DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Financial Management Group

Ms. Marlia Mattke
Associate Deputy Administrator
Division of Health Care Access and Accountability
Department of Health Services
1 West Wilson St., Room 350
Madison, WI 53701-0309

APR - 9 2015

RE: Wisconsin State Plan Amendment (SPA) 14-0017

Dear Ms. Mattke:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-0017. Effective for services on or after July 1, 2014, this amendment revises reimbursement methodologies for inpatient hospital access payment rates and reorganizes the state plan to make information flow more logically.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 14-0017 is approved effective. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Tom Caughey at (517) 487-8598.

Sincerely,

Timothy Hill
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-017

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
47 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 ..... $0K
b. FFY 2015 ..... $0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages i to iii and 1 to 53. .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages i to ii and 1 to 62.

10. SUBJECT OF AMENDMENT:
Inpatient hospital rates and methodologies.

11. GOVERNOR'S REVIEW *(Check One)*:
☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITT[redacted]
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Kevin Moore

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED:
September 30, 2014

16. RETURN TO:
Kevin Moore
Deputy Secretary
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR - 9 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

Wisconsin Medicaid Program

Inpatient Hospital State Plan, Attachment 4.19-A

Method and Standards for Determining Payment Rates

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OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT

This section is a brief overview of how reimbursement to hospitals is determined for inpatient services that are provided by hospitals to eligible recipients of the Wisconsin Medicaid Program (WMP). The WMP uses a reimbursement system based on Diagnosis Related Groups (DRGs). The DRG system covers acute care, children's, long-term care, and critical access hospitals. Excluded from the DRG system are rehabilitation hospitals, State Institutions for Mental Disease (IMDs), and psychiatric hospitals, which are reimbursed at rates per diem. Also, reimbursement for certain specialized services is exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases, and brain injury cases. Special provisions for payment of each of these DRG-exempted services are included in this State Plan. Organ transplants are covered by the DRG system.

Approved inpatient hospital rates are not applicable for hospital-acquired conditions that are identified as non-payable by Medicare. This hospital-acquired conditions policy does not apply to WMP supplemental or enhanced payments and WMP disproportionate share hospital (DSH) payments.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn, and psychiatric cases. The grouper classifies a patient's hospital stay into an established DRG based on the diagnosis of and procedures provided to the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each DRG based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a DRG weight of 1.0, while the average hospitalization with a DRG with a weight of 0.5 would consume half the resources of the average hospitalization with a DRG weight of 1.0.

Each hospital is assigned a unique "hospital-specific DRG base rate". This hospital-specific DRG base rate includes an adjustment for differences in wage levels between rural and metropolitan areas throughout the state. It also includes an amount, based on a hospital's most recent audited 12-month Medicare cost report, for capital and direct medical education costs.

Given a hospital's specific DRG rate and the weight for the DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined by multiplying the hospital's rate by the DRG weight.

A "cost outlier" payment is made when the cost of providing a service exceeds a pre-determined "trimpoint". Each inpatient hospital claim is tested to determine whether the claim qualifies for a cost outlier payment.

For additional information, contact:

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2000
STATUTORY BASIS

The Wisconsin inpatient hospital payment system is designed to promote the objectives of the Wisconsin state statutes regarding payment for hospital services (Chapter 49, Wis. Stats.) and to meet the criteria for Title XIX hospital payment systems contained in the federal Social Security Act and federal regulations (Title 42 CFR, Subpart C). The inpatient payment system shall comply with all current and future applicable federal and state laws and regulations and reflect all adjustments required under said laws and regulations. Federal regulations (42 CFR §447.272) require that the payment system not pay more for inpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

3000
DEFINITIONS

Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible inpatient discharge. See §9600 for further details.

Acute Care Hospital. A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective January 1 of each year based on more current Medicare cost reports.

Border Status Hospital. A hospital not located in Wisconsin, which has been certified by the WMP as a border status hospital to provide hospital services to WMP recipients. Border status hospitals can have major border status or minor border status. Exact criteria for eligibility for border status are provided in §4240.

Centers for Medicare and Medicaid Services (CMS). The federal agency which regulates the WMP.

Children's Hospital. Acute care hospital that meets the federal definition of a children's hospital (42 CFR 412.23(d)) and whose primary activity is to serve children.

Core Based Statistical Area (CBSA). A geographic area based around an urban center of at least 10,000 people.

Critical Access Hospital (CAH). A hospital that meets both the requirements under 42 CFR Part 485, Subpart F and the following requirements: no more than 25 beds for inpatient acute care and/or swing-bed services; no more than 4 beds for observation services; an annual average inpatient stay of no more than 96 hours; provision of emergency services and availability of registered nurses on a 24-hour-per-day basis; and establishment of a written referral agreement with one or more network hospitals.

Department. The Wisconsin Department of Health Services (or its agent); the State agency responsible for the administration of the WMP.

DRG. Diagnosis Related Group, a patient classification system that establishes clinically-similar groupings of services that can be expected to consume similar amounts of hospital resources.

Fee-for-Service (FFS). A WMP payment methodology in which providers are reimbursed service-by-service for serving WMP members. Most WMP members are either enrolled with Health Maintenance Organizations (HMOs) or have their services reimbursed on a FFS basis.

Graduate Medical Education (GME). The phase of training that occurs after the completion of medical school in which physicians serve as residents, typically at a teaching hospital, and receive several years of supervised, hands-on training in a particular area of expertise. Hospitals that train residents incur real and significant costs beyond those customarily associated with providing patient care; in recognition of this, the WMP provides various payment adjustments to help defray the direct costs of GME programs.

Healthcare Cost Report Information System (HCRIS). The centralized electronic clearinghouse for Medicare cost reports maintained by CMS.

Hospital P4P Guide. The annual publication, available on the Wisconsin ForwardHealth Portal, that supplements this State Plan with additional details about, among other things, the HWP4P program.

Hospital-Specific DRG Base Rate. The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the RY. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay.

Hospital Withhold Pay-for-Performance (HWP4P) Program. A performance-based reimbursement system in which the WMP withholds 1.5% of payment for inpatient hospital services and allows hospitals to earn back those dollars by meeting various quality benchmarks. See §6620 for further details.

HWP4P Pool Amount. The amount of money withheld from inpatient hospital reimbursement for use in the HWP4P program.

IMD. Institution for Mental Disease, as defined in 42 CFR 435.1009.

Long-Term Care Hospital. A separately licensed hospital that meets the requirements of 42 CFR 412.23(e) and is reimbursed by Medicare under the Medicare prospective payment system for long-term care hospitals.

Measurement Year (MY). The time period from April 1 through March 31 during which an iteration the HWP4P program is administered. The named year of the MY is the calendar year in which the MY ends; for example, MY 2014 runs from April 1, 2013 to March 31, 2014.

Medicaid Deficit. The amount by which the cost of providing inpatient services to WMP recipients exceeds the WMP payment for those services. See §9100 for further details.

Medicaid Management Information System (MMIS). The system used by the WMP to process and document provider claims for payment.

Medicare Cost Report. The CMS 2552 form. To establish cost for inpatient rate setting, the Department utilizes the most recent audited 12-month Medicare cost report (as of the March 31 that occurs before the RY) available in HCRIS maintained by CMS. If the most recent audited 12-month Medicare cost report available in HCRIS is greater than five years old, the Department may use an unaudited 12-month Medicare cost report. However, if an unaudited Medicare cost report is used, the Department will recalculate the inpatient rate once the unaudited Medicare cost report has been audited to determine the final rate.

Metropolitan Statistical Area (MSA). A geographical region with a relatively high population density at its core and close economic ties throughout the area.

Non-Border Status Hospital. A hospital not located in Wisconsin and which has not been certified by the WMP as a border status hospital.

Office of Management and Budget (OMB). The federal agency that, among other things, sets standards and announces results for classifications within Core Based Statistical Areas.

Prospective Rate per Diem. The hospital-specific rate for each day of service.

Psychiatric Hospital. A general psychiatric hospital which is not a satellite of an acute care hospital and for which the department has issued a certificate of approval that applies only to the psychiatric hospital. A subcategory of psychiatric hospital is Institution for Mental Disease (IMD), which is defined in 42 CFR 435.1009, though IMDs are only eligible for Medicaid reimbursement under specific circumstances.

Rate Notification Letter. The notification mailed to hospitals at the conclusion of the annual rate update informing each hospital of its updated reimbursement rates and how to appeal them if necessary.

Rate Year (RY). The time period from January 1 through December 31 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

Rehabilitation Hospital. A separately licensed hospital that meets the requirements of 42 CFR 412.23(b) and is reimbursed by Medicare under the Medicare prospective payment system for rehabilitation hospitals. The hospital provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple traumas to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

Rural Referral Center. A classification that may be bestowed by Medicare on a participating acute care hospital.

Standard DRG Group Rate. The statewide DRG base rate that serves as the starting point for the hospital-specific DRG base rate development process.

State Fiscal Year (SFY). July 1 – June 30. For example, SFY 2014 is defined as July 1, 2013 – June 30, 2014.

Upper Payment Limit (UPL). The maximum amount the WMP may reimburse a hospital for services provided to WMP members. This is formally specified in 42 CFR 447.272.

Usual and Customary Charges. A provider's charge for the provision of a given service to persons not entitled to WMP benefits.

Wisconsin CheckPoint. A centralized electronic clearinghouse for quality data for Wisconsin hospitals, maintained by the Wisconsin Hospital Association, available at www.wicheckpoint.org.

Wisconsin ForwardHealth Portal. A website administered by the WMP listed at www.forwardhealth.wi.gov.

Wisconsin Medicaid Program (WMP). The State of Wisconsin's implementation of Medical Assistance as per Title XIX of the federal Social Security Act.

4000
DIFFERENCES IN RATE SETTING BETWEEN IN-STATE AND OUT-OF-STATE HOSPITALS

4100 Hospitals Located in Wisconsin

General acute care hospitals, including children's, critical access, and long-term care hospitals, located in Wisconsin (in-state hospitals) are reimbursed according to the DRG-based payment method described in §6000 herein. All inpatient stays within these hospitals are reimbursed under the DRG-based payment method with certain exceptions. These exceptions include AIDS patient care, ventilator patient care, unusual cases, and brain injury care. Organ transplants are paid under the DRG-based payment method. Rehabilitation and psychiatric hospitals and state IMDs are reimbursed under a rate per diem methodology, not the DRG-based payment system.

4200 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin but which provide inpatient services to WMP recipients may be reimbursed by the WMP for their services. Some such hospitals may be granted "border status" by the WMP. Others will not have border status under the WMP (non-border status hospitals).

4210 Non-Border Status Hospitals
Out-of-state hospitals which *do not have border status* are reimbursed under the DRG-based payment method described in §11000 herein. Payment is based on the standard (statewide) portion of the DRG base rate only. The rate is not adjusted to recognize hospital-specific capital and direct medical education costs, differences in wage areas, or rural hospital adjustment factors. All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMP. This differs from the prior authorization requirements for in-state and border status hospitals.

4220 Minor Border Status Hospitals
Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed using the same methodology as a non-border status hospital. However, minor border status hospitals are not subject to the prior authorization requirements for non-border status hospitals.

4230 Major Border Status Hospitals
Major border status hospitals are reimbursed according to the DRG-based payment method. This is the same DRG method as is used for in-state hospitals; it provides a rate that is adjusted to recognize hospital-specific capital and direct graduate medical education costs and contains a wage area adjustment.

4240 Criteria for Major Border Status
Major border status hospitals are those border status hospitals which have had 75 or more WMP recipient discharges <u>or</u> at least $750,000 in inpatient charges for services provided to WMP recipients over the two SFYs preceding the annual rate update. The table below provides examples of the years used for a series of annual rate updates. Not included in these amounts are discharges and charges for (1) stays which were paid in full or part by Medicare and (2) stays paid in full by a payer other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMP would have paid for the stay. For each RY, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital.

Annual Rate Update Effective Date	State Fiscal Years Looked At for Discharges and Charges
January 1, 2014	July 2011 to June 2012 <u>and</u> July 2012 to June 2013
January 1, 2015	July 2012 to June 2013 <u>and</u> July 2013 to June 2014

4250 Rehabilitation Hospitals with Border Status
A major border status hospital that the Department determines qualifies as a rehabilitation hospital, as defined in §3000, is reimbursed on a prospective rate per diem consistent with in-state rehabilitation hospitals.

4260 Alternative Payments to Border Status Hospitals for Certain Services
For any out-of-state acute, children's, critical access, or long-term care hospital, regardless of border status, all inpatient stays are reimbursed under the DRG-based payment method except AIDS patient care, ventilator patient care, unusual cases, and brain injury care. These cases are reimbursed under the alternative payment methods described in §7000 if the hospital requests and qualifies for the alternative reimbursement according to §7000.

5000
COST REPORTING

5100 Use of Cost Reports in Rate Setting

The WMP uses the Medicare cost report to establish certain components of an in-state or major border status hospital's specific payment, including the capital, direct graduate medical education, and rural hospital components of the base rate per discharge. Cost reports are also used to establish the cost-to-charge ratio for outlier payments and individual hospital allotments for DSH payments. The Department obtains audited Medicare cost reports through the Healthcare Cost Report Information System (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS).

5200 Selection of Cost Reporting Period

The Department uses the most recent audited 12-month Medicare cost report available in HCRIS as of the March 31 prior to the start of the RY. If the most recent audited 12-month Medicare cost report available is a "no utilization" cost report, the Department may request an alternate 12-month cost report from the hospital. If the most recent audited 12-month Medicare cost report available is greater than five years old, or if no audited 12-month Medicare cost report is available, the Department may use an unaudited 12-month Medicare cost report. If no unaudited 12-month Medicare cost report is available in HCRIS, the Department will request an unaudited 12-month Medicare cost report from the hospital directly. However, if an unaudited Medicare cost report, either from HCRIS or a hospital, is used, the Department will recalculate the inpatient rate once the unaudited Medicare cost report has been audited to determine the final rate.

5300 Cost Reports for Recent Hospital Combinings

A "hospital combining" is the result of two or more hospitals combining into one operation, under one WMP provider certification, either through merger or consolidation, or 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 hospital's physical plant. For combining hospitals for which there is not an audited 12-month Medicare cost report available for the combined operation, the Department combines data from the most recent audited 12-month Medicare cost reports of the individual combining hospitals prior to the hospital combining.

6000
DRG-BASED PAYMENT SYSTEM

6100 Introduction

A hospital is paid a prospectively-established amount for each discharge under the DRG-based payment system. In the Department's annual rate update, a "hospital-specific DRG base rate" is calculated for each hospital. This rate is the result of adjusting a uniform "standard DRG group rate" to recognize the wage area of each hospital. In addition, hospital-specific rate supplements for capital, direct graduate medical education, and rural hospital status are added to the "standard DRG group rate." This results in hospital-specific DRG base rates.

For each WMP recipient's stay, the hospital's specific DRG base rate is multiplied by the weight for the DRG which applies to the hospital stay. The result of this multiplication is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high-cost cases.

6110 Hospitals Covered by the DRG-Based Payment System

The DRG-based payment system as described in §6000 applies to in-state and major border status acute care, children's, critical access, and long-term care hospitals. Reimbursement for rehabilitation and psychiatric hospitals is described in §8000. Reimbursement for minor border status and out-of-state hospitals is described in §11000.

6120 Services Covered by DRG Payments

All covered services provided during an inpatient hospital stay, except professional services described in §6130, are considered inpatient hospital services for which payment is provided under this DRG-based payment system. (Reference: Wis. Admin. Code, HS 107.08(3) and (4))

All covered inpatient hospital stays are reimbursed under the DRG-based payment method except AIDS patient care, ventilator patient care, unusual cases, and brain injury care. These cases are reimbursed under the alternative payment methods described in §7000 if the hospital requests and qualifies for the alternative reimbursement according to §7000.

Organ transplants are covered by the DRG-based payment method.

6130 Professional Services Excluded from DRG Payments

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately-certified provider and billed on the CMS 1500 claim form. Services are excluded when the professionals providing them or the services themselves are functioning as:

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water, and land ambulance

6200 Standardized DRG Payment Factors

Certain standard factors are used in determining the amount of payment hospitals receive for services covered by the DRG-based payment method. The Department adjusts these standard factors for each RY. These include the DRG grouper and the DRG weights.

6210 DRG Grouper

The DRG grouper is a classification system that sorts each patient stay into one DRG. The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). For psychiatric stays, WMP has enhanced the grouper's MDC 19 (Mental Diseases and Disorders).

The version of the Medicare grouper used by the WMP is updated for each RY. For a given RY, the Medicare grouper version used is the latest available as of the July 1 preceding the start of the RY.

6220 DRG Weights

DRG weights are designed to reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services, and the relative cost of those services. WMP recipient inpatient hospital claims are used to ensure that the weights developed are relevant to the types and scope of services provided to WMP recipients.

For each RY, revised DRG weights are established based on (1) the updated version of the Medicare grouper, (2) more current claims information, and (3) more current inpatient hospital Medicare cost report information.

6221 Claims Used. To develop the DRG weights, the Department uses the three most recent complete SFYs of WMP inpatient hospital adjudicated claims, paid through MMIS, that are available as of the July 1 before the start of the RY. Claims not covered by the WMP's DRG-based payment system, such as those for which payment is made at rates determined under §8000 and §7000, are not used. Claims from any hospital designated as a CAH during any portion of the selected period are also excluded.

6222 Calculating Weights. The Department applies the updated version of the DRG grouper, as described in §6210, to the set of claims described in §6221. Each claim is classified and assigned to its appropriate DRG by the grouper.

Separately, the Department calculates the cost of each claim. This is a hospital-specific claim cost that requires cross-walking the services charged on a claim to corresponding cost centers of the hospital's Medicare cost report. For each claim, the Department multiplies the accommodation services for the hospital stay by the cost-to-charge ratio for accommodation services derived from that hospital's Medicare cost report. The result is the estimated cost of accommodations for the hospital stay represented by the claim. The Department repeats this process for ancillary service charges and acquisition charges for transplanted organs (where specific cost-to-charge ratios for the respective organs are used). The Department sums the resulting accommodation cost, ancillary service cost, and organ acquisition cost for the claim to derive the total cost of the hospital stay.

The Department further standardizes the cost of each inpatient stay by adjusting for area wage differentials and reducing for cost attributed to capital, direct graduate medical education, and outlier costs.

The Department then increases each claim's cost using an inflation multiplier to trend forward to the current RY. The inflation multiplier is derived from the IHS publication, "Hospital and Related Healthcare Costs Index."

Next, the Department calculates the average cost of the claims in each DRG and a combined overall average cost of all DRG claims. The weight for each respective DRG is the average cost of the DRG's claims divided by the combined overall average cost.

The Department reviews and analyzes anomalies and incongruities in the resulting weights in the light of the prior year's weights and the cost and volume of claims involved. DRG weights may be adjusted based on the outcome of this analysis; for example, a significant decrease in the weight of any individual DRG could be mitigated unless cost, volume, central tendency, and deviation data justify the significant decrease. Low-volume DRGs are especially vulnerable to significant year-to-year swings in their weights.

Once all weights are finalized, the Department disseminates a listing of the resulting final DRG weights to in-state and major border status hospitals.

6223 Cochlear Implants. The Department provides a separate weight for inpatient hospital stays for cochlear implants. Payment at this weight is available upon written request by the hospital and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus.

6224 DRG Weights for MDC 15 (Mental Diseases and Disorders). The WMP has expanded the standard DRGs of MDC 15 (Mental Diseases and Disorders). For each of the DRGs in this category, the Department develops separate weights for members over age 17 and members age 17 and younger. These weights only apply to hospital stays in acute care hospitals; they do not apply to hospital stays in IMDs or psychiatric hospitals.

6230 Hospital-Specific DRG Base Rate

The Department calculates a "hospital-specific DRG base rate" for in-state and major border status hospitals as follows:

First, the Department develops a uniform "standard DRG group rate" based on the RY's projected WMP inpatient utilization, case mix, and budget for DRG hospitals (less the projected expenditures for CAH base rates, which are developed such that projected reimbursement for CAHs fully covers cost). For RY 2014, the standard DRG group rate is $3,443.

Second, the Department determines "hospital-specific DRG base rates" by adjusting the standard DRG group rate for each hospital to account for differences in the wage area adjustment index, rural hospital adjustment qualifications, capital costs, and direct graduate medical education costs. The labor portion of the standard DRG group rate is adjusted by the wage area adjustment index applicable to the hospital; the sum of the adjusted labor portion and the unadjusted non-labor portion forms the "total labor-adjusted group rate." §6240 describes the wage area adjustment index. To form the hospital-specific DRG base rate, the Department adds to the hospital's total labor-adjusted group rate its specific base payment add-on amounts for capital and direct graduate medical education costs and its specific add-on percentage for the rural hospital adjustment (if applicable), described in §6250 through §6270.

Finally, the Department adjusts the standard DRG group rate to account for the impact of including capital, direct graduate medical education, and rural hospital adjustment costs in the development of the hospital-specific DRG base rates. This action, in turn, serves to adjust the hospital-specific DRG base rates as well.

6240 Wage Area Adjustment Indices

6241 Introduction. The Department adjusts the portion of the standard DRG group rate attributable to labor by a "wage area adjustment index" specific to each hospital. The following sections describe how the Department develops these wage indices. The Department develops two distinct sets of wage indices, one for hospitals located within the State of Wisconsin and one for major border status hospitals.

6242 Sources of Data. The Department develops the wage area adjustment indices based on hospital wage data available through the CMS website. For hospitals for which CMS has no data, such as non-acute care, new, and children's hospitals, the Department uses data from other sources.

Provider information must be submitted to the Department no later than the first day of the previous RY for the subsequent RY. Only wage data from hospitals certified as WMP providers is used.

The following hospitals are not included in the calculation of the wage indices.

(1) Hospitals not covered by the DRG payment system.
(2) Hospitals in Wisconsin designated as CAHs as of the June 30 immediately preceding the RY.
(3) Hospitals known to be closed or to have discontinued operating as a hospital as of the June 30 immediately preceding the RY, not including hospitals combining or merging with another hospital.
(4) Out-of-state non-border status hospitals and minor border status hospitals.

The Department obtains wage data through the CMS website from the "Final Occupational Mix Factor by Provider" file for the most recent fiscal year available at the time of rate development. This file is organized by provider and includes occupational mix adjusted and unadjusted wages, occupational mix adjusted and unadjusted average hourly wages, the nurse occupational mix adjustment factor, and the CBSA nurse occupational mix adjustment factor. The Department employs the unadjusted wage data to create the wage area adjustment indices.

6243 Wage Area Adjustment Indices for Hospitals Located in the State of Wisconsin. The Department develops the wage area adjustment indices for hospitals located within Wisconsin by calculating a statewide average wage from the wage data for in-state, WMP-certified hospitals. A hospital's specific wage area adjustment index is the ratio of that hospital's average wage to the statewide average wage. Thus, the statewide average wage has a wage area adjustment index of 1.00, and a hospital-specific wage index of 1.05 indicates that the hospital's average wage is 5% higher than the statewide average. A hospital-specific wage index of 0.90 indicates that the hospital's average wage is 10% lower than the statewide average.

For hospitals for which wage data is not available or which have not submitted hospital-specific information for consideration, the Department applies an average wage area adjustment index using data from hospitals located in the same metropolitan statistical area (MSA), as defined by CMS. This process is followed until wage area data for the hospital is published and identifiable in the CMS wage data referenced above.

6244 Wage Area Adjustment Indices for Major Border Status Hospitals. The Department develops the wage area adjustment indices for major border status hospitals by calculating an average wage from the wage data for WMP-certified major border status hospitals ("major border status average wage"). A hospital's specific wage area adjustment index is the ratio of that hospital's average wage to the major border status average wage. Thus, the major border status average wage has a wage area adjustment index of 1.00, and a hospital-specific wage index of 1.05 indicates that the hospital's average wage is 5% higher than the major border status average. A hospital-specific wage index of 0.90 indicates that the hospital's average wage is 10% lower than the major border status average.

For hospitals for which wage data is not available or which have not submitted hospital-specific information for consideration, the Department applies an average wage area adjustment index using data from hospitals located in the same metropolitan statistical area (MSA), as defined by CMS. This process is followed until wage area data for the hospital is published and identifiable in the CMS wage data referenced above.

6250 Capital Costs Adjustment

6251 General. Under the DRG-based payment system, the Department adds an amount for capital costs to the hospital-specific DRG base rates of hospitals located in Wisconsin and major border status hospitals. The amounts for this add-on are prospectively established based on each individual hospital's historical capital costs.

6252 Standard Calculation Methodology.

The Department determines the capital cost add-on amount for a hospital using cost information from the hospital's rate setting Medicare cost report.

1. The Department determines the capital cost attributable to WMP inpatient services by multiplying the overall allowed inpatient cost attributable to WMP recipients by the ratio of total allowed inpatient capital costs to total allowed inpatient costs.

2. The Department limits the resulting WMP capital cost to no more than 8% of a hospital's total cost of treating WMP recipients.

3. The Department inflates the amount from step 2 to the RY using an inflation rate derived from the IHS "Hospital and Related Healthcare Costs Index."

4. The Department divides the amount from step 3 by the number of WMP recipient discharges for the period of the rate setting Medicare cost report.

5. The Department divides the resulting amount per discharge by the average DRG case mix index per discharge.

6. The result from step 5 is the hospital's specific base capital cost add-on amount at a 1.00 DRG weight. The Department adds this amount to the hospital's specific DRG base rate.

6253 Calculation Where No Audited Cost Report Is Available. For hospitals for which there is no audited 12-month Medicare cost report available and which have not filed a previous appeal with the WMP, the Department applies the statewide average capital cost payment adjustment.

For in-state acute care hospitals, the Department determines this adjustment by dividing the total WMP capital costs (capped at 8% of a hospital's total cost) of all in-state acute care hospitals by the total number of recipient discharges for the period of the rate setting Medicare cost reports of all in-state acute care hospitals. This average capital cost per discharge calculation yields the statewide average capital cost payment that the Department adds onto the qualifying hospital's specific DRG base rate.

For major border status hospitals, the Department determines this adjustment by dividing the total WMP capital costs (capped at 8% of a hospital's total cost) of all major border status hospitals by the total number of recipient discharges for the period of the rate setting Medicare cost reports of all major border status hospitals. This average capital cost per discharge calculation yields the average capital cost payment that the Department adds onto the qualifying hospital's specific DRG base rate.

6260 Direct Graduate Medical Education and Approved Nursing and Allied Health Activities Adjustment

6261 General. Under the DRG-based payment system, the Department adds an amount for costs associated with direct graduate medical education programs to the hospital-specific DRG base rates of hospitals located in Wisconsin and major border status hospitals. The amounts for this add-on are prospectively established based on each individual hospital's historical direct graduate medical education costs.

6262 Standard Calculation Methodology.

The Department determines the direct graduate medical education and approved nursing and allied health activities add-on amount for a hospital using cost information from the hospital's rate setting Medicare cost report.

1. The Department determines the direct graduate medical education and approved nursing and allied health activities costs attributable to WMP inpatient services by multiplying the overall allowed inpatient cost attributable to WMP recipients by the ratio of total allowed inpatient direct graduate medical education and approved nursing and allied health activities costs to total allowed inpatient costs.

2. The Department inflates the resulting amount to the RY using an inflation rate derived from the IHS "Hospital and Related Healthcare Costs Index."

3. The Department divides the resulting amount by the number of WMP recipient discharges for the period of the rate setting Medicare cost report.

4. The Department divides the resulting amount per discharge by the average DRG case mix index per discharge.

5. The result from step 4 is the hospital's specific base direct graduate medical education and approved nursing and allied health activities add-on amount at a 1.00 DRG weight. The Department adds this amount to the hospital's specific DRG base rate.

6263 Calculation Where No Audited Cost Report Is Available. For hospitals for which there is no audited 12-month Medicare cost report available and which have not filed a previous appeal with the WMP, the Department applies the statewide average direct graduate medical education and approved nursing and allied health activities payment adjustment.

For in-state acute care hospitals, the Department determines this adjustment by dividing the total WMP direct graduate medical education and approved nursing and allied health activities costs of all in-state acute care hospitals by the total number of recipient discharges for the period of the rate setting Medicare cost reports of all in-state acute care hospitals. This average direct graduate medical education and approved nursing and allied health activities cost per discharge calculation yields the statewide average direct graduate medical education and approved nursing and allied health activities cost payment that the Department adds onto the qualifying hospital's specific DRG base rate.

For major border status hospitals, the Department determines this adjustment by dividing the total WMP direct graduate medical education and approved nursing and allied health activities costs of all major border status hospitals by the total number of recipient discharges for the period of the rate setting Medicare cost reports of all major border status hospitals. This average direct graduate medical education and approved nursing and allied health activities cost per discharge calculation yields the average direct graduate medical education and approved nursing and allied health activities cost payment that the Department adds onto the qualifying hospital's specific DRG base rate.

6270 Rural Hospital Adjustment

6271 Qualifying Criteria. A hospital may qualify for a rural hospital adjustment if it meets the following conditions in the most recent state fiscal year for which data is available at the time of the annual rate update. Critical access hospitals are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin.

2. The hospital is classified as being located in a rural Core Based Statistical Area (CBSA) designated by the Office of Management and Budget (OMB).

3. The hospital is not classified as a Rural Referral Center by Medicare.

4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics:

    a. total discharges excluding newborns,
    b. the Medicare case-mix index, and
    c. the WMP case-mix index.

5. The combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%.

CBSA rural/urban designations, Rural Referral Center designations, and provider-specific Medicare case-mix indices are determined from the latest published CMS Hospital Inpatient "PPS Final Rule Impact File". Hospitals which are not listed in the Final Rule Impact File are excluded from qualifying for the rural hospital adjustment.

6272 Adjustment Percentage. The amount of the rural hospital adjustment is based on a qualifying hospital's WMP utilization rate. The WMP utilization rate is determined by dividing the total WMP inpatient days by the total inpatient days from the individual hospital's rate setting Medicare cost report.

The Department has determined that a total of $5,000,000 will be available for the rural hospital adjustment percentage (for all hospitals combined) in FY2008 and years thereafter.

NOTE: To clarify for the federal Center for Medicare and Medicaid Services (CMS), the adjustment described in the above §6270, specifically §6271 and §6272, is NOT a disproportionate share hospital (DSH) adjustment under §1923 of the Social Security Act.

6273 Lump Sum Rural Adjustment Payments. Hospitals that do not qualify for a rural hospital adjustment percentage, but are classified as rural under the Medicare wage index, are eligible for an annual lump sum payment of $300,000 per hospital per state fiscal year.

6300 Outlier Payments under DRG-Based Payment System

6310 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment. Cost based outlier adjustments are provided. The Department may evaluate the medical necessity of services provided and appropriateness of outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

6320 Qualifying Criteria for a Cost Outlier Payment

For a hospital's claim to qualify for cost outlier payment, the following criteria apply:

1. The charges for a given case must be usual and customary.
2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.
3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows:

	Trimpoint Amount	
Type of Hospital / Bed Size	**Less than 100 Beds**	**100 Beds or Greater**
Acute Care Hospitals	$13,000	$34,273
Critical Access Hospital	$300	N/A

4. Hospital stays for which payment is <u>not</u> provided under the DRG payment system do not qualify for outlier payment consideration. This includes, but is not necessarily limited to, cases treated at rehabilitation hospitals and IMDs exempt from DRGs, cases treated at hospitals reimbursed on a percent-of-charges basis, and cases for services exempted from DRG payment system under §7000. Claims for chronic, stable ventilator-dependent hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

6330 Charges Adjusted-To-Cost

Claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMP inpatient services. The cost-to-charge ratio is drawn from the Medicare cost report used for rate setting. For hospitals for which the Department does not have an audited 12-month Medicare cost report, then the cost-to-charge ratio is the average state-wide cost-to-charge ratio, which is the ratio of the total state-wide inpatient hospital costs for WMP services to the total charges for those services.

6340 Outlier Payment Calculation

Variable costs in excess of the DRG payment and the trimpoint will be paid. Following are the steps for calculation of an outlier payment. Examples of cost outlier calculations are presented in appendices §21000 and §22000.

1. Allowed claim charges are adjusted to cost by multiplying the charges by the hospital's WMP cost-to-charge ratio.

2. The allowed excess claim cost is calculated by subtracting the case-mix adjusted DRG payment and the hospital's trimpoint from the claim cost. (Claim cost – Case-mix adjusted DRG payment - Trimpoint = Excess cost, must be positive to qualify).

3. The outlier payment is the result of multiplying the excess claim cost by the variable cost factor. The variable cost factors are:

Type of Hospital	Variable Cost Factor
General Medical & Surgical Hospitals	77%
Major Border Status Hospitals	77%
Non-Border Status and Minor Borders Status Hospitals	77%
Critical Access Hospitals	100%

6350 Bed Count, Source and Changes

The trimpoint amount for each hospital shall be established effective January 1 of the rate year based on the bed count on file with the Department's Division of Quality Assurance, as of July 1 of the preceding rate year.

If a hospital changes its bed count after July 1, the hospital must notify the Department and any change in the trimpoint amount will not be effective until the subsequent rate year.

6400 Alternative DRG Base Rates

6410 Reimbursement for Critical Access Hospitals
Critical access hospitals are reimbursed the lower of the hospital's allowable cost or charges for the services provided to WMP recipients.

The Department calculates a prospective cost based rate per discharge, using the Medicare cost report used for rate setting, per the following steps:

1. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles.
2. Costs will be apportioned to the WMP by multiplying the cost per day times WMP days from the Medicaid Management Information System (MMIS).
3. WMP ancillary costs will be calculated by deriving cost-to-charge ratios for each ancillary service cost center. The total ancillary WMP costs will be calculated by multiplying the cost-to-charge ratios by WMP ancillary charges from the Medicaid Management Information System (MMIS).
4. Outlier payments will be projected based upon claims data corresponding to the cost report period and will be netted from WMP costs.
5. Costs associated with capital will be limited to no more than 8% of a hospital's total WMP costs.
6. The WMP routine costs plus ancillary costs, net of outlier payments and capital cost reduction amounts, will be divided by the number of WMP discharges from MMIS corresponding to the cost report period.
7. The cost per discharge rate will be inflated to the current rate year by applying the "Hospital and Related Healthcare Costs Index" published by IHS.

The prospective cost based rate will not be subject to an annual WMP cost settlement. If no audited 12-month Medicare cost report is available, the hospital will receive the statewide average payment rate. Total inpatient payments may not exceed charges as described in §10000.

6420 Payment Rates for New Acute Care, Children's, and Long-Term Care Hospitals

The Department will establish payment rates for new acute care, children's, and long-term care hospitals under a method other than that described in §6200 until Medicare cost reports are available for application of that methodology.

6421 New Acute Care Hospital and Start-Up Period. The start-up period for a new acute care, children's and long-term care hospital begins the date the hospital admits its first WMP recipient. The start-up period ends when an audited 12-month Medicare cost report is available to the Department at time of rate calculation.

6422 Rates for Start-Up Period. New acute care, children's and long-term care hospitals are paid a statewide average "DRG payment rate adjusted by case mix." New Hospitals are eligible to receive an "outlier" payment for very high cost cases. The statewide average cost-to-charge ratio will be used in determining outlier payments during the start-up period. The statewide average cost-to-charge ratio will be calculated by summing the total cost of treating WMP patients in existing in-state acute care hospitals divided by total WMP charges associated with WMP patients in the rate year.

6500 Other Provisions Relating to DRG Payments

6510 Review by External Quality Review Organization (EQRO)

The Department contracts with an External Quality Review Organization (EQRO) to review selected hospitalizations of WMP recipients for medical necessity and appropriateness. The process to select those hospitalizations which are reviewed is approved by the Department. The EQRO review criteria are premised on objective clinical signs of patient illness and documentation that intensive hospital services were being provided. The EQRO review process represents a highly professional, clinically sound approach for assuring that hospital services are used only when medically necessary. EQRO criteria are approved by the federal Center for Medicare and Medicaid Services (CMS). The review criteria and periodic updates to it are disseminated to all hospitals in the state.

6511 EQRO Control Number. The hospital must contact the EQRO and acquire a unique case-specific control number from the EQRO for each of the following types of inpatient admissions:

- urgent/emergent admissions to hospital IMDs for recipients under 21 years of age,
- medical elective admissions, and
- admissions for ambulatory/outpatient procedures identified by the Department as needing control numbers.

Payment of inpatient claims for these admissions will be denied if the claims do not include the required case-specific control number from the EQRO.

6512 DRG Validation Review. As part of the EQRO review process, the information provided on the hospital claim is verified with the medical record documentation. This review may determine that the DRG initially assigned to the hospital stay was inappropriate. The Department may adjust DRG payment pursuant to the result of EQRO reviews and recover any overpayment which has been made.

6520 Medically Unnecessary Stays

Medically unnecessary stays are those stays that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See §6510 regarding criteria.)

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays and/or inappropriate services based on determinations by the Department, the External Quality Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMP recipients and payments made to providers of such services. Wisconsin statute, §49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

6530 Inappropriate Admissions

6531 Inappropriate Inpatient Admission. Payment for inpatient care which could have been performed on an outpatient basis shall not exceed the facility's outpatient rate-per-visit paid under Attachment 4.19-B of this State Plan. If payment has been made, the difference between the payment and the outpatient rate-per-visit will be recovered.

6532 Inappropriate Discharge and Readmission. If the EQRO determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, no payment will be made for the first discharge. If payment has been made, it will be recouped.

6540 Transfers

6541 Hospital to Hospital Transfers. Patient transfers may be reviewed by the EQRO or the Department for medical necessity. If the transfer is determined to have been medically necessary, then both the transferring and the receiving hospital will be paid the full amount for the respective stay. If the transfer is determined not to have been medically necessary, then no payment will be made for the stay that was not deemed medically necessary.

6542 IMD to Hospital Transfers. An inpatient at an IMD may transfer to an acute care hospital for a short term stay, then return to the IMD and eventually be discharged from the IMD. If the person's absence from the IMD is due to the person being an inpatient of one or more acute care hospitals for a period of three or less consecutive days, the IMD will not be paid a payment for the transfer to the acute care hospital. If the absence is for a period exceeding three consecutive days, the IMD will receive payment for the transfer to the acute care hospital. Three or less consecutive days means the patient is absent or on-leave from the IMD for three or less successive midnight census counts of the IMD. The IMD will be eligible for payment for each medically necessary day the patient was included in the census counts of the IMD. The acute care hospital, to which the patient was transferred, will be reimbursed for the medically necessary stay without regard to the patient's length of the stay in the acute care hospital. Any payment to the IMD for a person's inpatient stay is subject to the person being eligible for MA coverage for their stay in the IMD.

6550 Days Awaiting Placement

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. A DRG weighted discharge payment will not be adjusted for days a WMP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-MR is delayed, not on the hospital's part, for completion of required pre-admission screening for mental illness and/or mental retardation (required under Subtitle C, Part 2 of PL 100-203, the Omnibus Budget Reconciliation Act of 1987), the hospital may request and receive a per diem payment for each allowed day identified as waiting placement due to the lack of the pre-admission screen. This payment shall be in addition to the DRG payment, not to exceed the estimated statewide average NF rate. Each allowed day awaiting placement must be adequately documented for review in the patient chart.

6560 Outpatient Services Related to Inpatient Stays

Outpatient hospital claims for services provided to a recipient during an inpatient stay are considered part of the inpatient stay and will be denied. Emergency room services shall be considered part of the inpatient stay, not outpatient services, if the patient was admitted and counted in the midnight census. Outpatient or professional claims on the date of admission or discharge will be allowed if billed by a provider other than the admitting inpatient hospital.

6570 Obstetrical and Newborn Same Day Admission/Discharge

A hospital stay shall be considered an inpatient stay when a WMP recipient is admitted to a hospital and delivers a baby, even if the mother and the baby are discharged on the date of admission and not included in the midnight census. This consideration applies to both the newborn infant and the mother and also applies in those instances when the recipient and/or newborn are transferred to another hospital.

6580 Changes of Ownership

Payment rates will not change solely as a result of a change of ownership. At the time of ownership change, the new owner will be assigned the hospital-specific DRG base rate of the prior owner. Subsequent changes to the hospital-specific DRG base rate for the new owner will be determined as if no change in ownership had occurred; that is, the prior owner's Medicare cost reports will be used until the new owner's Medicare cost reports come due for use in the annual rate update.

6590 Provisions Relating to Organ Transplants

6591 Coverage Criteria. In order for a hospital to receive payment for transplant services, the following criteria must apply:

a. The transplant must be performed at an institution approved by the Organ Procurement and Transplant Network and/or CMS for performing organ transplantation for the type of transplant provided.

b. Any transplant other than a transplant of a solid organ must be prior authorized by the Department. Criteria for coverage of solid organ transplants are provided in Attachment 3.1-E and the organ transplants listed are heart, heart-lung and lung, liver, and pancreas. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.

c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization.

6592 Organ Procurement. Organs must be obtained in compliance with the requirements of Federal and State statute and regulations.

6593 Transplant Log. Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMP recipient (except bone marrow) indicating the organ procurement organization or agency or source of the organ and all costs associated with procurement. A copy of this log must be submitted along with the transplant hospital's WMP cost report, so that the WMP may document compliance.

6600 Performance-Based Payments

6610 Assessment-Funded Performance-Based Payments

The Department reserves $5 million (all funds) in each SFY for its Hospital Assessment Pay-for-Performance (HAP4P) program, which provides for payments to acute care, children's, and rehabilitation hospitals located in Wisconsin. Critical access hospitals are not included in the HAP4P program because they already receive cost-based reimbursement. Psychiatric hospitals are not included because they are paid under a different reimbursement methodology in the State Plan.

The HAP4P program is administered on a measurement year (MY) basis. Each MY runs from April 1 through March 31 of the next calendar year, and is named after the calendar year in which it ends. Payments for each MY are made annually by the December 31 following the conclusion of the MY.

The remainder of this section describes the program's design and requirements for MY 2015. In order to be eligible for HAP4P 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 (effective October 15, 2014 for MY 2015) published on the Wisconsin ForwardHealth Portal.

Hospitals receive payment for scoring at or above the averages published in the P4P Guide for the three CheckPoint measures, and their respective sub-measures, as listed below.

1) Perinatal Measures ($2 million) – Hospitals are scored on three sub-measures (AHRQ PSI 17, AHRQ PSI 18, AHRQ PSI 19). A hospital can earn a 75% "partial share" of the $2 million by scoring at or above the published average on one of the sub-measures, or can earn a 100% "full share" of the $2 million by scoring at or above the published average on at least two of the sub-measures.

2) Patient Experience of Care ($1.5 million) – Hospitals are scored on ten sub-measures drawn from the 27-question Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey completed by patients. A hospital can earn a 100% "full share" of the $1.5 million by scoring at or above the published average on at least three of the sub-measures.

3) Central Line Associated Blood Stream Infections (CLABSI) ($1.5 million) – Hospitals are scored based on their performance on this standard infection ratio that is calculated for all Wisconsin hospitals. A hospital can earn a 100% "full share" of the $1.5 million by scoring at or above the published average for this measure.

Only data submitted to CheckPoint as of the September 30 following the conclusion of the MY are included in the calculations of performance on these measures.

The Department determines the payment amounts and recipients for each measure separately. The Department calculates the "full share" payment amount for a measure by dividing the budget for the measure by the sum of ("partial" and "full") shares earned by hospitals; the "partial share" payment amount is the "full share" payment amount multiplied by the "partial share" percentage. For example, if, for the Perinatal Measures, 25 hospitals qualify for "full shares" and 20 hospitals qualify for 75% "partial shares," the sum of the shares is 40 (25 + 0.75 x 20), so the 25 hospitals each earn $50,000 ($2 million / 40) while the 20 hospitals each earn $37,500 ($50,000 x 0.75).

HAP4P payments are limited by the federal UPL regulations at 42 CFR §447.272. All HAP4P payments are included in the UPL calculation for the MY regardless of when payments are actually made.

6620 Withhold-Based Performance-Based Payments

The Department has a Hospital Withhold Pay-for-Performance (HWP4P) program that provides for payments for acute care, children's, critical access, and psychiatric hospital services. Long-term care, rehabilitation, and out-of-state hospitals are exempt from the HWP4P program.

The Department administers the HWP4P program on a measurement year (MY) basis. The chart below shows the start and end dates for the first two MYs of the HWP4P program, which did not occupy a full 12 months.

MY 2013	**Start:** July 1, 2012	**End:** March 31, 2013
MY 2014	**Start:** May 15, 2013	**End:** March 31, 2014

Subsequent MYs are on a 12-month cycle, from April 1 through March 31 of the next calendar year.

For each MY, the Department pays FFS claims for services at the rate of 98.5% of the reimbursement in effect during the MY. The HWP4P pool amount is the remaining 1.5% of the reimbursement in effect during the MY for those same FFS claims.

Hospital supplemental payments made to eligible providers, including access payments, are excluded from the HWP4P pool amount.

The Department makes HWP4P payments for each MY annually by the December 31 following the conclusion of the MY.

The remainder of this section describes the program's design and requirements for MY 2015. In order to be eligible for HWP4P 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 (effective October 15, 2014 for MY 2015) published on the Wisconsin ForwardHealth Portal.

Hospitals that meet both reporting requirements and performance-based targets, for the measures described later in this section, are eligible to receive payments from the HWP4P pool as follows:

a. The Department calculates individual HWP4P pool amounts for each eligible hospital. At the end of the MY, the Department divides each individual HWP4P pool amount by the number of measures applicable to the respective hospital to determine the value of each measure. (E.g., if a hospital's individual pool equals $100,000 and it qualifies to participate in four measures, then each measure is worth $25,000.) As a result, the value of a given measure will vary from hospital to hospital, impacted by both the size of the individual hospital's HWP4P pool amount and the number of measures for which the hospital qualified.
b. If a hospital meets all of its performance targets for all applicable measures, it receives a payment equal to its individual HWP4P pool amount.
c. If a hospital does not meet all of its performance targets, it earns dollars for those measures where the targets were met, in a graduated manner as specified in the Hospital P4P Guide.
d. If all participating hospitals meet all of their individually applicable targets, no additional HWP4P pool funds are available and thus no bonus payments beyond those described above can be made to any hospital.
e. If at least one participating hospital does not receive its full HWP4P pool amount, the Department aggregates all remaining HWP4P pool funds and distributes them as additional bonus payments to hospitals that met their performance targets.

The Department ensures that all HWP4P pool dollars are paid back to hospitals by providing bonus payments. If a hospital meets all reporting requirements and performs in the highest tier on at least one applicable pay-for-performance (as opposed to pay-for-reporting) measure, it qualifies to receive a bonus payment. Bonus dollars are shared proportionally among hospitals weighted by two factors: the relative magnitudes of the individual HWP4P pool amounts for all hospitals that qualified for the additional bonus and the percentage of applicable measures for which the hospitals performed in the highest performance tier. Therefore, hospitals with a larger HWP4P pool amount receive a larger portion of the additional bonus dollars available, while high-performing hospitals are also rewarded. The University of Wisconsin Medical Center and CAHs are only eligible for WMP payment, including the HWP4P payments, up to cost.

The Department notifies each eligible hospital, prior to the MY, of the minimum performance requirements to receive the HWP4P pool payment. Complete details, including technical information regarding specific quality and reporting metrics, performance requirements, and HWP4P adjustments, are available in the Hospital P4P Guide. The performance measures that are in effect in this State Plan on the first day of each MY are the measures that are used for that MY. Except in cases of emergency rule, providers are given at least 30 days' written notice of any and all changes to the Hospital P4P Guide.

The measures for MY 2015 are:

1) Thirty-day hospital readmission – Hospitals are scored on the percentage of patients that had a qualifying readmission within 30 days of a qualifying discharge. This measure is applicable to a hospital that has at least 30 observations during the MY. To qualify for its earn-back on this measure, a hospital must exceed either the state average or its past performance (MY 2013).

2) Mental health follow-up visit within 30 days of discharge for mental health inpatient care – Hospitals are scored on the percentage of patients that had a mental health follow-up appointment within 30 days of a qualifying mental health discharge. This measure is applicable to a hospital that has at least 30 observations during the MY. To qualify for its earn-back on this measure, a hospital must improve upon its past performance (MY 2013) (since the Department is not using a risk adjustment methodology for this measure, a hospital's score is not compared to the state average).

3) Asthma care for children – Hospitals are scored on the percentage of children admitted to a hospital with a qualifying asthma diagnosis that were discharged with a Home Management Plan of Care (HMPC). This measure is applicable to children's hospitals that have at least 30 observations during the MY. To qualify for its earn-back on this measure, a hospital must submit its data to the Joint Commission by the September 30 following the MY and must exceed either the national average or its past performance (MY 2013) on this measure.

4) Initial antibiotic for community-acquired pneumonia (PN-6) – Hospitals are scored on the percentage of immunoincompetent patients with community-acquired pneumonia that receive an initial antibiotic within 24 hours of admission into the hospital. This measure is applicable to a hospital that has at least 25 observations during the MY. To qualify for its earn-back on this measure, a hospital must submit its data to Wisconsin CheckPoint prior to the September 15 following the MY and must exceed either the state average or its past performance (MY 2013) on this measure.

5) Healthcare personnel influenza vaccination – Hospitals are evaluated on their performance on the Health Care Personnel Influenza Vaccination measure submitted via the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) module. To qualify for its earn-back on this measure, a hospital must exceed either the national average (as published by NHSN) for the previous flu season or its past performance (MY 2013). Hospitals must report their healthcare personnel influenza vaccination results to the NHSN module prior to the deadline set by NHSN.

6) Early elective induced deliveries - PC-01 (pay-for-reporting) – Hospitals are evaluated on their submission of the early elective induced delivery data to Wisconsin CheckPoint. To qualify for its earn-back on this measure, a hospital must submit its data to CheckPoint prior to the September 15 following the MY.

7) Catheter Associated Urinary Tract Infections (CAUTI) (pay-for-reporting) – Hospitals are evaluated on their submission of CAUTI data to Wisconsin CheckPoint. To qualify for its earn-back on this measure, a hospital must submit its data to CheckPoint prior to the September 15 following the MY.

HWP4P payments, including the additional bonus payments, are limited by the federal UPL regulations at 42 CFR §447.272. All HWP4P payments, including the additional bonus payments, are included in the UPL calculation for the MY regardless of when payments are actually made.

6700 Payment Adjustment for Provider Preventable Conditions

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

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Attachment 4.19-A:

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

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

__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 4447.26 (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 the 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 WMP beneficiaries.

7000
SERVICES EXEMPTED FROM THE DRG-BASED PAYMENT SYSTEM

7100 Payment for Acquired Immunodeficiency Syndrome (AIDS)

7110 AIDS Acute Care and AIDS Extended Care Rates of Payment

The current payment rates per diem for AIDS acute care and for AIDS extended care are listed in §7900. These per diem rates apply for in-state hospitals, major and minor border-status hospitals and non-border status hospitals.

Total payment is calculated as the sum of the acute care per diem times the number of approved acute care days plus the extended care per diem times the number of approved extended care days. Payment will not exceed total covered charges.

7120 Patient Criteria for Approval to Receive AIDS Rate of Payment

7121 Acute Care. Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMP. The request is to be submitted through the WMP prior authorization (PA) process. The following criteria apply:

a. The patient must have an established diagnosis of AIDS.
b. Clinical findings and other relevant medical information must substantiate the medical necessity and appropriateness of the hospitalization and its payment at the AIDS acute care rate.
c. Medical record documentation supporting the medical necessity and appropriateness of acute inpatient care must be submitted with the request for approval.

Approval for the acute care per diem is granted for a specified period of time. If the patient still meets the intensity and severity criteria for acute care, the provider must submit a subsequent request for extension of the payment approval.

7122 Extended Care. Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMP. The request is to be submitted through the WMP prior authorization (PA) process. The following criteria must be met:

a. The patient must have an established diagnosis of AIDS.
b. The patient must be medically stable per discharge indicators appropriate for the system involved.
c. The patient must require infection control procedures and isolation techniques.
d. Reasonable attempts at securing alternative living situations that allow for correct infection control procedures and isolation techniques must have been unsuccessful and an appropriate plan of care and discharge plan must have been established.
e. The degree of debilitation and amount of care required must equal or exceed the level of skilled nursing care provided in a nursing facility (NF).
f. Sufficient documentation supporting these criteria must be submitted with the request for approval.

Approval for the extended care rate is granted for a specified period of time, after which if the patient still meets the intensity and severity criteria for extended care, the provider must submit a subsequent request for extension of the payment approval.

The progression of illness may require acute care services during the period established for extended care. Therefore, during an "extended care" period, the acute care payment rate will be approved for payment after the hospital has provided an acute level of care for at least five days and the WMP determines the above acute care criteria are met.

7130 No Outlier Payment and Administrative Adjustment

AIDS cases paid under the per diem rate of this section do not qualify for outlier payments. AIDS reimbursement rates are not subject to administrative adjustment.

7140 If AIDS Exemption Discontinued

In the event that the AIDS payment rate is discontinued, the Department is obligated to pay for services at the latest rate adjusted annually for inflation until alternative placement for these patients can be found. The hospital will provide care to these patients at this latest rate until such time that an alternative placement can be found.

7200 Payment for Ventilator-Assisted Patients

7210 Rate of Payment

The per diem payment rate for long-term ventilator services is listed in §7900. Hospitals are required to bill at least on a monthly basis. This rate applies to instate hospitals, major and minor border-status hospitals and non-border status hospitals.

7220 Criteria for Approval to Receive Ventilator-Assistance Payment Rate

7221 Patient Criteria. Payment of the ventilator-assistance rate for a patient's hospital stay must be requested by the hospital and approved by the WMP based on the following criteria. The request is to be submitted through the WMP prior authorization (PA) process. If one or more of the following criteria are not met, payment of the ventilator-assistance rate may be approved by the WMP if it is determined that payment of such rate to the hospital for the patient's stay is expected to be less costly than alternative ventilator assistance services.

a. The patient must have been hospitalized continuously in one or more hospitals for at least thirty consecutive days;
b. The ventilator-assisted patient must be in a medically stable condition requiring an inpatient level of care;
c. Attempts at weaning the patient from the ventilator are inappropriate or must have failed;
d. The ventilator-assisted patient must require ventilator assistance six or more hours per day;
e. Home care must be an unacceptable alternative because of financial/economic hardship or because of the lack of adequate support system; and
f. Nursing home placement must be inappropriate because of the high level or type of care required or non-availability.

7222 Dedicated Unit Provisions. If a hospital has a specialized nursing unit dedicated to the care of ventilator-assisted patients, the Department will allow the hospital to be reimbursed retroactive to the first day of the stay in the dedicated unit even if that date is prior to the date of approval for payment at the ventilator-assistance rate.

7223 Transfers. Hospitals will continue to be paid the ventilator rate when ventilator-assisted patients are transferred to acute care or intensive care units within the hospital for complications associated with their ventilator dependency. Hospitals will be paid the prospective DRG rate for transfers and/or admissions to acute care settings for medical problems unrelated to their ventilator dependency, provided the acute care stay lasts more than five days.

7230 If Ventilator-Assistance Exemption Discontinued

In the event that the Department discontinues the ventilator-assisted payment rate, the Department is obligated to pay for services at the most current rate adjusted annually for inflation until such time as an alternate placement for patients is found. The hospital will continue to provide care to these patients at this rate until alternative placement is found.

7300 Payment for Department of Corrections Inmates

7310 Introduction

As authorized under 2013 Wisconsin Act 20, the WMP reimburses hospitals for state prison inmate inpatient hospital stays, when the inmate has been determined eligible for Medicaid, for dates of admission on or after April 1, 2014.

7320 Eligibility

The inmate must meet the following eligibility criteria:

a) Only inmates of a state prison, not a county jail, are eligible.

b) Only Wisconsin Medicaid or BadgerCare Plus benefit plans are eligible for reimbursement. To qualify for Wisconsin Medicaid or BadgerCare Plus, state prison inmates must meet all applicable eligibility criteria.

c) Inmates are eligible for the WMP for the duration of their hospital stay only. Eligibility begins on the inmate's date of admission and ends on the inmate's date of discharge.

d) Medical services provided to inmates who do not qualify for the WMP are coordinated and reimbursed by the Department of Corrections (DOC).

7330 Services Covered

The following services are covered for state prison inmates:

a) Inpatient hospital services that are allowed by the WMP and last for at least 24 hours.

b) Emergency room (ER) services that result in an admission to the hospital, directly from the ER, which persists through the next midnight census or 24 hours after the inmate's release from the prison, whichever is longer. ER services meeting these criteria are subsumed under the inpatient services provided.

c) Observation stays that result in an admission to the hospital, directly from the observation, which persists through the next midnight census or 24 hours after the inmate's release from the prison, whichever is longer. Observation services meeting these criteria are subsumed under the inpatient services provided.

7340 Reimbursement

The WMP reimburses for services provided to WMP-eligible state prison inmates as follows:

a) Acute care hospitals are reimbursed at 49 percent of their usual and customary charge.

b) Other types of hospitals are reimbursed according to their existing WMP reimbursement methodology.

7350 Prior Authorization

WMP services provided to state prison inmates are subject to the same prior authorization (PA) requirements as WMP services provided to other WMP enrollees. If PA is denied for a given service, the DOC is responsible for reimbursement of that service.

7400 Negotiated Payments for Unusual Cases

Notwithstanding other reimbursement provisions of this plan, the Department may allow an alternative payment for non-experimental inpatient hospital services if the WMP determines that all of the following requirements are met:

1. The services are:
    a. Necessary to prevent death of a recipient; or
    b. Necessary to prevent life threatening impairment of the health of a recipient; or
    c. Necessary to prevent grave and long lasting physical health impairment of a recipient; or
    d. Cost effective compared to an alternative service or alternative services.
2. At the time this plan was submitted, the service(s) as proposed:
    a. Was not reasonably accessible for WMP recipients; or
    b. Had not been a WMP approved service provided for the particular purpose(s) intended; or
    c. Had not been a WMP approved service provided under similar medical circumstances; or
    d. Required performance in the hospital which, given the circumstances of the recipient's case, is the only feasible provider or one of the only feasible providers known to the WMP.
3. Existing payment methods are inadequate to ensure access to the services proposed for the recipient.
4. All applicable prior authorization requirements are met.

This §7400 applies to in-state hospitals, major and minor border status hospitals, and out-of-state hospitals not having border status. Alternative payments made under this provision shall be set on a case by case basis and shall not exceed the hospital's charges.

Requests for alternative payments under this provision are to be made to the: Office of the Administrator, Department of Health Services, 1 West Wilson Street, Suite 350, P.O. Box 309, Madison, WI 53701-0309 (telephone 608-266-2522 or FAX 608-266-1096).

Requests must be submitted prior to admission, during the hospital stay or not later than 180 days after the WMP recipient's discharge from the requesting hospital in order for an alternative payment to apply, at the discretion of the WMP, beginning with the admission date (if applicable prior authorization requirements have been met to allow retroactive payment).

7500 Brain Injury Care

7510 In-State and Border-Status Hospitals

A per diem rate is provided for prior authorized care of MA recipients in a hospital's brain injury care program which has been approved by the WMP. The hospital's brain injury care program must be approved by the WMP and each recipient's participation in the program must be prior authorized by the WMP. The criteria for approval of a program and for prior authorization of an MA recipient's participation in the program is available from the Department of Health Services (see address, §1000, page 1).

Periodic payment will be made to the hospital at the applicable rate per diem specified below. After completion of the hospital's fiscal year, total payments at the per diem rates in effect for brain injury care of prior authorized MA recipient services during its fiscal year will be determined. These total payments will be compared to the hospital's charges for the services and to the hospital's audited cost of providing the services. If the total payments exceed the total charges or the total costs, whichever is lesser, then the excess amount of payments will be recovered from the hospital.

The rates per diem for brain injury care programs for in-state and major and minor border status-hospitals are listed in §7900. The WMP may determine and approve additional rates for brain-injury care programs which provide significantly different services than are provided in the types of programs listed in §7900.

7900 Payment for Services Exempted from DRG-Based Payment System

These payment rates are established by applying the general payment rate increase provided by the state's biennial budget to the rate in effect for the prior rate year. The payment rates are effective for rate year 2014 and subsequent years.

Section	Services	Rate Per Diem Effective January 1, 2014
7100	AIDS Acute Care.....	$ 597
7100	AIDS Extended Care.....	$ 329
7200	Long-Term Ventilator Services.....	$ 1,564
7500	Brain Injury Care	
	Neurobehavioral Program Care.....	$ 1,222
	Coma-Recovery Program Care.....	$ 2,182

7910 Services Covered by Payment Rates in This Section

All covered services provided during an inpatient stay, except professional services described in §7920, are considered hospital inpatient services for which payment is provided under the payment rates listed in §7900 above. [Reference: Wis. Admin. Code, HS 107.08(3) and (4)]

7920 Professional Services Excluded from Payment Rates in This Section

Certain professional and other services are not covered by the payment rates listed in §7900 above. To be reimbursed by the WMP, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-04 hospital claim form. The following services are excluded from the above payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

8000
HOSPITALS PAID UNDER PER DIEM RATE

8100 Covered Hospitals

Rehabilitation hospitals, state-operated IMD Hospitals, and psychiatric hospitals will be paid under a rate per diem. Services described in §7000 are exempted from reimbursement under this section if reimbursement is requested by and approved for the hospital according to §7000.

8200 Payment Rates

This section describes how hospital institutions for mental disease owned and operated by the State, psychiatric hospitals and rehabilitation hospitals are reimbursed for services provided to WMP recipients. All services provided during an inpatient stay, except professional services described in §8420, will be considered inpatient hospital services for which payment is provided.

8210 State Owned and Operated IMDs

8211 Interim Per Diem Rate. Patient stays in a hospital covered by this section will be paid at interim or temporary rates per diem until a final reimbursement settlement can be completed for the hospital's fiscal year.

8212 Final Reimbursement Settlement. After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for WMP inpatient services provided during the year. The allowable costs a hospital incurred for providing WMP inpatient services during its fiscal year will be determined from the hospital's audited Medicare cost report for the fiscal year. Allowable costs will include the net direct costs of education activities incurred by the hospital as determined according to 42 CFR §413.85. Covered education activities include those allowed under §413.85 and approved residency programs, allowed under 42 CFR §413.86, in medicine, osteopathy, dentistry and podiatry.

The final reimbursement settlement will take the following federal payment limits into consideration:

(1) Total final reimbursement may not exceed charges according to §10000.
(2) Compliance with the federal upper payment limit of 42 CFR §447.272, also known as the Medicare upper-limit, will be retrospectively determined when the final settlement is determined. If necessary, final reimbursement will be reduced in order that this federal upper payment limit is not exceeded.

If the total amount of final reimbursement for the hospital's fiscal year exceeds the total interim payments for the year, then the difference will be paid to the facility. The difference will be recovered if the total final reimbursement is less than the total interim payments.

8220 All Other Psychiatric and Rehabilitation Hospitals

Patient stays in a hospital covered by this section will be paid at a prospective per diem cost based rate. The prospective per diem rate will be based on the rate setting Medicare cost report. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. WMP ancillary costs will be apportioned by deriving cost-to-charge ratios for each ancillary service. The total routine and ancillary WMP costs will be divided by total paid WMP days from the Medicaid Management Information System (MMIS). The cost per diem rate will be inflated to the current rate year by applying the "Hospital and Related Healthcare Costs Index" published by IHS. Final hospital-specific per diem payment rates are based on provider costs but are subject to a budget reduction factor to ensure compliance with the Department's annual budget. For rate year 2014 and subsequent years, the budget reduction factor used to ensure compliance with the Department's annual budget is 85.08%.

8221 Rates for New Hospitals. The Department will establish payment rates for new psychiatric and rehabilitation hospitals under a method other than that described above until Medicare cost reports are available for application of the above methodology. The start-up period for a new psychiatric and rehabilitation hospital begins the date the hospital admits its first WMP recipient. The start-up period ends when an audited 12-month Medicare cost report is available to the Department at time of rate calculation. The per diem rates to be paid during the start-up period shall be an average of the rates being paid to other psychiatric and rehabilitation hospitals in the state, not including rates being paid to new psychiatric or rehabilitation hospitals during a start-up period. The start-up rate being paid to a new psychiatric hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment. Rates will be established according to the methodology described in §8220 above after the start-up period ends and an audited 12-month Medicare cost report is available.

8300 Other Provisions Relating to Per Diem Rate System

8310 Review by External Quality Review Organization (EQRO)

§6510 applies to hospitals under the per diem rate system.

8311 EQRO Control Numbers. §6511 applies to hospitals under the per diem rate system.

8320 Medically Unnecessary Days (Under Per Diem Rate System)

Medically unnecessary days are those days that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See §8310 regarding criteria.)

8321 Authority for Recovery (Under Per Diem Rate System). The Department will recover payments previously made or deny payments for medically unnecessary hospital stays or days and/or inappropriate services based on determinations by the Department, the Wisconsin Peer Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMP recipients and payments made to providers of such services. Wisconsin statute, §49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

8322 Calculation of Recoupment (Under Per Diem Rate System). The amount to be recouped for medically unnecessary stays or days is calculated by multiplying the rate per diem times the number of denied days, less any co-payment or third-party payment.

8330 Inappropriate Admissions

§6530 applies to hospitals having per diem rates.

8340 Temporary Hospital Transfers (Under Per Diem Rate System)

When an inpatient in a hospital paid under the prospective rate per diem system is transferred to an acute care hospital and transferred back, no per diem payment shall be provided to the hospital for the days of absence. The acute care hospital, to which the patient temporarily transferred, will be reimbursed by the WMP for medically necessary stays.

8350 Days Awaiting Placement (Under Per Diem Rate System)

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. Payment under the prospective rate-per-diem will be adjusted for days a WMP recipient patient is awaiting placement to an alternative living arrangement. For those days identified as awaiting placement, payment shall be adjusted to an amount not to exceed the statewide average skilled care per diem rate for nursing facilities (NFs). Each allowed day awaiting placement shall be documented through patient chart review and subject to criteria established by the WMP. The amount to be recouped is calculated by subtracting the skilled care rate from the rate per diem and multiplying by the days awaiting placement. The amount to be recouped is also reduced by the applicable amount of co-pay and third-party liability (TPL) payments.

8360 Outpatient Services Related to Inpatient Stay

§6560 applies to hospitals under the per diem rate system.

8380 Changes of Ownership

§6580 applies to hospitals under the per diem rate system.

8400 Covered and Non-Covered Services

8410 Services Covered

All covered services provided during an inpatient stay, except professional services described in §8420, shall be considered hospital inpatient services for which per diem payment is provided under this §8000.
[Reference: Wis. Admin. Code, HFS 107.08(3) and (4).]

8420 Professional Services Excluded

Certain professional and other services are not covered by the per diem payment rates under this §8000. To be reimbursed by the WMP, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-04 hospital claim form. The following services are excluded from the per diem payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

9000
SUPPLEMENTAL PAYMENTS

Supplemental payments are provided to hospitals located in Wisconsin which provide a significant amount of services to specialty populations. The payments will be subject to the payment limitation of §10000 by which the total of the overall payments to an individual hospital during the state fiscal year may not exceed the hospital's total charges for the covered services.

9100 Funding of Inpatient Medicaid Deficit

A hospital in Wisconsin can receive additional reimbursement from the WMP for costs it incurred for providing inpatient hospital services to WMP recipients if provisions of this section are met. This is referred to as Medicaid deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. The reimbursement as described below is available beginning September 1, 2013 and is determined based on a hospital's Medicare cost report for its completed fiscal year.

9110 Qualifying Criteria

A hospital can qualify for Medicaid deficit reduction funding if:

a) it is an acute care hospital operated by the State or a local government in Wisconsin or is a non-state public psychiatric hospital located in Wisconsin; and
b) it incurred a deficit from providing WMP inpatient services (described in §9120 below); and
c) the operator of the hospital certifies that it has expended public funds to cover the deficit.

9120 Deficit from Providing Medicaid Inpatient Services

The deficit from providing inpatient services to WMP recipients (that is, the Medicaid deficit) is the amount by which the cost of providing the services exceeds the WMP payment for those services. The cost of providing the WMP inpatient services is identified from the hospital's audited Medicare cost report for the hospital's fiscal year under consideration for the Medicaid deficit reduction. Payment refers to the total of the reimbursement provided under the provisions of §6000 and §9300 to §9700 of this Attachment 4.19A of the State Plan for inpatient services for the respective fiscal year.

9130 Interim Payment

The Department identifies the total amount of uncompensated WMP FFS inpatient hospital costs as described in §9120 to determine interim payments under this section until finalized hospital Medicare cost reports are available. For the hospital fiscal year, the per diem costs for routine cost centers and cost-to-charge ratios for ancillary cost centers are determined using the hospital's most recently filed Medicare cost report as available on HCRIS. The process for the interim payment calculation is as follows:

1. Total hospital room and board and routine costs are identified from Worksheet B Part I, Column 27, lines 25 through 33. These cost centers are specific to routine and room and board services and their cost calculations are performed separately from ancillary service costs. Total hospital patient days for inpatient routine costs are identified from Worksheet S-3 Part I, Column 6.
2. The cost and total hospital patient days from Step 1 represent the total hospital costs and days for purposes of determining the calculated per diem cost for routine cost centers.
3. Total ancillary hospital costs are identified from Worksheet B Part I. These cost centers pertain to only ancillary service cost centers. The hospital's total charges by cost center are identified from Worksheet C Part I. These costs and charges are identified in order to determine the cost-to-charge ratios for ancillary cost centers.
4. Costs for organs transplanted to WMP recipients will be calculated by first determining the organ acquisition cost-to-charge ratio using Worksheet D-6 cost data from the Medicare cost report. The organ acquisition cost-to-charge ratio is then multiplied by WMP hospital Fee-for-Service (FFS) organ acquisition charges identified from MMIS records for the most recent completed state fiscal year ending June 30.
5. The Department will calculate the cost per diem for each routine cost center. For each inpatient routine cost center a cost per diem is calculated by dividing total hospital costs identified from Step 1, Worksheet B Part I , line , by total days identified in Step 1 Worksheet S-3 Part I. The cost per diem is multiplied by WMP hospital Fee-for-Service (FFS) days identified from MMIS records for the most recent completed state fiscal year ending June 30. Long-term care cost centers and other non-hospital related cost centers are excluded from this process. The Adults & Pediatrics (A&P) routine per diem, in accordance with the Medicare cost report worksheet D-1, is computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

The Department will calculate a cost-to-charge ratio for each ancillary cost center. For ancillary cost centers, a cost-to-charge ratio is calculated by dividing the total hospital costs from Step 1 Worksheet B Part I by the total hospital charges from Step 3 Worksheet C Part I.

The hospital cost-to-charge ratios and per diem allocation determined through the above process (steps 1-5) for the filed Medicare cost report year are used to determine the hospital's costs for the payment year. The hospital costs for WMP FFS for the payment year are determined as follows:

6. To determine the inpatient hospital routine and ancillary cost center costs for the payment year, the hospital's projected WMP FFS inpatient charges by cost center are used. To project WMP hospital FFS charges as accurately as possible for the payment year, the projection will be based upon the hospital's actual experience of WMP FFS inpatient charges for the most recent 6-month period. The projected charges are multiplied by the inflation rate from the IHS "Hospital and Related Healthcare Costs Index." The projected charges are then multiplied by the cost-to-charge ratios from Step 5 for each respective ancillary cost center and the per diem cost is multiplied by the WMP hospital FFS inpatient days to determine the WMP FFS inpatient costs for each routine service cost center.
7. The WMP hospital FFS costs eligible to be reimbursed under this section are determined by adding the WMP FFS inpatient costs from Step 6, and subtracting estimated WMP FFS inpatient payments. The payment estimate will be based on the hospital's WMP FFS payment experience for the most recent 6-month period.

9140 Interim Reconciliation

The hospital costs determined through the methods described for the payment year are reconciled to the as-filed Medicare cost report for the payment year once the Medicare cost report has been made available on HCRIS. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out except for the changes noted below:

Steps 1 – 5: Hospital costs and charges and patient days from the as-filed Medicare cost report are used.
Step 6: WMP hospital FFS charges and inpatient days from MMIS paid claims data are used subject to provider reconciliation.
Step 7: WMP hospital FFS payments subject to provider reconciliation are used.

9150 Final Reconciliation

Once the Medicare cost report for the payment year has been finalized on HCRIS, reconciliation of the finalized amounts will be completed, including use of the Worksheet D apportionment process. In the final reconciliation, WMP FFS cost is computed using the methodology as prescribed by the Medicare cost report.

Worksheet D series including 1) computing a per diem for each routine cost center and applying the applicable WMP inpatient days from MMIS records for the completed state fiscal year ending June 30 to the per diem amount; 2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and 3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable WMP hospital charges for each ancillary cost center. Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly exempt for WMP.

9160 Limitations on the Amount of Deficit Reduction Funding

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

The aggregate deficit reduction funding provided to hospitals under this section shall not exceed the amount for which federal matching dollars are available under federal UPLs at 42 CFR 447.272.

There can be no Medicaid FFS deficit for inpatient hospital services used to calculate any Disproportionate Share Hospital (DSH) payment.

9170 Payment in Excess of Cost

If hospital payments exceed hospital costs, the financial gain from MA payments or payments for the uninsured will be applied against the unrecovered cost of uninsured patients/MA shortfall.

9200 Disproportionate Share Hospital (DSH) Payments

9210 Standard DSH Payments

9211 General. The special payments described in this §9210, specifically §9211 through §9216, are disproportionate share hospital payments provided in accord with the federal Social Security Act, §1902(a)(13)(A)(iv) and §1923. DSH payments are allocated to hospitals that provide a disproportionate share of services to WMP and low-income patients. A hospital may qualify for a disproportionate share payment if the hospital's WMP utilization rate is at least 1% and if either (1) the hospital's *WMP utilization rate* is at least one standard deviation above the mean WMP utilization rate for in-state and major border status hospitals, or (2) has a *low-income utilization rate* of more than 25%. The DSH payment described in this section is a lump sum payment provided to hospitals on an SFY basis.

9212 Obstetrician Requirement. In order for a qualifying hospital to receive its payment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the payment.

9213 Medicaid Utilization Method. A hospital with high WMP utilization may qualify for a disproportionate share hospital (DSH) payment.

- *Statewide Amounts Calculated*: The Department annually calculates a "Medicaid inpatient utilization rate" for each in-state and major border status hospital that receives WMP payments. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated.

- *Qualifying Hospital under Medicaid Utilization Method*: A hospital qualifies for a DSH payment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

- *Hospital Specific Payment Calculated*: A "DSH payment" is calculated according to the following formula for a hospital that qualifies under the Medicaid utilization method:

  Allotted DSH Funding for State Fiscal Year / (# of Hospitals qualifying for DSH Payment Under Medicaid Utilization + # of Hospitals qualifying for DSH Under the Low-Income Utilization Method) = Hospital Specific Payment Amount

  The DSH payment amount shall be limited by the budgetary restrictions as outlined in §9216.

- *Medicaid Inpatient Utilization Rate:* The term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for WMP, and the denominator of which is the total number of the hospital's inpatient days. Medicaid inpatient days (the numerator) include WMP HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital. Medicaid inpatient days in the numerator do not include any days of inpatient stays which were paid in full or part by Medicare. Paid in full means the amount received by the hospital equals or exceeds the amount WMP would have paid for the stay. Some MA recipient stays, which are <u>not</u> paid in full or part by Medicare, may be paid fully or partially by a third party insurance payer and/or by a recipient's MA eligibility spend-down funds. If the hospital stay is paid in full, then the days of the recipient's stay will <u>not</u> be included in the numerator as MA inpatient days. If the hospital is not paid in full and the WMP reimburses the hospital for the unpaid balance, then all days of the stay are included in the numerator as MA inpatient days to the extent that the days of the stay were allowed by the WMP.

9214 Low-Income Utilization Method. A hospital with a low-income utilization rate exceeding 25% may also qualify for a disproportionate share hospital payment. A hospital must make a specific request to the Department to be considered under this method for a disproportionate share hospital payment. A hospital's "low income utilization rate" is the sum of the following two percentages calculated as described below. The Department will designate the cost reporting period.

- *First Percentage:* Total payments from WMP to the hospital and total county general assistance program payments to the hospital for inpatient and outpatient services plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period. Revenues shall be net revenues after deducting bad debts, contractual allowances and discounts, that is, reductions in charges given to other third-party payers, such as HMOs or Medicare. Revenues shall also exclude recorded charges for charity care.

- *Second Percentage:* The total amount of the hospital's charges for inpatient hospital services attributable to charity care in a cost reporting period, less the portion of any cash subsidies described above in the period reasonably attributable to inpatient hospital services in the same period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period.

- *Charity Care:* Charity care means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including non-qualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. Charity care does not include any of the following: (1) care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care; (2) contractual adjustments in the provision of health care services below normal billed charges; (3) differences between a hospital's charges and payments received for health care services provided to the hospital's employees, to public employees or to prisoners; (4) hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or (5) bad debts. Bad debts are claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

- *Hospital Specific Payment Calculated*: A "DSH payment" is calculated according to the following formula for a hospital that qualifies under the low-income utilization method.

  Allotted DSH Funding for State Fiscal Year / (# of Hospitals qualifying for DSH Payment Under Medicaid Utilization + # of Hospitals qualifying for DSH Under the Low-Income Utilization Method) = Hospital Specific Payment Amount

  The DSH payment amount shall be limited by the budgetary restrictions as outlined in §9216.

9215 Which Method Allowed. A hospital will only be allowed a payment either under the Medicaid utilization method of §9213 or under the low-income utilization method of §9214. If the Department determines a hospital qualifies for a disproportionate share payment under the Medicaid utilization method but the hospital requests a payment under the low-income method and qualifies under this method as well, the hospital will receive only one DSH payment.

9216 Budget for Standard DSH Payments. The Department has determined that a total of $100,000 (for all hospitals combined) will be available for the DSH hospital payments per SFY.

9220 Supplemental DSH Payments for State, County, and Private Hospitals

There is a separate DSH allotment for hospitals owned and operated by the State of Wisconsin, for hospitals owned and operated by county governments of the State of Wisconsin, and for private acute care hospitals located in the State of Wisconsin. The private acute care hospitals may not be an institute for mental diseases (IMD) or critical access hospitals. To be eligible for DSH payments made under this section, such hospitals must meet minimum federal requirements for Medicaid DSH payments as specified in §1923(b) and (d) of the Social Security Act [42 U.S.C. 1396r-4(b) and (d))].

9221 Introduction. State, county, and private acute care hospitals located in Wisconsin may receive a disproportionate share hospital (DSH) payment adjustment for the costs of uncompensated care as defined in §1923(g)(1)(A) of the Social Security Act [42 U.S.C. 1396r-4(g)(1)(A)]. This amount shall not exceed the costs incurred by the hospital during the applicable year of furnishing hospital services (net of payments under Title XIX, other than under §1923, and net of any self-pay amounts or any other third-party payments by or on behalf of uninsured patients) with respect to individuals who are eligible under Title XIX or have no health insurance or other third party health coverage for hospital services during that year.

9222 Qualifying Criteria. The hospital must meet the following criteria:

a) The hospital must meet the obstetrician requirements of §9212; and
b) The hospital must have a Medicaid inpatient utilization rate of at least 1% determined under §9228; and
c) The hospital must be owned and operated by the State of Wisconsin; or
d) The hospital must be owned and operated by a county government of the State of Wisconsin.
e) The hospital must be a private, acute care hospital located in the State of Wisconsin that is neither an IMD nor a critical access hospital.

9223 Reimbursable Costs. Costs are reimbursable only if allowable under Medicare principles of cost reimbursement. The allowable costs incurred by the hospital during the applicable year of furnishing services will be determined for WMP recipients enrolled in Health Maintenance Organizations and individuals who had no health insurance or other third party health coverage for hospital services, using Medicare/Medicaid hospital cost reports required under §5200.

Inpatient and outpatient hospital costs per unit of service for the applicable year will be compared to WMP HMO payments for inpatient and outpatient hospital services rendered in the applicable year and self-pay amounts collected from individuals without coverage for inpatient and outpatient hospital services rendered in the applicable year, to determine a total net WMP HMO inpatient payment shortfall, if any, and a total net cost to the hospital of uncompensated inpatient care for uninsured individuals for the applicable year. The sum of the WMP HMO inpatient and outpatient shortfall plus the net cost of uncompensated inpatient and outpatient care is the hospital-specific upper payment limit for disproportionate share hospital inpatient payment adjustments for the applicable year. This sum for each qualifying hospital may be subject to payment under §9223 to the extent that the Wisconsin governmental entity that owns and operates the qualifying hospital submits in a timely manner, to the WMP, certified public expenditure forms supported by auditable documentation satisfying all requirements under 42 CFR 433.51, as amended.

9224 Amounts of DSH Allotment and Payments. The amount of the DSH payment, when combined with all other DSH payments under the Plan, shall not exceed the State DSH allotment for Wisconsin for the relevant federal fiscal year, as published by CMS pursuant to § 1923(f) of the Social Security Act [42 USC § 1396r-4(f)].

The Department will establish a methodology for distributing the DSH allotment under this section among qualifying hospitals such that the amount of the DSH payment to each hospital in any state fiscal year, when combined with any other DSH payment to the hospital, results in a total DSH payment that is not greater than the hospital's uncompensated costs for that state fiscal year as determined under § 1923(g)(1)(A) of the Social Security Act [42 USC § 1396r–4(g)(1)(A)] or less than a hospital's minimum payment adjustment under the tests set forth in § 1923(c) of the Social Security Act [42 USC § 1396r–4(c)].

9225 Distribution of DSH funds to state hospitals. The Department shall determine the total allotment for hospitals under §9220 after the Department determines the amounts of DSH payments under §9210 and §9230. To the extent that there is a remaining State DSH allotment for Wisconsin for the relevant federal fiscal year, within the amounts determined by CMS pursuant to §1923(f) of the Social Security Act, the remaining allotment may be distributed among qualifying §9220 state hospitals taking into account the charges and costs of those hospitals using the following method:

1. Total charges are tabulated for each respective state hospital for inpatient and outpatient services provided in the calendar year prior to the state fiscal year.
2. These charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific service cost.
3. The hospital-specific service cost of all state hospitals qualifying under §9220 is summed.
4. The maximum DSH funding divided by this sum of hospital-specific service costs results in a ratio of funding-to-costs.
5. The ratio of funding-to-costs multiplied by the service cost of each qualifying hospital results in the annual DSH allowance for each hospital and a proportional distribution of the DSH funding among qualifying state hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the DSH allowances do not exceed total reimbursable service costs of the qualifying state hospitals.
6. This annual amount is paid to the respective qualifying state hospitals.

9226 Distribution of DSH funds to county hospitals. After the distribution among qualifying §9220 state hospitals has been calculated, to the extent that there is any remaining State DSH allotment for Wisconsin for the relevant federal fiscal year, within the amounts determined by CMS pursuant to §1923(f) of the Social Security Act, that remaining amount may be distributed among qualifying §9220 county hospitals taking into account the charges and costs of those hospitals using the following method:

1. Total charges are tabulated for each respective county hospital for inpatient services provided in the calendar year prior to the state fiscal year.
2. These charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific service cost.
3. The hospital-specific service cost of all county hospitals qualifying under §9220 is summed.
4. The maximum DSH funding divided by this sum of hospital-specific service costs results in a ratio of funding-to-costs.
5. The ratio of funding-to-costs multiplied by the service cost of each qualifying hospital results in the annual DSH allowance for each hospital and a proportional distribution of the DSH funding among qualifying county hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the DSH allowances do not exceed total reimbursable service costs of the qualifying county hospitals.
6. This annual amount is paid to the respective qualifying county hospitals.

9227 Distribution of DSH funds to private acute care hospitals. Finally, after the distribution among qualifying §9220 state and county hospitals has been calculated, to the extent that there is any remaining State DSH allotment for Wisconsin for the relevant federal fiscal year, within the amounts determined by CMS pursuant to §1923(f) of the Social Security Act, that remaining amount may be distributed among qualifying §9220 private acute care hospitals taking into account the charges and costs of those hospitals using the following method:

1. Total charges are tabulated for each respective private acute care hospital for inpatient services provided in the calendar year prior to the state fiscal year.
2. These charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific service cost.
3. The hospital-specific service cost of all private acute care hospitals qualifying under §9220 is summed.
4. The maximum DSH funding divided by this sum of hospital-specific service costs results in a ratio of funding-to-costs.
5. The ratio of funding-to-costs multiplied by the service cost of each qualifying hospital results in the annual DSH allowance for each hospital and a proportional distribution of the DSH funding among qualifying private acute care hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the DSH allowances do not exceed total reimbursable service costs of the qualifying private acute care hospitals.
6. This annual amount is paid to the respective qualifying private acute care hospitals.

9228 Interim Payments Pending the Inpatient Final Settlement. A hospital's final settlement is not calculated until an audited Medicare cost report is available for the hospital's fiscal year. Qualifying DSH hospitals, as defined under §9222 may apply for an interim DSH payment amounts. Qualifying hospitals will provide an as-filed Medicare cost report so that an interim payment amount can be determined in the same manner as is described in §9224.

9230 Supplemental DSH Payments for In-State Hospitals

The following section establishes supplemental disproportionate share hospital (DSH) payments for qualifying hospitals located in the State of Wisconsin. To be eligible for supplemental DSH payments under this section, hospitals must meet minimum federal requirements for Medicaid DSH payments as specified in §1923(b) and (d) of the Social Security Act [42 U.S.C. 1396r-4(b) and (d))] as well as the qualifying criteria outlined below.

9231 Introduction. Hospitals located in the State of Wisconsin may receive a supplemental DSH payment for serving a disproportionate share of low-income patients. The aggregate DSH pool amounts are $36,792,000 for state fiscal year 2014 and $36,728,700 for state fiscal year 2015; a qualifying provider will receive a proportion of this pool. The DSH payment amount shall not exceed the costs incurred by the hospital during the applicable state fiscal year of furnishing hospital services (net of payments under Title XIX, other than under §1923, and net of any self-pay amounts or any other third-party payments by or on behalf of uninsured patients) with respect to individuals who are eligible under Title XIX or have no health insurance or other third party health coverage for hospital services during the state fiscal year.

9232 Qualifying Criteria. The hospital must meet the following criteria:

a) The hospital is recognized as a hospital by DQA.
b) The hospital is located in the State of Wisconsin.
c) The hospital provides a wide array of services, including services provided through an emergency department recognized by DQA.
d) The hospital has a Medicaid inpatient utilization rate (MIUR) greater than or equal to 6 percent. A hospital's MIUR is defined as the fraction (expressed as a percentage) whose numerator is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for WMP and whose denominator is the total number of the hospital's inpatient days. Medicaid inpatient days (the numerator) will include WMP HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital.
e) The hospital meets applicable, minimum requirements to be a DSH under 42 USC 1396r–4 and any other applicable federal law.
f) The hospital must meet the obstetrician requirements as specified in §9212.

9233 Amounts of DSH Allotment and Payments. The amount of the DSH payment, when combined with all other DSH payments under the Plan, shall not exceed the State DSH allotment for Wisconsin for the relevant federal fiscal year, as published by CMS pursuant to § 1923(f) of the Social Security Act [42 USC § 1396r-4(f)]. The Department sets forth a methodology as defined in §9234 for distributing supplemental DSH payments under this section among qualifying hospitals. The amount of the supplemental DSH payment to each hospital in any state fiscal year, when combined with all other DSH payments to the hospital, will not exceed the hospital's uncompensated costs including Medicaid shortfall amounts for that state fiscal year as determined under § 1923(g)(1)(A) of the Social Security Act [42 USC § 1396r–4(g)(1)(A)]. The total amount of the DSH payment will not be less than a hospital's minimum payment adjustment under the tests set forth in § 1923(c) of the Social Security Act [42 USC § 1396r–4(c)].

9234 DSH Allocation Methodology. The Department distributes supplemental DSH payments in accordance with an annual budget set on a state fiscal year basis. To distribute this supplemental DSH money among the qualifying hospitals, the Department performs a series of calculations using the following formulas:

a) The sum of all supplemental DSH payments made to hospitals equals the annual budget amount:
Annual Budget = Payment to Hospital 1 + Payment to Hospital 2 + ... + Payment to Hospital n

b) The supplemental DSH payment made to each separately licensed, qualifying hospital for a given state fiscal year under this section is the lesser of 1) the product of its "DSH add-on percentage" and its "projected WMP inpatient fee-for-service payments" and 2) $2,500,000:
Payment to Hospital i = min(DSH Add-On Percentage x Projected WMP IP FFS Payments, $2,500,000)

c) A hospital's projected WMP inpatient fee-for-service payment for a given state fiscal year is the projected payment developed through the rate setting process from two years' prior; for example, the projected payments for SFY 2014 are drawn from SFY 2012 projected payments.

d) A hospital's DSH add-on percentage is its "DSH add-on factor" minus 100% (in other words, the DSH add-on factor compares base payments to total (base + DSH) payments while the DSH add-on percentage compares base payments to DSH supplemental payments only):
DSH Add-On Percentage of Hospital i = DSH Add-On Factor of Hospital i - 1

e) A hospital's DSH add-on factor is a function of the "base DSH add-on factor" and the amount by which its MIUR exceeds 6 percent, such that a hospital with a higher MIUR receives a higher DSH add-on factor:
DSH Add-On Factor of Hospital i = Base DSH Add-On Factor + ((MIUR of Hospital i – 0.06) x 0.75)

f) A hospital's MIUR is the ratio of its Medicaid inpatient days to its total inpatient days, drawn from a data period two years' prior to the given state fiscal year:
MIUR of Hospital i = Hospital i's Total Medicaid Inpatient Days / Hospital i's Total Inpatient Days

g) The base DSH add-on factor is determined per the constraints provided by the equations above. Since one of those equations (for the DSH supplemental payment) is nonlinear, there is no clean formula for the base DSH add-on factor; rather, it can only be derived by iteratively solving the above system of equations. This is possible due to the fact that every other variable involved in the above equations has a known value.

Given the base DSH add-on factor for a given state fiscal year, the Department employs the above formulas to calculate the DSH supplemental payment to each qualifying hospital.

9300 Supplemental Payments for Essential Access City Hospitals (EACH)

NOTE: The supplement payment described in this §9300, specifically §9310 through §9320, is NOT a disproportionate share hospital (DSH) adjustment under §1923 of the Social Security Act.

Supplemental payments are provided for any hospital located in Wisconsin which meets the following criteria for an "essential access city hospital" (EACH).

9310 Level 1 EACH Supplement

9311 Qualifying Criteria. A hospital qualifies for the Level 1 EACH supplement in the current state fiscal year if the hospital met the following criteria during the year July 1, 1995 through June 30, 1996.

1. The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
2. At least 30% of the hospital's WMP recipient inpatient stays are for WMP recipients who reside in an inner city zip code area listed above.
3. More than 30% of the hospital's total inpatient days are WMP covered inpatient days.
    a. Including WMP HMO covered days and WMP covered stays on which the WMP made no payment due to the stay being covered by some other payer such as hospitalization insurance
    b. Not including days of WMP recipients' stays that are covered in full or part by Medicare.
    c. The hospital is an acute care hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

9312 Amount of Supplement. The Level 1 EACH supplement is paid in a prospectively established monthly amount based on the past WMP utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming state fiscal year. The total statewide funding for the Level 1 EACH supplement is limited to $2,988,700 per state fiscal year. This amount is distributed proportionately among qualifying hospitals based on WMP inpatient days of the qualifying hospitals. A qualifying hospital's Level 1 EACH supplement will be determined as follows:

$$\text{Hospital's Annual Level 1 EACH Supplement} = \frac{\text{WMP days for hospital}}{\text{Sum of WMP days of qualifying hospitals}} \times \text{Statewide Annual Funding}$$

The monthly amount is the above annual amount divided by 12 months.

WMP days are a hospital's total covered inpatient days for WMP recipients for the calendar year prior to the state fiscal year for which the Level 1 EACH supplement is being calculated. The days include WMP HMO covered days and WMP covered days on which the WMP made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of WMP recipient stays that are covered in full or part by Medicare.

9313 Sanction on Not Continuing To Meet Qualifying Criteria. A hospital receiving the Level 1 EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a state fiscal year, the monthly supplement of other qualifying hospitals will not be recalculated to redistribute the total annual funding for the Level 1 EACH supplement.

9320 Level 2 EACH Supplement

9321 Qualifying Criteria. A hospital qualifies for the Level 2 EACH supplement in the current state fiscal year if the hospital met the following criteria during the previous state fiscal year.

1. The Hospital did not qualify for the Level 1 EACH Supplement
2. The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
3. At least 30% of the hospital's WMP recipient inpatient stays are for WMP recipients who reside in an inner city zip code area listed above.
4. More than 30% of the hospital's total inpatient days are WMP covered inpatient days.
    a. Including WMP HMO covered days and WMP covered stays on which the WMP made no payment due to the stay being covered by some other payer such as hospitalization insurance
    b. Not including days of WMP recipients' stays that are covered in full or part by Medicare.
    c. The hospital is an acute care hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

9322 Amount of Supplement. The Level 2 EACH supplement is paid in a prospectively established monthly amount based on the past WMP utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming state fiscal year. The total statewide funding for the Level 2 EACH supplement is limited to $996,200 per state fiscal year. This amount is distributed proportionately among qualifying hospitals based on WMP inpatient days of the qualifying hospitals. A qualifying hospital's Level 2 EACH supplement will be determined as follows:

$$\text{Hospital's Annual Level 2 EACH Supplement} = \frac{\text{WMP days for hospital}}{\text{Sum of WMP days of qualifying hospitals}} \times \text{Statewide Annual Funding}$$

The monthly amount is the above annual amount divided by 12 months.

WMP days are a hospital's total covered inpatient days for WMP recipients for the calendar year prior to the state fiscal year for which the Level 2 EACH supplement is being calculated. The days include WMP HMO covered days and WMP covered days on which the WMP made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of WMP recipient stays that are covered in full or part by Medicare.

9323 Sanction on Not Continuing To Meet Qualifying Criteria. A hospital receiving a Level 2 EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a state fiscal year, the monthly supplement of other qualifying hospitals will not be recalculated to redistribute the total annual funding for the Level 2 EACH supplement.

9400 Pediatric Supplement

9410 Qualifying Criteria

A hospital qualifies for this pediatric supplement if the hospital meets the following criteria.

1) The hospital is an acute care hospital located in Wisconsin.
2) During the hospital's fiscal year described here, inpatient days in the hospital's acute care pediatric units and intensive care pediatric units of the licensed facility totaled more than 12,000 days. Days for stays in neonatal intensive care units are not included in this determination. The inpatient days are counted for the hospital's fiscal year that ended in the second calendar year preceding the beginning of the state fiscal year. For example, for the state fiscal year beginning July 1, 1998, the hospital's fiscal year that ended in 1996 is used.

9420 Amount of Payment

The pediatric inpatient supplement is paid as a monthly amount established according to the following method. A total of $2,000,000 is distributed each state fiscal year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of WMP pediatric days as described below.

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

$$\text{Hospital's annual pediatric supplement} = \frac{\text{WMP Pediatric Days for Hospital}}{\text{Sum of WMP Pediatric Days of All Qualifying Hospitals}} \times \text{\$2,000,000 Statewide annual funding}$$

WMP pediatric days for the above calculation are a hospital's total covered inpatient days for pediatric WMP recipients, including HMO covered pediatric WMP recipients, for patient discharges occurring in the state fiscal year that began two years prior to the beginning of the current state fiscal year. For example, for a current state fiscal year beginning July 1, 1998 the state fiscal year July 1, 1996 through June 30, 1997 is used. A pediatric patient is a patient that has not attained 18 years of age as of the day of admission. WMP pediatric days do not include: (a) days of WMP recipient stays that are covered in full or part by Medicare and (b) days of WMP covered stays on which the WMP made no payment due to the stay being covered by some other payer such as private hospitalization insurance.

9500 Supplement Payment for Adult Level One Trauma Centers

For services provided on or after July 1, 2012, WMP will provide annual statewide funding of $4,000,000 per SFY to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons. The WMP makes this payment to hospitals with an Adult Level One Trauma Center to assist with the high costs associated with operating a center with this designation.

The WMP pays the trauma inpatient supplement monthly. The WMP distributes the funds proportionately among qualifying hospitals based on the number of eligible hospitals as described below.

A qualifying hospital's inpatient supplement is determined as follows:

$$\text{Hospital's annual trauma supplement} = \frac{\text{Qualifying Trauma Hospital}}{\text{Total Number of Hospitals Qualifying as Trauma Hospital}} \times \text{\$4,000,000 Statewide Annual Funding}$$

9600 Inpatient Access Payments

To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible inpatient FFS discharge. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per discharge are not differentiated by hospital based on acuity or individual hospital cost. However, critical access hospitals receive a different access payment per discharge than do acute care, children's, and rehabilitation hospitals.

The amount of the hospital access payment per discharge is based on an available funding pool appropriated in the state budget and aggregate hospital upper payment limits (UPLs). This amount of funding is divided by the estimated number of paid inpatient FFS discharges for the SFY to develop the per discharge access payment rate.

For SFY 2015, the FFS access payment funding pool amount for inpatient acute care, children's, and rehabilitation hospitals is $115,169,366, resulting in a projected access payment amount of $3,816 per discharge; the FFS access payment funding pool amount for inpatient critical access hospitals is $2,688,610, resulting in a projected access payment amount of $951 per discharge. These access payment per discharge amounts are identified on the hospital reimbursement rate web page of the Wisconsin ForwardHealth Portal. This payment per discharge is in addition to the base DRG and per diem payments described in other sections of this document. Access payments per discharge are only provided until the FFS access payment funding pool amount has been expended for the SFY.

Access payments are subject to the same federal UPL standards as base rate payments. Access payment amounts are not interim payments and are not subject to settlement. Psychiatric hospitals are not eligible for access payments because of the unique rate setting methods used to establish rates for those hospitals.

9700 Graduate Medical Education Supplemental Payments for Hospitals

This section establishes supplemental payments for graduate medical education residents at qualified hospitals training physicians for practice in Wisconsin. To be eligible for payments under this section, hospitals must be otherwise eligible to receive WMP payments and meet the qualifying criteria outlined below.

9710 Introduction

Hospitals located in the State of Wisconsin may receive supplemental payments of up to $225,000 annually to support new graduate medical education residents. §1900, 146.64 of Wisconsin Act 20 authorizes the Department to distribute such payments to hospitals to fund the addition of resident positions to existing accredited graduate medical education programs in family medicine, general internal medicine, general surgery, pediatrics and psychiatry.

9720 Qualifying Criteria

The hospital must meet the following criteria:

a) The hospital serves rural and underserved communities in Wisconsin.

b) The hospital serves as an approved training site for an accredited graduate medical education program in one or more of the following specialties: family medicine, general internal medicine, general surgery, pediatrics or psychiatry.

c) The hospital meets applicable, minimum requirements to be WMP-certified.

Priority for funding will be given to hospitals that meet the following criteria:

d) The hospital is located in the State of Wisconsin.

e) The hospital and its' associated graduate medical education program has a retention rate of at least 30 percent of graduate residents remaining to practice in Wisconsin's rural and underserved communities.

f) The hospital serves underserved areas with a population of less than 50,000; more rural areas, e.g., those with populations of less than 10,000 receive higher priority.

g) The hospital includes a focus on physician training in working with team-based care, in prevention and public health, in cost effectiveness and health care economics, and in working in new service delivery models, e.g., Accountable Care Organizations or patient-centered medical homes.

9730 Amounts of Supplemental Payments

The amount of payment per hospital shall not exceed $75,000 per resident per state fiscal year, and the hospital shall not receive more than $225,000 per state fiscal year. It is the intention of the Department that payments be made annually for the duration of the residencies expanded under the supplemental payment program.

Funds are restricted to direct costs of the resident, i.e., salary, fringe benefits, travel expenses incurred in travel to and from required participating sites, and malpractice insurance. Funds cannot be used for capital improvements, equipment and supplies (medical and non-medical), sub-contracts, consultant fees, research, or planning activities. These funds shall not be used to supplant or replace existing funds supporting the proposed targeted specialty program from other sources, including local, state or federal funds.

The Department sets forth a methodology as defined in §9740 for distributing the graduate medical education resident supplemental payments.

9740 Allocation Methodology

a) The Department shall solicit competitive applications for supplemental payments for residents through a Request for Applications from qualified hospitals.
b) The existing, accredited residency program at the hospital must be in family medicine, general internal medicine, general surgery, pediatrics or psychiatry.
c) Each separately participating qualifying hospital cannot receive more than $75,000 per resident or $225,000 per state fiscal year.

10000
PAYMENT NOT TO EXCEED CHARGES

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to WMP recipients. Overall payments from all sources includes, but are not necessarily limited to, WMP payments, recipient co-payments, third party liability payments, and local and related matching FFP amounts under §9100. The state fiscal year is July 1 through June 30. Disproportionate share (under §9200) in the WMP payment rates will be added to the allowable charges. If an individual hospital's overall payments for the period exceed charges-plus-disproportionate share, the WMP will recoup payments in excess of charges-plus-disproportionate share.

10100 Limit on Disproportionate Share Payment to a Hospital

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients. The amount of disproportionate share payments which exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Statutory Background. §1923(g) of the federal Social Security Act.)

10101 Payment Shortfall for MA Recipient Services. The payment shortfall for MA recipient services is the amount by which the costs of inpatient and outpatient services provided MA recipients exceed the payments made to the hospital for those service excluding disproportionate share hospital payments. Disproportionate share hospital payments are payments provided a hospital under this State Plan according to the provisions of the Social Security Act, §1902(a)(13)(A)(iv) and §1923. If payments exceed costs, the financial gain from MA payments will be applied against the uncompensated care costs for the uninsured.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited WMP cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMP will be included.

For outpatient MA services, interim outpatient payments limited to charges for the hospital's fiscal year will be used. For inpatient MA services, payments limited to charges will be also used. Payments limited to charges will be the lesser of (a) charges made by the hospital during its fiscal year for MA services, or (b) overall payments from all sources (as defined in §10000) for MA services during its fiscal year, excluding disproportionate share payments. This charge limit will be applied separately to payments for inpatient services and payments for outpatient services for the period of the hospital's fiscal year.

10102 Unrecovered Cost of Uninsured Patients. The unrecovered cost of uninsured patients is the amount by which the costs of inpatient and outpatient services provided to uninsured patients exceed any cash payments made by them. However, as provided in the Social Security Act, §1923(g)(1)(A), "For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government with a State shall not be considered to be a source of third party payment."

If payments exceed costs, the financial gain from payments for the uninsured will be applied against the MA shortfall. An uninsured patient is an individual who has no health insurance or source of third party payment for the services provided by the hospital. The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited WMP cost report on file with the Department.

10103 Recovery of Excess Disproportionate Share Payments. If total disproportionate share payments to the hospital for services provided during its fiscal year exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients, then the excess disproportionate share payments will be recovered from the hospital.

10104 Effective Date. This limitation applies only to hospitals owned or operated by a State or by a unit of local government beginning July 1, 1994. With respect to hospitals that are not owned or operated by a State or unit of local government, this limitation applies beginning July 1, 1995 unless the federal Department of Health and Human Services exempts such hospitals or modifies the limitation for them.

For hospitals with fiscal years in progress (not beginning) on July 1, 1994 (or July 1, 1995 if applicable), the MA shortfall and the unrecovered cost of uninsured for the fiscal year will be prorated between the period before July 1 and the period on and after July 1 based on the proportion of disproportionate share payments applicable to each period.

11000
PAYMENT TO MINOR BORDER STATUS AND OUT-OF-STATE HOSPITALS

11100 Introduction

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG-based payment system described in this §11000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under §6000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals.

For any out-of-state hospital, border status or not, certain services will not be reimbursed according to the DRG methodology if the hospital takes the necessary action to receive reimbursement under an available alternative payment. These services and their alternative payment method are described in §7000 and include AIDS care, ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: Department of Health Services, P.O. Box 309, Madison, Wisconsin 53701-0309; telephone (608) 261-7838.

Any pre-established standard payment amounts which are described below and the DRG weighting factors for the current state fiscal year, July 1 through June 30 may be requested from the above address.

11200 DRG-Based Payment System (For Minor and Non-Border Status Hospitals)

11210 Base DRG Rate

The base DRG rate for all minor border status and non-border status hospitals shall be the standard DRG group rate which is determined under §6230 for the hospital grouping entitled "acute care hospitals." There is no further adjustment for wage area, capital, direct graduate medical education, DSH or rural hospital.

11220 Cost Outliers

Minor border status hospitals and non-border status hospital claims may qualify for cost outlier claims as described in §6300.

11300 Payment Not to Exceed Charges

For out-of-state hospitals not having border-status, payment on each discharge may not exceed the hospital's charges for allowable services. This limit applies to discharges paid under the DRG-based payment system and to payment for services exempt from the DRG payment system.

For minor border-status hospitals, payments are limited to charges according to the method described in §10000. This method limits aggregate annual payments to charges, not by individual claims.

12000
ADMINISTRATIVE ADJUSTMENT ACTIONS

12100 Introduction

The Department provides an administrative adjustment procedure through which an in-state or major border status hospital may receive prompt administrative review of its inpatient reimbursement. Department staff will review a request for an adjustment and determine if it should be denied or approved; if a request is approved, Department staff will determine the amount of adjustment.

An in-state or major border status hospital may appeal its inpatient reimbursement for one of the reasons listed in §12200 within 60 days of the date of its 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 RY.

If, at any time during the RY, the Department identifies a rate calculation error (that is, qualifications (a) through (c) below), it may, at its own discretion, recalculate a hospital rate and apply the new rate to all claims with dates of service in the RY. The Department does not initiate rate adjustments due to qualification (d); adjustments under that qualification only occur after a successful appeal initiated by a provider.

12200 Qualifying Determination

Allowable reasons for an inpatient payment rate appeal include:

a) the application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's Medicare cost report or to other incomplete or incorrect data used to determine the hospital's inpatient payment rate; or
b) a clerical error in calculating the hospital's inpatient 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 inpatient payment rate or in determining any administrative adjustment of a hospital's inpatient payment rate; or
d) the most recent audited 12-month Medicare cost report used for the calculation was more than five years old.

To resolve appeals arising from qualification (d) above, the 12-month Medicare cost report that will be used for RY 2015 is the provider's FY 2012 12-month Medicare cost report, obtained from HCRIS as of September 30, 2014. If the FY 2012 12-month Medicare cost report is an unaudited Medicare cost report, the Department will recalculate the hospital's inpatient payment rate once the Medicare cost report becomes audited. If no FY 2012 12-month Medicare cost report is available from HCRIS for the provider, the Department will use the next most recent available 12-month Medicare cost report (for example, the Department would first try to use the FY 2011 12-month Medicare cost report, then the FY 2010 12-month Medicare cost report, and so on).

21000
APPENDIX 1: IN-STATE ACUTE CARE HOSPITAL COST OUTLIER PAYMENT EXAMPLE

BASE DATA

APPROVED BEDS	250
T-19 INPATIENT COSTS (Cost Report Source: Worksheet E-3 part III line 1)..	$2,669,763
T-19 INPATIENT CHARGES (Cost Report Source: Worksheet E-3 part III line 21) Divide by	$4,348,653
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS (Ratio of T-19 inpatient costs to T-19 inpatient charges)	= 0.6139

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 123,550
2.	Cost-to-charge ratio (see above)	X .6139
3.	Claim charges adjusted to cost	$ 75,847.35
4.	DRG Payment	($ 18,419.91)
5.	Claim cost exceeding DRG payment	$ 57,427.44
6.	Applicable trimpoint for hospital bed size (Trimpoints applicable to current rate year are listed in §6320.)	($ 34,273)

7. Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?
   _x_ Yes - Continue at Line 8
   ___ No - No outlier payment in addition to DRG payment

8.	Claim cost exceeding DRG payment and trimpoint	=	$ 23,154.44
9.	Disproportionate share adjustment percentage (Note A).	X 1.043	
10.	Adjusted variable cost factor	X	1.043
11.	OUTLIER PAYMENT	=	$ 24,150.08
12.	DRG PAYMENT	+	$ 18,419.91
13.	TOTAL PAYMENT FOR CLAIM including outlier payment		$ 42,569.99

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used.

For Line 4 above, example calculation of base DRG payment.

	Total
Hospital-Specific Base Rate	$ 6,540
Times: DRG Weight for stay	2.8165
Basic DRG Payment	$ 18,419.91

22000
APPENDIX 2: MAJOR BORDER STATUS HOSPITAL COST OUTLIER PAYMENT EXAMPLE

BASE DATA

APPROVED BEDS		142
T-19 INPATIENT COSTS (Cost Report Source: Worksheet E-3 part III line 1)..		$ 663,287
T-19 INPATIENT CHARGES (Cost Report Source: Worksheet E-3 part III line 21)	Divide by	$1,036,753
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS (Ratio of T-19 inpatient costs to T-19 inpatient charges)		= 0.6397

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 113,982
2.	Cost-to-charge ratio (see above)	X .6397
3.	Claim charges adjusted to cost	$ 72,914.29
4.	DRG Payment	($ 5,160.95)
5.	Claim cost exceeding DRG payment	$ 67,753.34
6.	Applicable trimpoint for hospital bed size (Trimpoints applicable to current rate year are listed in §6320.)	($ 34,273)

7. Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?
   _x_ Yes - Continue at Line 8
   ___ No - No outlier payment in addition to DRG payment

8.	Claim cost exceeding DRG payment and trimpoint	=	$ 33,480.34
9.	Variable cost factor	.77	
10.	Disproportionate share adjustment percentage (Note A).	X 1	
11.	Adjusted variable cost factor		X .77
12.	OUTLIER PAYMENT	=	$ 25,779.86
13.	DRG PAYMENT	+	$ 5,160.95
14.	TOTAL PAYMENT FOR CLAIM including outlier payment		**$ 30,940.81**

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used

For Line 4 above, example calculation of base DRG payment.

	Total
Hospital-Specific Base Rate	$ 4,430
Times: DRG Weight for stay	1.1650
Basic DRG Payment	$ 5,160.95

23000
APPENDIX 3: RURAL HOSPITAL ADJUSTMENT PERCENTAGES

The following table lists the rural hospital adjustment percentages that are applied under §6270. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's WMP utilization rate falls. For example, a WMP utilization rate of 7.34% falls in the "5.0% through 9.99%" range that has a corresponding 11% rural hospital percentage. Similarly, an 11.23% utilization rate corresponds to a 17% rural hospital percentage.

EFFECTIVE ON and AFTER JULY 1, 2001

WMP Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%	5.00%
5.0% through 9.99%	11.00%
10.0% through 14.99%	17.00%
15.0% and greater	23.00%

EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

WMP Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%	8.00%
5.0% through 9.99%	17.00%
10.0% through 14.99%	26.00%
15.0% and greater	35.00%