

## **A WSHA Description of the Model Analyzing the Proposed Changes for Medicare Inpatient Hospital Payment as of October 1, 2007**

The most significant changes in the proposed rule, modeled in this analysis, include:

- a full 3.3% market basket for inpatient operating payments plus a budget neutrality factor of 0.1%, yielding an update factor of 3.4%;
- a freeze on capital payments for urban hospitals (zero market basket update) and a full, 0.8% capital market basket update for rural hospitals;
- a 2.4% “Behavioral Offset” reduction to both inpatient operating and capital payment rates intended to compensate for anticipated increases to overall case-mix as a result of hospitals’ improved coding (as they adapt to the new DRGs);
- replacement of the current diagnosis related groups (DRGs) with Medicare-Severity (MS) DRGs and the second year of transition to cost-based DRG weights (a combined impact);
- updated values for the wage indexes and geographic adjustment factors (GAFs);
- an increase in the Indirect Medical Education (IME) formula multiplier from 1.32 to 1.35; and
- elimination of the 3% large urban add-on to capital payments.

This analysis does not include any rate reductions for non-reporting of Quality data.

### **Data Sources:**

Individual hospital characteristics (disproportionate share percent, interns and residents, bed size, average daily census, etc.) are taken from the most recent available Medicare cost reports and IPPS impact files, provided as public use files by the Centers for Medicare and Medicaid Services (CMS). For the purpose of this analysis, which is intended to measure the impact of proposed policy changes only, hospitals’ Disproportionate Share Hospital (DSH) percentages, Intern and Resident to Bed (IRB) ratios, and the Interns and Residents per Average Daily Census (IRC) are held constant. Hospitals’ provider types are also held constant at the 2007 status; hence, for example, this analysis will not measure the impact of a hospital converting from rural to special rural provider status in 2008.

In addition, hospital volumes have been held constant, again in order to measure the impacts of policy changes only. Medicare cases and case-mix indexes are taken from the FFY 2008 Impact File. This Impact File is provided by CMS and includes cases, case-mix index and transfer-adjusted cases resulting from running the FFY 2005 Medicare claims data through the two DRG Grouper software programs (Grouper Version 24.0 for FFY 2007 and Grouper Version 25.0 for FFY 2008). *Note: “Medicare Cases Billed (adjusted for transfers)” in the “Hospital*

*Payments* report may differ from FFY 2007 to FFY 2008. The difference is due to transfer adjustment changes that result from the two different sets of DRG weights.

Standard Amounts, Federal Rates, wage indexes, and GAFs are taken from the final FFY 2007 and proposed FFY 2008 IPPS rules, as published in the *Federal Register*. Note: The wage index and GAF values for FFY 2008 are preliminary calculations and could change in the final rule. Hospital-specific rates, for special rural providers, were calculated by HANYS based upon historical data (the FFY 2008 Impact File does not appear to contain reliable data on hospital-specific payment amounts.)

**Methods:**

The dollar impact of each proposed component change has been calculated by first determining FFY 2007 IPPS payments. Estimated FFY 2007 payments reflect the wage index, labor-share, DSH, and IME adjusted federal payment amount (or hospital-specific or blended payment amount) multiplied by each hospitals' appropriate cases and case-mix index.

Next, the FFY 2007 to FFY 2008 percent change due to each proposed component is calculated and applied to the FFY 2007 payment amount. The percentage impacts are applied sequentially in order to capture the compounded dollar impacts. For example, the percent change due to the update factor (including budget neutrality) is applied to total FFY 2007 payments. Then, the percent change in the wage index is applied to the dollar result of the first change. This method continues for the remaining proposed changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. The same process was used to calculate the impact on capital payments.

Sole Community Hospitals and Medicare Dependent Hospitals are identified based upon their provider status in FFY 2007. If the hospital-specific payment rate is more beneficial than the adjusted federal rate (after wage index, DSH, and IME adjustments), that amount is used and is shown on the hospital rate calculation report. Hospitals paid at the hospital-specific rate are not subject to short stay transfer payment adjustments; therefore the non-transfer adjusted cases and case-mix are applied in those instances. The hospital-specific rates are also not subject to the wage-index budget neutrality factor. This analysis does not apply any budget neutrality adjustment to hospital-specific rates – these rates are updated by the 3.3% market basket only. Hospital-specific rates have been reduced by the proposed 2.4% Behavioral Offset.

Wage indexes were calculated based upon the CBSA-level tables from the *Federal Register* and information about the hospitals' permanent and reclassified wage areas from the Impact File and the tables in the *Federal Register*. Instances where the wage index provided in the Impact file does not match the HANYS-calculated wage index have been noted on the Hospital Payments table. These include instances where:

- the FFY 2008 reclassified CBSA is different from the FFY 2007 reclassified CBSA;
- the wage index published by CMS is not the highest value available to the hospital;
- there appears to be a misapplication of the out-migration adjustment;

#### Attachment 4

- there appears to be an incorrect CBSA wage index; or
- there is an unexplained variation between the wage index published in the CMS Impact file and the calculated wage index.

*Note: For FFY 2007, due to the wage index appeals process, in rare instances, a hospital may be receiving a wage index that differs from the last published value provided by CMS.*

If you have questions or would like to discuss this analysis, please contact Will Callicot, Director, Financial Policy at [willc@wsha.org](mailto:willc@wsha.org) or (206) 216-2533.