Wisconsin Medicaid Program

Outpatient Hospital State Plan, Attachment 4.19B
Methods and Standards for Determining Payment Rates
With Amendments Effective July 1, 2011

TABLE OF CONTENTS Page

1000 Overview 2

2000 Statutory Basis. 2

3000 General Items 2

4000 Reimbursement of Outpatient Services of In-State Hospital Providers 3
For Outpatient Visits On and After July 1, 2011
4100 Introduction 3
4200 Establishing a Hospital-Specific Rate per Outpatient Visit 3
4205 Cost Report Used and Base Year 3
4210 Calculate Average Inflated Cost Per Visit 4
4220 Calculate Rate per Outpatient Visit 4
4250 Budget Neutrality Factor 5
4260 Outpatient Access Payments 5
4300 Interim Payments 5
4400 Computation of Retroactive Settlement 5
4900 Critical Access Hospitals 6
4910 Interim Payments 6
4920 Computation of Retroactive Settlement 6
4930 Limitations on Laboratory Reimbursement 6

5000 Reimbursement For Outpatient Services Provided Out-of-State 6

5700 Hospital Outpatient Extended Nursing Services 6

6000 Administrative Adjustment Actions 7
6100 Introduction - 7
6200 Criteria for Administrative Adjustment 7

7000 Funding of Outpatient Medicaid Deficit in Governmental Hospitals 8
7001 General Introduction 8
7010 Qualifying Criteria 8
7020 Deficit From Providing Medicaid Outpatient Services 8
7030 Limitation on the Amount of Deficit Reduction Funding 9

8000 Supplemental Funding For Adult Level One Trauma Centers 10

APPENDIX
Example Calculation of Rate Per Outpatient Visit 11

End of Outpatient Hospital State Plan 11

SECTION 1000 OVERVIEW

This section is an overview of how the Wisconsin Medicaid program (WMP) establishes payment rates for hospital outpatient care provided persons eligible for fee-for-service coverage under the WMP. The payment is for outpatient medical services provided by a hospital in its inpatient hospital licensed facility, for which the patient does not need to be admitted for an overnight stay, and for which the WMP does not pay another certified Medicaid provider. Payment rates are hospital-specific, cost-based and annually adjusted to recognize that hospitals vary significantly in the types of medical services they provide.

Hospitals located in the State of Wisconsin are reimbursed for outpatient services at an interim rate per visit with a subsequent retrospective final settlement as described in §4000. The settlement takes into account the costs incurred by the hospital during its cost-reporting period. Reimbursed costs under the retrospective settlement are limited to a prospectively established ceiling amount. The ceiling amount is a prospective, hospital-specific rate per outpatient visit that is based on a hospital's historical cost and adjusted to stay within the State's available funding for outpatient hospital services. Providers' allowable outpatient cost includes a limitation on capital costs to no more than 8% of the hospitals' total cost. Critical access hospitals are paid a prospective cost based per visit payment rate and are also subject to the capital cost limitation.

Ceiling rates are recalculated annually for the upcoming State fiscal year effective July 1 based on an audited cost report for each hospital. Payments for outpatient hospital laboratory tests are limited to the WMP's fee schedule for laboratory tests.

For hospitals not located in the State, reimbursement is at a percentage of charges (§5000). No final cost settlement is done for these hospitals. Under §5700, a prospective outpatient payment is provided for approved respiratory nursing care for part of a day on the site of an acute care general hospital. Payment for this service is separate from and not covered by the final cost settlements.

SECTION 2000 STATUTORY BASIS

The outpatient reimbursement shall comply with all current and future applicable Federal and State laws and regulations and shall reflect all adjustments allowed under said laws and regulations. Federal regulations (42 CFR §447.321) require the Medicaid agency not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

SECTION 3000 GENERAL ITEMS

Inpatient Hospital Licensed Facility. A inpatient *hospital licensed facility* is that part of the physical entity, surveyed and licensed by the Wisconsin Department of Health and Social Services under Chapter 150, Wis. Stats., in which inpatient care is provided. Any emergency department, clinic or other part of the licensed hospital that is not located on the same premises as the inpatient hospital licensed facility is not part of the inpatient hospital licensed facility for purposes of reimbursement under the Outpatient Hospital State Plan, irrespective of whether that off-premises emergency department, clinic or other part is considered to be part of the hospital under the hospital license or for purposes of Medicare reimbursement. For hospitals not located in Wisconsin, a hospital facility is the physical entity that is covered by surveying, licensure, certification, accreditation or such comparable regulatory activities of the state in which the hospital is located.

Hospital Licensure of Provider Premise. Only medically necessary covered services provided within the

inpatient *hospital licensed facility (even if the facility is considered to be part of the hospital under the hospital license or for purposes of Medicare reimbursement)* are eligible for reimbursement under outpatient hospital payment rates described in this document entitled "Methods and Standards for Determining Outpatient Hospital Payment Rates". This means a hospital cannot bill as outpatient hospital services those services provided off the physical premise of the licensed hospital facility or in an unlicensed portion of the hospital facility.

Outpatient Visit. Unless otherwise specified in 49.45(3)(e)10m and 49.45(3)(e)10r of state statutes, an admission to an outpatient department of an inpatient hospital licensed facility on a given calendar day, regardless of the number of procedures or examinations performed or departments visited. A maximum of one outpatient visit per patient per calendar day shall be recognized and paid.

Cost Reporting. To establish cost for outpatient rate setting, DHS will utilize the most recently available audited cost report (as of the January 1 date that occurs before the rate year) in the Health Cost Report Information System (HCRIS) maintained by the federal Center for Medicare and Medicaid Services (CMS). If the most recently audited cost report available in HCRIS is greater than five years old from the prior fiscal year, the Department may use an unaudited Medicare cost report. However, if an unaudited cost report is utilized, the Department will recalculate the outpatient rate once the unaudited cost report is audited to determine the final rate.

Clinical Diagnostic Laboratory Reimbursement. The lower of laboratory fee schedule amounts of the Wisconsin Medicaid program or the hospital's laboratory charges for services provided. This payment will not exceed the Medicare rate on a per test basis.

Upcoming State Fiscal Year. The upcoming state fiscal year is the fiscal year of the State of Wisconsin that begins each July 1 for which prospective outpatient rates are calculated under §4200.

Critical Access Hospital. A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS (HCFA), and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

SECTION 4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS FOR OUTPATIENT VISITS ON AND AFTER JULY 1, 2011

4100 Introduction. This section describes the methodology for reimbursing hospitals located in the State of Wisconsin for outpatient hospital services provided in outpatient departments of inpatient hospital licensed facilities to persons eligible for fee-for-service medical coverage by the Wisconsin Medicaid program (WMP). The methodology described in §4200 through §4400 applies for outpatient visits occurring on and after July 1, 2011. Special provisions for the reimbursement of critical access hospitals are described in §4900 also effective July 1, 2011. An example of the calculation of a hospital's rate per outpatient visit is in the Appendix.

4200 Establishing a Hospital-Specific Rate per Outpatient Visit

4205 Cost Report Used and Base Year. A hospital's rate per outpatient visit is based on a hospital's historical cost of a recent fiscal period. To establish cost for outpatient rate setting, DHS will utilize the most recently available audited cost report (as of the January 1 date that occurs before the rate year) in the Health Cost Report Information System (HCRIS) maintained by the federal Center for Medicare and Medicaid Services (CMS). If the most recently audited cost report available in HCRIS is greater than five years old from the prior fiscal year, the Department may use an unaudited Medicare cost report. However, if an unaudited cost report is utilized, the Department will recalculate the outpatient rate once the

unaudited cost report is audited to determine the final rate.

A new owner may take-over the operation of a hospital. Cost reports from the prior owner of the hospital are used to establish the prospective rate per outpatient visit until an audited cost report becomes available under the new ownership. Separate hospitals may combine into one operation, under one WMP provider certification, either through merger or consolidation or through a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospitals physical plant. The audited cost reports of the separate hospitals are combined to establish the prospective rate per outpatient visit for the combined hospital provider until an audited cost report is available for the combined operation.

For a new in state hospital in which an audited cost report is not available, outpatient hospital services shall be paid at the average percentage of allowed outpatient hospital charges paid to in-state non-CAH hospitals. Reimbursement for diagnostic laboratory services will be the lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered.

It should be noted that the audited cost report is the basis for calculating the rate per outpatient visit of §4220. The same audited cost report is used for the retrospective settlement period process described in §4410.

4210 Calculate Average Inflated Cost per Visit. An average cost per visit is established from the audited cost report of each hospital. The cost report includes a methodology of cost finding that identifies the amount of costs applicable to outpatient services provided persons covered by the WMP. Capital costs applicable to outpatient services provided to WMP recipients is limited to no more than 8% of the total outpatient cost. Capital costs are calculated from Worksheet B Part II and Part III of the Medicare cost report. Specifically, capital costs are taken from column 27, line 103 from Worksheet B Part II and Part III. However the Department removes non hospital and non allowable capital costs, specifically the following cost centers are removed to calculate total capital costs: cost centers 34 through 36, 63.5 through 81, 92, 93, and 96 through 100. Total cost is calculated in the same manner but the values are taken from Worksheet B Part I, column 27, line 103 from the Medicare cost report. If a facility's total capital costs are greater than 8 percent of total costs, a limitation is imposed. The total allowable outpatient cost is inflated to the upcoming State fiscal year by an inflation adjustment multiplier. The resulting inflated cost divided by the number of WMP outpatient visits incurred by the hospital during the cost report period results in the hospital's *"average inflated cost per visit".*

Inflation adjustment multipliers result from the following ratio calculation:

> Price index for the beginning quarter of the upcoming State fiscal year divided by the price index for the ending quarter of the audited cost report of each hospital. The index used is from the publication, "Health Care Cost Review" that is published quarterly by the IHS Global Insight Company. (Prior to the second quarter of 2001, the "Health Care Cost Review" was published quarterly by the Standard & Poor's DRI division of The McGraw-Hill Companies.) Specifically used is the Hospital and Related Services Individual Price Index.

4220 Calculate Rate per Outpatient Visit. A prospective *"rate per outpatient visit"* is calculated for each hospital for the period of each upcoming State fiscal year beginning July 1. The average inflated allowable cost per visit is multiplied by a budget neutrality factor. The budget neutrality factor is a percentage applied to costs in order to maintain payments within the federal upper payment limits of 42 CFR §447.321 and the State's available funding for outpatient hospital services for the upcoming State fiscal year. The factor is 31.72% for rate year 2013. The resulting *"rate per outpatient visit"* is a prospective payment rate and is considered final payment, except for laboratory services which are

subject to the retrospective settlement that will be done in subsequent years.

4250 Budget Neutrality Factor. A budget neutrality factor is calculated for each upcoming State fiscal year. Before calculating the budget neutrality factor, the Department identifies the amount of funds that are available in the upcoming State fiscal year to reimburse hospitals for outpatient services. The Department also estimates the gross projected costs to be incurred by each and all hospitals for these outpatient services. The budget neutrality factor is the quotient of the total funding available for reimbursing non-CAH hospitals for outpatient services divided by the projected costs of outpatient services of all non-CAH hospitals. The budget neutrality factor is 31.72% for rate year 2013 (beginning on July 1 and ending on June 30).

According to §4220, the budget neutrality factor times the average inflated costs per visit for each hospital results in each hospital's rate per outpatient visit.

4260 Outpatient Access Payments. To promote WMP member access to acute care, children, rehabilitation, and critical access hospitals throughout Wisconsin, WMP will provide a hospital access payment amount per outpatient visit. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per visit are not differentiated by hospital based on acuity or individual hospital cost. However, the access payment per visit paid to critical access hospitals are reimbursed at a different payment rate compared to the access payment rate per visit paid to acute care, children, and rehabilitation hospitals.

The amount of the hospital access payment per visit is based on an available funding pool appropriated in the state budget. This amount is divided by the estimated number of paid outpatient visits for the state fiscal year. The funding pool amount for rate year 2013 is $116,965,165 for acute care, children's, and rehabilitation hospitals. The funding pool amount for rate year 2013 is $2,692,382 for critical access hospitals. The access payment per visit amount is identified on the hospital reimbursement rate web page of the Wisconsin Forward Health website at www.forwardhealth.wi.gov. This payment per visit will be in addition to the base payment per visit described in §4220.

Access payments are subject to the same federal upper payment limit standards as base rate payments. Access payment amounts are not interim payments and are not subject to settlement. Access payments per visit are only provided until the fee-for-service hospital access payment funding pool has been expended for the rate year.

4300 Interim Payments.

Payments to acute care hospitals, children, rehabilitation, and psychiatric hospitals are based on the rate setting methodology outlined in Section 4210. The payment per visit is a prospective based rate and is not subject to annual cost settlement. However, each hospital is subject to a retroactive settlement only for laboratory services billed as outpatient hospital services as outlined in section 4400.

4400 Computation of Retroactive Settlement

4410 Retroactive Settlement Period. Payments to acute care hospitals, children, rehabilitation, and psychiatric hospitals are based on the rate setting methodology outlined in Section 4210. The payment per visit is a prospective based rate and is not subject to annual cost settlement. However, each hospital is subject to a retroactive settlement only for laboratory services billed as outpatient hospital services as outlined in section 4400.

4420 Limitations On Laboratory Reimbursement. The amount of allowable outpatient payment that is finally reimbursed in the retroactive settlement is limited by all of the following amounts.

1. The *"total allowed charges"* for the outpatient visits of WMP recipients during the cost report period are tabulated and summed from the UB-04 billing claims submitted by the hospital to the WMP. Allowed charges means charges for medically necessary services covered by the WMP.
2. A *"gross laboratory-fee-limited ceiling"* is the sum of the amounts calculated under items (a) below.
   (a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests is based on the lower of the WMP fee schedule, which per test is less than or equal to the Medicare rate, or the outpatient payment per visit as outlined in section 4210,

If payments for laboratory services for the fiscal year exceed "the WMAP fee schedule", then the Department recovers the excess payments.

4500 Performance-Based Payments

The Department is initiating a Hospital Pay for Performance (P4P) program for payments for acute care, children's, critical access, and psychiatric hospital services with dates of discharge on or after July 1, 2012. Long term care, rehabilitation and out of state hospitals are exempt from the Hospital P4P Program.

The initial measurement period is of 9 month duration of July 1, 2012 through March 31, 2013. Subsequent measurement periods, beginning April 1, 2013 will be on a 12-month cycle, from April 1 through March 31 of the next calendar year.

For each measurement period, the Department will pay claims for services at the rate of 98.5% of the fee schedule in effect on July 1, 2012. The P4P pool will be calculated as an amount equal to 1.5% of the fee schedule amounts in effect on July 1, 2012 for those same claims.

The calculation of the pool amount equal to 1.5% of the fee schedule amounts in effect on July 1, 2012 for those same claims does not apply to hospital supplemental payment amounts made to eligible providers, including access payments.

Payments will be made annually by December 31, 2013 and December 31 of each year thereafter.

In order to be eligible for P4P program payments, hospitals are required to report performance measure data and meet performance-based targets as specified in the Hospital Pay-for-Performance (P4P) Guide available at https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/medicaid/hospital/P4P_FY2013.pdf.spage.

Hospitals that meet both reporting requirements and performance-based targets for the measures described below are eligible to receive payments from the P4P pool as follows:

a. The total amount available in the P4P pool for Hospital services will be calculated as an amount equal to 1.5% of the total claim-based fee-for-service payments, excluding supplemental payments, made during the measurement period for Medicaid inpatient services to eligible hospitals.

b. Hospital P4P pool amounts will be individually calculated for each eligible hospital as an amount equal to 1.5% of the total claim-based fee-for-service payments, excluding supplemental payments, made during the measurement period for Medicaid inpatient services to the eligible hospital. At the end of the measurement period, the total P4P pool amount available for each hospital will be divided by the number of measures applicable to that hospital to determine the value of each measure. (I.e., if the hospital's individual pool equals $100,000 and the hospital qualifies to participate in four measures, each measure would be worth a maximum supplemental payment of $25,000.)

c. If a hospital meets all of its performance targets for all applicable measures, it will receive a supplemental payment equal to the hospital's total P4P pool amount for all measures.

d. If a hospital does not meet all of its performance targets, it will earn dollars for those measures where the targets were met in a graduated manner, as specified in the P4P Guide.

e. If all participating hospitals meet all of their individually applicable targets, no P4P additional pool funds would be available and no supplemental payments above those described in 5600.a will be made to any hospital.

f. If any participating hospital does not meet its performance target, the hospital will not receive any additional payment and the pool amount attributable to that hospital for that measure will be aggregated and distributed as an additional bonus payment to other hospitals that met all of their performance targets.

   The Department has designed the additional bonus pool to ensure that all P4P pool dollars are paid back to hospitals. Bonus dollars will be shared proportionally among hospitals based on the relative amounts calculated for the P4P pool for all hospitals that qualified for the additional bonus. Therefore hospitals with a larger P4P pool calculated amount will receive a larger portion of the additional bonus dollars available. The University of Wisconsin Medical Center and Critical Access Hospitals are only eligible for payment up to cost for base hospital payments, including the performance-based payments.

The state will notify each eligible hospital, prior to the measurement year, of the minimum performance requirements to receive the 1.5% P4P pool payment. Complete details including technical information regarding specific quality and reporting metrics, performance requirements and P4P adjustments are available in the State FY2013 Hospital Pay-for-Performance (P4P) Guide available at https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/medicaid/hospital/P4P_FY2013.pdf.spage. The performance measures that are in effect in this SPA on the first day of each performance year will be the measures that are used for that measurement year. Except in cases of emergency rule, providers will receive at least 30-days written notice of any and all changes to the State FY2013 Hospital Pay-for-Performance (P4P) Guide.

The P4P pool amount will be distributed prior to December 31 following the measurement period to those hospitals for the following six measures, as applicable to the hospitals:

1) Thirty-day hospital readmission – Hospitals will be scored on the percent of patients that had a qualifying readmission within 30 days of a qualifying discharge. This measure will be applicable to a

hospital that has at least 23 observations during the measurement year. To qualify for its earn back on this measure, a hospital must improve upon its past performance (since the Department is not using a risk adjustment methodology for this measure, it is not appropriate to compare a hospital's score to the statewide average). Past performance was calculated using calendar year 2010 data, or subsequent year thereafter.

2) Mental health follow-up visit within 30 days of discharge for mental health inpatient care – Hospitals will be scored on the percent of patients who had a mental health follow-up appointment within 30 days of qualifying mental health discharge. This measure will be applicable to a hospital that has at least 23 observations during the measurement year. To qualify for its earn back on this measure, a hospital must improve upon its past performance (since the Department is not using a risk adjustment methodology for this measure, it is not appropriate to compare a hospital's score to the statewide average). Past performance was calculated using calendar year 2010 data, or subsequent year thereafter.
3) Asthma care for children – Hospitals will be scored on the percent of children admitted to a hospital with a qualifying asthma diagnosis that were discharged with a Home Management Plan of Care (HMPC). This measure will be applicable to children's hospitals that have at least 30 observations during the measurement year. To qualify for its earn back on this measure, a hospital must submit their data to the Joint Commission by September 30 following the measurement year and must exceed either the national average or their past performance on this measure.
4) Surgical infection prevention index (SCIP Index) - Hospitals will be scored on the percent of surgical patients that were given all the care they needed to prevent an infection based on selected measures. This measure will be applicable to a hospital that has at least 25 observations during the measurement year. To qualify for its earn back on this measure, a hospital must submit their data to the Wisconsin CheckPoint (www.checkpoint.org) by December 31 of the measurement year and must exceed either the state average or their past performance on this measure.
5) Initial antibiotic for community-acquired pneumonia (PN-6) – Hospitals will be scored on the percent of immunoincompetent patients with community-acquired pneumonia that receive an initial antibiotic within 24 hours of admission into the hospital. This measure will be applicable to a hospital that has at least 25 observations during the measurement year. To qualify for its earn back on this measure, a hospital must submit their data to CheckPoint by December 31 of the measurement year and must exceed either the state average or their past performance on this measure.
6) Healthcare personnel influenza vaccination (pay-for-reporting) – Hospitals will be evaluated based on their submission of the Health Care Personnel Influenza Vaccination data via the National Healthcare Safety Network (NHSN) module or to the Wisconsin Division of Public Health (WI DPH). To qualify for its earn back on this measure, a hospital must report its healthcare personnel influenza vaccination data to the NHSN module or WI DPH prior to August 15 following the measurement year.

P4P payments, including the additional bonus payments, are limited by the federal upper payment limit (UPL) regulations at 42 CFR §447.272, All P4P payments, including the additional bonus payments, are included in the UPL calculation for the measurement year regardless of when payments are actually made.

1. The *"total allowed charges"* for the outpatient visits of WMP recipients during the cost report period are tabulated and summed from the UB-04 billing claims submitted by the hospital to the WMP. Allowed charges means charges for medically necessary services covered by the WMP.
2. A *"gross laboratory-fee-limited ceiling"* is the sum of the amounts calculated under items(a) below.
   (a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests is based on the lower of the WMP fee schedule, which per test is less than or equal to the Medicare rate, or the outpatient payment per visit as outlined in section 4210,

If payments for laboratory services for the fiscal year exceed "the WMAP fee schedule", then the Department recovers the excess payments.

4900 Critical Access Hospitals

4910 Interim Payments. Interim payments are made at the critical access hospital's (CAH) average inflated cost per visit as calculated according to section §4210 above, including limitation of capital costs to no more than 8% of total cost. This payment is a cost based prospective payment per visit and is not subject to annual cost settlement. However, each critical access hospital is subject to a retroactive settlement for laboratory services billed as outpatient hospital services as outlined in section 4920.

4920 Computation of Retroactive Settlement for Laboratory Services

4930 Limitations On Laboratory Reimbursement. The amount of allowable outpatient payment that is finally reimbursed in the retroactive settlement is limited by all of the following amounts.

1. The *"total allowed charges"* for the outpatient visits of WMP recipients during the cost report period are tabulated and summed from the UB-04 billing claims submitted by the hospital to the WMP. Allowed charges means charges for medically necessary services covered by the WMP.
2. A *"gross laboratory-fee-limited ceiling"* is the sum of the amounts calculated under item (a) below.
   (a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests is based on the lower of the WMP fee schedule, which per test is less than or equal to the Medicare rate, or the outpatient payment per visit as outlined in section 4210,

If payments for laboratory services for the fiscal year exceed "the WMAP fee schedule", then the Department recovers the excess payments.

SECTION 5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, shall be paid at the average percentage of allowed outpatient hospital charges paid to in-state non-CAH hospitals. Reimbursement for diagnostic laboratory services will be the lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered, which per test is less than or equal to the Medicare rate. Payment for outpatient services provided by out-of-state hospitals which are not certified as border status will be limited to emergency services or services prior authorized by the Wisconsin Medical Assistance Program.

SECTION 5700 HOSPITAL OUTPATIENT EXTENDED NURSING SERVICES

Hospital outpatient extended nursing services are nursing services and respiratory care provided by nurses, for

part of a day, in a group setting, on the site of an acute care general hospital approved under Wis. Admin. Code ch. HS 124 or in a building physically connected to an acute care general hospital approved under Wis. Adm. Code ch. HS 124. The nursing services must be administered by or under the direct on-site supervision of a registered nurse. All medical care services must be prescribed by a physician.

Prior Authorization. Hospital outpatient extended nursing services must be prior authorized by the WMAP and, if not prior authorized, will not be reimbursed. Only persons who require eight or more hours per day of nursing services as determined by the WMAP may qualify for outpatient extended nursing services. The WMAP will use its criteria for private duty nursing services to determine a person's need for nursing services. The request for prior authorization must describe the expected means by which the participant will regularly be transported between the participant's residence and the hospital.

Reimbursement. Reimbursement for outpatient extended nursing services shall cover all nursing services and shall recognize the additional costs associated with individuals who must remain for observation for extended periods of time. The services will be reimbursed at an hourly rate. The hourly outpatient extended nursing services rate may be billed only for the time during which an outpatient extended nursing services patient is physically present at the hospital and attended by a nurse or a hospital staff person under the direct supervision of a nurse. Any portion of a quarter of an hour of presence at the hospital for outpatient extended nursing services can be charged as a full quarter of an hour.

The payment rate is the lesser of the provider's usual and customary charge per hour or the maximum hourly fee established by the Wisconsin Medicaid program for private duty nursing services provided by a registered nurse (RN) certified for respiratory care. The methods and standards for establishing the maximum fee is described in Item F, Methods and Standards for Establishing Payment Rates for Non-Institutional Care, of Attachment 4.19B of this state plan as amended by Wisconsin State Plan Amendment 96-013, effective April 1, 1996.

No Final Settlement. The reimbursement for outpatient extended nursing services will not be included in the outpatient final settlement described in §4000.

Cost Reporting. A hospital must separately identify and report in its cost report those direct and indirect costs attributable to the outpatient extended nursing services in order to qualify.

SECTION 6000 ADMINISTRATIVE ADJUSTMENT ACTIONS

For Hospitals In Wisconsin Only

6100 Introduction.

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement under the circumstances described in §6200. Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment.

6200 Criteria for Administrative Adjustment: Correction of a Rate Calculation Error

The Department provides a mechanism through which a hospital may receive review of its outpatient reimbursement in case of a calculation error. This mechanism is described below:

Qualifying Determination: The interim payment rate or a final settlement must have been inappropriately calculated under the rate setting plan.

(a) The application of the rate setting methodology or standards to incomplete or incorrect data contained

in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or

(b) A clerical error in calculating the hospital's payment rate, or

(c) Incorrect or incomplete application by the Department of provisions of the reimbursement methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment.

Hospitals may appeal the accuracy of their rate calculation under this section within 60 days of the date of their rate notification letter. If the appeal results in a new rate determination, the rate will apply to all claims with dates of service in the rate year. The Department at its own discretion may recalculate a hospital rate at any time during the rate year if the Department identifies a rate calculation error.

SECTION 7000 FUNDING OF OUTPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

7001 GENERAL INTRODUCTION

An acute care general hospital operated by the State or a local government in Wisconsin will receive reimbursement from the Wisconsin Medicaid program for costs it incurred for providing outpatient hospital services to Wisconsin Medicaid recipients if provisions of this section are met. This is referred to as deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. This reimbursement is available for hospital fiscal years beginning on and after July 1, 2006 and is determined based on a hospital's Medicare cost report for its completed fiscal year.

7010 QUALIFYING CRITERIA

A hospital will qualify for deficit reduction funding if:

(a) The hospital is an acute care general hospital operated by the State or a local government in Wisconsin.
(b) It incurred a deficit from providing Medicaid outpatient services (described in §7020 below).
(c) The governmental unit that operates the hospital certifies it has expended public funds to fund the deficit.

7020 DEFICIT FROM PROVIDING MEDICAID OUTPATIENT SERVICES

The deficit from providing outpatient services to Wisconsin Medicaid recipients (that is, the Medicaid deficit) is the amount by which the cost, reduced for excess laboratory cost, exceeds the payment for the Medicaid outpatient hospital services.

Payment above refers to the total of the reimbursement provided under the provisions of §4000 of this Attachment 4.19B of the State Plan for the respective fiscal year.

Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures. Clinical diagnostic laboratory reimbursement is the lower of laboratory fee schedule amounts of the Medicaid program or the hospital's charges for the procedures (as defined in §3000).

This section describes the cost of providing outpatient hospital services. For the payment year, the cost to charge ratios for the routine and ancillary cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552) as filed with the Medicare fiscal intermediary. Routine outpatient costs refer to hospital based clinic services. The cost to charge ratios are calculated as follows:

Step 1

Total hospital costs will be identified from Worksheet C, Column 1, lines 37 through 62. These costs represent the total hospital costs for purposes of determining the outpatient cost to

charge ratios.

Step 2

The hospital's total charges by cost center are identified from Worksheet C Part I Columns 6 and 7.

Step 3

For each outpatient routine and ancillary cost center the cost to charge ratio is calculated by dividing the total hospital costs identified in Step 1 by the total hospital total charges identified in Step 2.

The cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's outpatient costs for the payment year. The hospital costs for Medicaid FFS for the payment year are determined as follows:

Step 4

To determine outpatient Medicaid costs for the payment year, the hospital's Medicaid FFS outpatient charges are aggregated by cost center. These charges are obtained from the Medicaid Management Information System (MMIS). To project Medicaid cost, the Medicaid charges from MMIS are inflated by the "Health Care Cost Review" index that is published quarterly by the IHS Global Insight Company. The projected charges are multiplied by the cost to charge ratios from Step 3 for each respective routine and ancillary cost center to determine the Medicaid FFS outpatient costs for each cost center.

Step 5

The Medicaid FFS costs eligible as certified public expenditures are determined by adding the Medicaid FFS outpatient costs from Step 4 and subtracting Medicaid FFS outpatient payments received as determined from the Medicaid Management Information System (MMIS). The Medicaid deficit is the difference of Medicaid cost compared to Medicaid payments.

Final Reconciliation

Once the CMS 2552 cost report for the payment year has been finalized and audited by the Medicare fiscal intermediary, a reconciliation of the finalized amounts will be carried out. This settlement will be completed within one year after the Medicare cost report has been audited by the Medicare fiscal intermediary. The same method as described for the interim reconciliation will be used except that the finalized amounts will be substituted as appropriate.

7030 LIMITATION ON THE AMOUNT OF DEFICIT REDUCTION FUNDING

The combined total of: (a) the deficit reduction funding, and (b) all other payments to the hospital for outpatient Medicaid services, will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction funding will be adjusted so the combined total payments do not exceed charges.

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP that is available under federal upper-payment limits at 42 CFR §447.321.

SECTION 8000 SUPPLEMENTAL FUNDING FOR ADULT LEVEL ONE TRAUMA CENTERS

For services provided on or after July 1st, 2011, the WMP will provide annual statewide funding of $4,000,000 per rate year to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons.

The trauma outpatient supplement is paid as a monthly amount established according to the following method. A total of $4,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of eligible hospitals as described below.

A qualifying hospital's outpatient supplement will be determined as follows:

$$\text{Hospital's annual trauma supplement} = \frac{\text{Qualifying Trauma Hospital}}{\text{Sum of all Hospitals qualifying as Trauma Hospital}} \times \$4{,}000{,}000 \text{ Statewide annual funding}$$

APPENDIX EXAMPLE CALCULATION OF RATE PER OUTPATIENT VISIT

Period of Hospital's Base Year Cost Report..... 7/1/05 to 6/30/06

1	Outpatient costs for WMP fee-for-service covered recipients.....	$237,433
2	Times: Inflation adjustment multiplier	1.13
3	= Inflated cost report cost	$ 268,299
4	Divide by: Outpatient visits	2,012
5	= Average inflated cost per visit.....	$ 133.35
6	Times: Budget neutrality factor.....	.70
7	= Rate per outpatient visit.....	$ 93.34

End of Outpatient Hospital State Plan As Amended to July 1, 2011

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below.

In compliance with 42 CFR 447.26 (c), the State provides:

1) That no reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of the treatment for that patient by that provider.
2) That reductions in provider payment may be limited to the extent that the following apply:
   a. The identified PPC would otherwise result in an increase in payment.
   b. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.
3) Assurance that non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.