital's cost reporting period	DW/DSS
Total Inpatient Bed Days	Total inpatient bed days for the hospital's cost reporting period	Medicare cost report CMS 2552-96 Worksheet S-3, Part I, column 6, sum of lines 1 and 6-10 Medicare cost report CMS 2552-10 Worksheet S-3 Part I, column 8, sum of lines 1 and 8-12

Data Input Name	Description	Source of Data
Total Charges	Total inpatient charges for the hospital's cost reporting period	Medicare cost report CMS 2552-96 Worksheet C, Part I, column 8, line 101 Medicare cost report CMS 2552-10 Worksheet C Part I, column 8, line 200
Charity Care Charges	Total charity care charges for the hospital's cost reporting period	Medicare cost report CMS 2552-96 Worksheet S-10, line 12 Medicare cost report CMS 2552–10 Worksheet S-10, column 3, line 20

Figure B.02: Medicaid Data Inputs for Hospital Payment Calculation

*This information is provided by DMS. Details on the methods used to identify these data inputs are explained in Section 1.2.2.1.

1.2.2.1 Medicaid Inpatient Bed Days and Medicaid Managed Care Inpatient Bed Days Calculation Methodology

Currently, the integrated delivery of benefit programs under the Wisconsin ForwardHealth programs leaves acute care hospitals and children's hospitals unable to distinguish between Medicaid (Title XIX) and CHIP (Title XXI) encounters. To assist hospitals in determining Title XIX encounters, DMS will calculate each hospital's Medicaid (Title XIX) inpatient bed day proportion using fee-for-service claims and managed care encounter data available through DW/DSS.

For the purposes of this calculation, Medicaid (Title XIX) inpatient bed days are defined as the number of days patients spent in an operating bed at the census-taking hour (midnight) during the reporting period where Medicaid paid all or part of the day's services. In situations where the patient was admitted and discharged on the same day, this will count as one inpatient bed day. The following exceptions apply:

1. Normal birth nursery bed days (DRG 795) are not considered inpatient bed days based on the level of care provided during a normal nursery stay.
2. Observation patient bed days (revenue codes 0769, 0760, 0761, and 0762) are not considered inpatient bed days.
3. Eligible Hospitals participating in the Wisconsin Medicaid PI Program may not include Medicare crossover patients in the Medicaid inpatient bed day count when calculating the Medicaid share.

DMS will refer to the following conditions when aggregating institutional claims into a hospital encounter.

Condition	Description
Hospital	Only encounters attributed to the hospital through the billing provider National Provider Identifier on the submitted encounter will be included in the aggregation of Medicaid inpatient bed days.
Claim Types	Hospitals only participating in the Medicaid PI Program will include inpatient encounters attributed to the hospital in their aggregation of Medicaid inpatient bed days only. If a hospital is participating in both the Medicaid and Medicare PI programs as a dually eligible hospital, inpatient bed days cannot be counted in the Medicaid

	share numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect, the inpatient bed days of a dually eligible patient could not be counted in the Medicaid share numerator. In this case, crossover claim types may not be included in the aggregation of Medicaid inpatient bed days.
Claim Status	Medicaid inpatient bed days will only include days for which Medicaid paid for the encounter. Encounters that have been denied, for any reason, will not be included. In addition, zero-pay Medicaid eligible days are also excluded from the numerator.
Payer	To clearly differentiate Title XIX encounters from Title XXI, DMS will use internal fund codes assigned to all managed care and fee-for-service encounters. A fund code is a predetermined combination of attributes that identifies any financial transaction in Wisconsin's Medicaid Management Information System, ForwardHealth interChange. Only Medicaid Title XIX assigned fund codes will be included in the Medicaid Share aggregation of Medicaid inpatient bed days.
Date of Service / Day Aggregation	When calculating inpatient bed days, the day of admission will be counted as day one. The day of discharge is not counted unless it is the same as the day of admission. For example, April 1–April 1 will be counted as one day for the patient. Under this clarification, April 1–April 2 also will be counted as one day per patient. An inpatient stay during the period of April 1–April 3 will be counted as two days for the patient.
Newborn Exclusion	Normal birth nursery bed days, identified through use of DRG 795, are not considered inpatient bed days based on the level of care provided during a normal nursery stay. Normal newborn birth discharges will be excluded from the Medicaid patient volume numerator.
Observation Day Exclusion	Observation patient bed days, defined as revenue codes 0769, 0760, 0761, and 0762, are excluded and not considered inpatient bed days.

Figure B.03: Hospital Encounters Conditions

1.3 Applying for a Payment

DMS will calculate the aggregate Medicaid Hospital PI payment amount during Payment Year 1 for each hospital. This incentive payment amount is the total amount the hospital is eligible to receive in Medicaid PI payments over the duration of the Medicaid PI Program. Hospital payments will be disbursed over a period of three years, with 50 percent of the aggregate disbursed in Payment Year 1, 40 percent in Payment Year 2, and 10 percent in Payment Year 3.

During the application process, the hospital will be responsible for obtaining all the variable data inputs from the sources listed under Section 1.2 of this document and entering them into the ForwardHealth Portal application as shown in Figure B.04.

Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
10/01/2009-09/30/2010	*	*	*	* $	* $
10/01/2008-09/30/2009	*				
10/01/2007-09/30/2008	*				
10/01/2006-09/30/2007	*				

Figure B.04: Application Screen for Entering Data Elements

DMS will provide the Medicaid inpatient bed day amount to each Eligible Hospital prior to its application for a Medicaid PI payment.

1.3.1 Applying with Less Than Four Years of Total Discharge Data

Following the publication of the Stage 1 Meaningful Use Final Rule, the Centers for Medicare & Medicaid Services (CMS) provided guidance that delivered flexibility for new hospitals with less than four years of total discharge data (cost reports) to participate in the Medicaid PI Program. CMS determined it is acceptable for new hospitals to apply with only two years of total discharge data.

To maintain consistency with CMS policy, DMS will accept applications from hospitals with less than four years of cost report data if they have at least two years of data. Under DMS policy, for the years where the hospital does not have total discharge data, the hospital will repeat the oldest cost report year's total discharge data. For example, if a hospital's 2012 total discharges are 17,000 and the 2011 total discharges are 16,500, the hospital would enter 16,500 for 2010 and 2009 (see Figure B.05).

Cost Report Data Available		Cost Report Data Unavailable	
Base Year = n	**n-1**	**n-2**	**n-3**
2012	**2011**	**2010**	**2009**
17,000	16,500	16,500	16,500

Figure B.05: Cost Report Data Example

In subsequent payment years, the hospital will remove the repeated data entered in the previous application and reconcile its cost report data with total discharge data from newly available cost reports. After the hospital reconciles the data, the hospital's payment is recalculated using the new growth rate until all four years of total discharge data are received.

2 Calculation Example

This section demonstrates the step-by-step calculation of a Medicaid Hospital PI payment. The red areas below are data inputs from Medicare cost reports.

- **Steps 1–5:** Calculate the overall PI amount by summing over four years (a) the base amount of $2,000,000 plus (b) the discharge-related amount, defined as $200 for the 1,150th through 23,000th discharge, and then applying the transition factor to prorate the amount for each payment year of the calculation—100 percent in Payment Year 1, 75 percent in Payment Year 2, 50 percent in Payment Year 3, and 25 percent in Payment Year 4.
- **Step 6:** Calculate the Medicaid share by calculating the percentage of the hospital's inpatient bed days attributable to Medicaid, adjusting for charity care.
- **Step 7:** The product of Steps 1–5 and Step 6 is multiplied to obtain the aggregate Medicaid Hospital PI payment.
- **Step 8:** Calculate the distribution of the aggregate Medicaid Hospital PI payment over the three years of the Medicaid PI Program.

Step 1 **Calculate the average annual growth rate for the last three years of available data using previous hospital cost reports. (For years 2–4, the growth rate is assumed to be the previous three years' average.)**

	Prior Year	Current Year	Increase/ Decrease	Growth Rate	Data Source (CMS 2552-96 Version)
Fiscal Year 2007	16,000	16,500	500	3.13%	Worksheet S-3, part I, col 15, line 12
Fiscal Year 2008	16,500	17,000	500	3.03%	Worksheet S-3, part I, col 15, line 12
Fiscal Year 2009	17,000	17,500	500	2.94%	Worksheet S-3, part I, col 15, line 12
		Total Increase/(Decrease)		9.10%	
		Average 3-Year Growth Rate		**3.03%**	

Step 2 Calculate the discharge-related amount using the annual growth rate to adjust discharges for years 2–4.

		Data Source (CMS 2552-10 Version)
Total Discharges (regardless of payer)	22,000	Worksheet S-3, Part I column 15 line 14

	Per-Discharge Amount	**Total Discharges**	**Disallowed Discharges**	**Allowable Discharges**	**Total Discharge-Related Amount**
Year 1	$200	22,000	1,149	20,851	$4,170,200
Year 2	$200	22,667	1,149	21,518	$4,303,600
Year 3	$200	23,354	1,149	21,851	$4,370,200
Year 4	$200	24,062	1,149	21,851	$4,370,200

Step 3 Calculate the initial amount for four years.

	Year 1	Year 2	Year 3	Year 4
Base Amount	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Discharge-Related Amount	$4,170,200	$4,303,600	$4,370,200	$4,370,200
Step 3 Total	**$6,170,200**	**$6,303,600**	**$6,370,200**	**$6,370,200**

Step 4 Apply the transition factor.

	Year 1	Year 2	Year 3	Year 4
Transition Factor	1.00	0.75	0.50	0.25
Step 4 Total	**$6,170,200**	**$4,727,700**	**$3,185,100**	**$1,592,550**

Step 5 Sum overall EHR amount for four years.	**$15,675,550**

Step 6 **Calculate the Medicaid share. Medicaid share** = {estimated Medicaid inpatient bed days + estimated Medicaid HMO inpatient bed days) / (total inpatient bed-days x [(est. total charges - est. charity care charges) / est. total charges]}

		Data Source
Total Medicaid Fee-for-Service Inpatient Bed Days	1,750	Wisconsin Medicaid Agency provides Medicaid Fee-for-Service Title XIX Inpatient Bed Days
Total Medicaid Managed Care Inpatient Bed Days	135	Wisconsin Medicaid Agency provides Medicaid Managed Care Title XIX Inpatient Bed Days
Total Medicaid Fee-for-Service and Managed Care Inpatient Bed Days	1885	
Total Hospital Inpatient Bed Days	5,000	Worksheet S-3, Part I column 8 sum of lines 1 and 8-12 CMS 2552-10 Version
Total Inpatient Hospital Charges	5,000,000	Worksheet C part I, column 8, line 200
Total Charity Care Charges	1,000,000	Worksheet S-10, column 3 line 20
Total Hospital Charges - Charity Charges	4,000,000	
Non-Charity Care Percentage	80.00%	*Note: If charity care data and uncompensated care cost data are not available Wisconsin will set the charity care ratio to 1.*
Total Hospital Inpatient Bed Days Excluding Charity	4,000	
Medicaid Share	**47.13%**	

Step 7 **Calculate Aggregate Medicaid Hospital PI Payment Amount**

Overall Amount for 4 years	$15,675,550
Medicaid Share	47.13%
Aggregate Medicaid Hospital PI Payment Amount	$7,387,886.72

Step 8 **Calculate Annual Incentive Payment Amount**

	Percentage	Payment
Year 1 Payment	**50%**	**$3,693,943.36**
Year 2 Payment	**40%**	**$2,955,154.69**
Year 3 Payment	**10%**	**$738,788.67**

Figure B.06: Medicaid Hospital PI Payment Calculation Example