Wisconsin Medicaid Program
Inpatient Hospital State Plan, Attachment 4.19-A
Method and Standards for Determining Payment Rates

***** TABLE OF CONTENTS *****

1000 OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT 1

2000 STATUTORY BASIS 2

3000 DEFINITIONS 3

4000 DIFFERENCES IN RATE SETTING BETWEEN IN-STATE AND OUT-OF-STATE HOSPITALS 6

4100 HOSPITALS LOCATED IN WISCONSIN 6
4200 HOSPITALS NOT LOCATED IN WISCONSIN AND BORDER STATUS HOSPITALS 6
4210 Non-Border Status Hospitals 6
4230 Border Status Hospitals 6
4240 Criterio for Border Status 6
4250 Rehobilitation Hospitols with Border Status 6
4260 Alternative Payments to Border Stotus Hospitals for Certain Services 6

5000 COST REPORTING 7

5100 USE OF COST REPORTS IN RATE SETTING 7
5200 SELECTION OF COST REPORTING PERIOD 7
5300 COST REPORTS FOR RECENT HOSPITAL COMBININGS 7

6000 DRG-BASED PAYMENT 5YSTEM 8

6100 INTRODUCTION 8
6110 Haspitals Covered by the DRG-Based Payment System 8
6120 Services Cavered by DRG Payments 8
6130 Prafessianal Services Excluded fram DRG Payments 8
6200 STANDARDIZED DRG PAYMENT FACTORS 9
6210 DRG Grauper 9
6220 DRG Weights 9
6230 Hospital-Specific DRG Bose Rote 10
6240 Wage Areo Adjustment Indices 11
6260 Direct Graduote Medical Education Adjustment 12
6270 Tronsfer Payment Palicy 13
6300 OUTLIER PAYMENTS UNDER DRG-BASED PAYMENT SYSTEM 14
6310 General 14
6320 Qualifying Criteria far o Cost Outlier Payment 14
6330 Charges Adjusted-To-Cost 14
6340 Outlier Payment Calculation 15
6350 Bed Count, Source and Changes 15
6360 Outlier Trimpoint for Haspital Combinings 15
6400 ALTERNATIVE DRG BASE RATES 16
6410 Reimbursement for Critical Access Hospitols 16
6420 Payment Rates for New Acute Care ond Children's Haspitals 16
6S00 OTHER PROVISIONS RELATING TO DRG PAYMENTS 17
6510 Review by External Quality Review Orgonization (EQRO) 17
6520 Medicolly Unnecessary Stays 17
6530 Inoppropriate Admissions 17
6540 Transfers 18
6550 Days Awaiting Placement 18

6560 Outpatient Services Related to Inpatient Stays *18*
6570 Obstetrical and Newborn Same Day Admission/Discharge *18*
6580 Changes of Ownership *18*
6590 Provisions Relating to Organ Transplants *19*
6600 Charge Cap Payment Policy *19*
6610 Transitional Corridor Payment Policy ..... ***Error! Bookmark not defined.***
6700 PERFORMANCE-BASED PAYMENTS 20
6710 Assessment-Funded Performance-Based Payments *20*
6720 Withhold-Based Performance-Based Payments ..... ***Error! Bookmark not defined.***
6800 PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS 22

7000 SERVICES EXEMPTED FROM THE DRG-BASED PAYMENT SYSTEM 23

7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS 23
7210 Rate of Payment *23*
7220 Criteria for Approval to Receive Ventilator-Assistance Payment Rate *23*
7230 If Ventilator-Assistance Exemption Discontinued *23*
7300 PAYMENT FOR DEPARTMENT OF CORRECTIONS INMATES 24
7310 Introduction *24*
7320 Eligibility *24*
7330 Services Covered *24*
7340 Reimbursement *24*
7350 Prior Authorization *24*
7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES 25
7500 BRAIN INJURY CARE 26
7510 In-State and Border-Status Hospitals *26*
7600 LONG-ACTING REVERSIBLE CONTRACEPTION 26
7900 PAYMENT FOR SERVICES EXEMPTED FROM DRG-BASED PAYMENT SYSTEM 27
7910 Services Covered by Payment Rates in This Section *27*
7920 Professional Services Excluded from Payment Rates in This Section *27*

8000 HOSPITALS PAID UNDER PER DIEM RATE 28

8100 COVERED HOSPITALS 28
8200 PAYMENT RATES 28
8210 State Owned and Operated IMDs *28*
8220 All Other Psychiatric, Rehabilitation, and LTAC Hospitals. *28*
8300 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM 28
8310 Review by External Quality Review Organization (EQRO) *29*
8320 Medically Unnecessary Days (Under Per Diem Rate System) *29*
8330 Inappropriate Admissions *29*
8340 Temporary Hospital Transfers (Under Per Diem Rate System) *29*
8350 Days Awaiting Placement (Under Per Diem Rate System) *29*
8360 Outpatient Services Related to Inpatient Stay *29*
8380 Changes of Ownership *29*
8400 COVERED AND NON-COVERED SERVICES 30
8410 Services Covered *30*
8420 Professional Services Excluded *30*

9000 SUPPLEMENTAL PAYMENTS 31

9100 FUNDING OF INPATIENT MEDICAID DEFICIT 31
9110 Qualifying Criteria *31*
9120 Deficit from Providing Medicaid Inpatient Services *31*
9130 Interim Payment *31*
9140 Interim Reconciliation *32*
9150 Final Reconciliation *32*
9160 Limitations on the Amount of Deficit Reduction Funding *33*
9170 Payment in Excess of Cost *33*

9200 DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS 34
9210 Standard DSH Payments *34*
9220 Supplemental DSH Payments for State, Caunty, and Private Hospitals ..... ***Error! Bookmark not defined.***
9300 CRITICAL CARE SUPPLEMENT 38
9400 SUPPLEMENTAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH) 39
9410 Level 1 EACH Supplement *39*
9420 Level 2 EACH Supplement *40*
9500 PEDIATRIC SUPPLEMENT 41
9510 Qualifying Criteria *41*
9520 Amaunt of Payment *41*
9600 SUPPLEMENT PAYMENT FOR ADULT LEVEL ONE TRAUMA CENTERS 41
9700 INPATIENT ACCESS PAYMENTS 42
9800 GRADUATE MEDICAL EDUCATION SUPPLEMENTAL PAYMENTS FOR HOSPITALS 43
9810 Introductian *43*
9820 Qualifying Criteria *43*
9830 Amounts of Supplemental Payments *43*
9840 Allacation Methodology *43*
9900 RURAL HOSPITAL SUPPLEMENT 44

10000 PAYMENT NOT TO EXCEED CHARGES 45

10100 LIMIT ON DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL 45

11000 PAYMENT TO OUT-OF-STATE HOSPITALS 46

11100 INTRODUCTION 46
11200 DRG-BASED PAYMENT SYSTEM (FOR NON-BORDER STATUS HOSPITALS) 46
11210 Base DRG Rate *46*
11220 Cost Outliers *46*

12000 ADMINISTRATIVE ADJUSTMENT ACTIONS 47

12100 INTRODUCTION 47
12200 QUALIFYING DETERMINATION 47

21000 APPENDIX 1: COST OUTLIER PAYMENT EXAMPLE 48

1000
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), psychiatric hospitals, and long term care hospitals which are reimbursed at rates per diem. Also, reimbursement for certain specialized services is exempted from the inpatient DRG system. These include 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 payments and WMP disproportionate share hospital (DSH) payments.

The WMP DRG reimbursement system uses the grouper that has been developed by 3M™ that uses an all patient sample, the All Patient Refined (APR) DRG. The grouper classifies a patient's hospital stay into an established DRG based on the diagnosis of and procedures provided to the patient. A grouped claim is then assigned a weight that is intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with an APR DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with an APR 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. APR DRG weights and average length of stay are established and maintained by 3M™.

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 areas throughout the state. It also includes an amount for direct medical education costs.

Given a hospital's specific DRG rate and the weight for the APR 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 and any applicable policy adjustor, and by taking into account the WMP's charge cap and transfer policies.

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:

Bureau of Rate Setting
Department of Health Services
1 W. Wilson Street, Room 550
P. O. Box 309
Madison, Wisconsin 53701-0309.

Telephone (608) 266-8922
FAX (608) 264-1096

E-mail DHSDMSBRS@dhs.wisconsin.gov

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 §9700 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).

All Patient Refined Diagnosis Related Group (APR DRG). A patient classification system developed and maintained by 3M™ establishing clinically-similar groupings of services that can be expected to consume similar amounts of hospital resources.

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 and Medicaid claims.

Base DRG. The first three numeric values assigned to an inpatient visit under APR DRG.

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. 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.

CMS Market Basket. The inflation index published by CMS used to estimate hospital inflation during the rate setting process.

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.

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.

Diagnosis Related Group (DRG). 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 and applicable policy adjustor 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 3% 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 claims experience period used to develop a benchmark for evaluation, as in the Hospital Withhold Pay-for-Performance (HWP4P) program.

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.

Metropolitan Statistical Area (MSA). Geographic regions designated by the Office of Management and Budget (OMB) consisting of one or more counties used by the Department for wage index assignment.

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.

Policy Adjustor. A factor used when calculating provider payment whereby the provider specific rate is multiplied by the DRG weight and applicable policy adjustor. Examples of policy adjustors include but are not limited to: specific services rendered, specific facility types and specific age categories.

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 sent 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.

Severity of Illness (SOI). The numeric value assigned to the fourth position under APR DRG to provide additional stratification of the base DRG. SOI values include 1 (minor), 2 (moderate), 3 (severe) and 4 (extreme).

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, and critical access, 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 ventilator patient care, unusual cases, and brain injury care. Organ transplants are paid under the DRG-based payment method. Rehabilitation, long-term care, 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 (i.e. non-border status hospitals). All out of state hospitals regardless of border status do not receive add-on payments for direct graduate medical education costs.

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 direct medical education costs and applies the lowest, in-state wage index adjuster. 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.

4230 Border Status Hospitals
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 and contains a wage area adjustment.

4240 Criteria for Border Status
Border status hospitals are hospitals providing essential and substantive services to WMP recipients. To be considered for border status, the provider must demonstrate an average of 100 or more inpatient claims annually over three consecutive years. Not included in the count of claims are (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. Border status is reviewed on a periodic basis by the WMP.

4250 Rehabilitation Hospitals with Border Status
A 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, or critical access hospital, regardless of border status, all inpatient stays are reimbursed under the DRG-based payment method except 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 hospital's specific payment for direct graduate medical education. Cost reports are also used to establish critical access hospitals' estimated costs and cost-to-charge ratio for outlier payments. The Department obtains 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 recently submitted 12-month Medicare cost report available in HCRIS as of the March 31 prior to the start of the RY. For example, rates effective January 1, 2015 (i.e. RY '15) would use the most recently submitted 12-month Medicare cost report available in HCRIS as of March 31, 2014. If the most recently submitted 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.

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 a submitted 12-month Medicare cost report available for the combined operation, the Department combines data from the most recent submitted12-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, a hospital-specific rate supplement for direct graduate medical education is added to the "DRG group rate" described in the following pages.

For each WMP recipient's stay, the hospital's specific DRG base rate is multiplied by the weight for the DRG and any applicable policy adjuster 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 border status acute care, children's, and critical access hospitals. Reimbursement for rehabilitation, psychiatric, and long-term care hospitals is described in §8000. Reimbursement for 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 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, DRG weights and policy adjusters.

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 by 3M™ for an all patient population, the All Patient Refined (APR) DRG grouper. The version of the APR DRG grouper used by the WMP is updated for each RY.

6220 DRG Weights

DRG weights are designed to reflect the relative resource consumption of each inpatient stay. DRG relative weights effective January 1 each rate year are based on 3M national weights for the APR DRG grouper version effective for the rate year, scaled to result in the same modeled aggregate case mix as the DRG weights from the prior rate year. Developed and maintained by 3M™, national weights rely upon a national, all patient sample including private, Medicare, and Medicaid payers. For each rate year where grouping software is updated, applicable weights are updated to reflect the grouper change.

6230 Policy Adjusters

Policy adjusters are applied at the claim level and are a numeric factor, much like a DRG weight, and are intended to enhance payments for select services, age groups, provider types, etc. The current rate year uses the following policy adjusters:

Policy Adjuster	Identification Basis	Factor
Neonate	DRG	1.30
Normal Newborn	DRG	1.80
Pediatric	Age (17 and Under)	1.20
Transplant	DRG	1.50
Level 1 Trauma Services	Provider Trauma Designation	1.30

Only one policy adjuster is applied per claim. When a claim is eligible for more than one adjuster, the single largest factor is applied when calculating payment. When no policy adjusters are applicable, a factor of 1.00 used.

6230 Hospital-Specific DRG Base Rate

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

The Department determines hospital-specific DRG base rates by inflating the standard DRG group rate from the prior rate year to the new rate year, and then adjusting for differences in the wage area index and direct graduate medical education costs for each hospital. 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 graduate medical education costs (if applicable), described in §6250 through §6270.

Finally, the Department adjusts the standard DRG group rate to account for the impact of including wage index adjustments and direct graduate medical education 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 the local of each hospital. The following sections describe how the Department applies these wage indices. The Department applies two distinct sets of wage indices, one for in-state hospitals and one for border status hospitals including non-border out of state hospitals. Providers receiving a cost-based reimbursement method have no wage index adjustment.

6242 Sources of Data. The Department adopts the raw CMS Final Rule Inpatient Prospective Payment System (IPPS) wage indexes values. IPPS values are published annually and are managed and maintained by CMS. Values are based upon geographical Metropolitan Statistical Area (MSA) and providers physically located in the same MSA are assigned the same wage index unless reclassified or an adjustment is applied such as out migration.

The following hospitals are not considered for wage area adjustment index.

(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.

6243 Wage Area Adjustment Indices for Hospitals Located in the State of Wisconsin. The Department applies the CMS Final Rule IPPS wage area adjustment to each IPPS participating provider. If a provider has a wage index reclassification or adjustment, the final adjusted wage index is applied. In cases where a provider does not participate in the CMS IPPS program, a weighted average wage index is calculated using the wage indices of providers in the county the provider (not participating in IPPS) is physically located weighted on the total inpatient Medicaid paid amount for these providers from the most recent full rate year at the time of rate setting (For example: Rate setting for RY2020 will use RY2018 Medicaid Paid).

6244 Wage Area Adjustment Indices for Border and non-Border Status Hospitals. The Department applies the CMS Final Rule IPPS wage area adjustment to each IPPS border status participating provider. If a border status provider has a wage index reclassification or adjustment, the final adjusted wage index is applied. In cases where a border status provider does not participate in the CMS IPPS program, a weighted average wage index is calculated using the wage indices of providers in the county the provider (not participating in IPPS) is physically located weighted on the total inpatient Medicaid paid amount for these providers from the most recent full rate year at the time of rate setting (For example: Rate setting for RY2020 will use RY2018 Medicaid Paid.) For non-border status hospitals, the lowest in-state wage index value is applied to the standard DRG group rate.

6260 Direct Graduate Medical Education 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. 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 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 costs attributable to WMP inpatient services by multiplying the overall allowed inpatient cost attributable to WMP recipients by the ratio of total allowed direct graduate medical education costs to total allowed hospital costs.

2. The Department inflates the resulting amount to the RY using an inflation rate derived from the CMS Market Basket for hospitals.

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 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 Cost Report Is Available. For hospitals for which there is no submitted 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 payment adjustment.

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

6270 Transfer Payment Policy

An acute care provider transferring a WMP member to another acute care provider is subject to a transfer payment policy review. DRG weights are derived using full length of stay claims and therefore do not reflect the relative resources of transfers. Transfers from an acute to post-acute setting are not subject to the transfer payment policy.

6271 Calculation of Transfer Base Payment

Transfer base payments are the lesser of: the full DRG payment or a calculated DRG per diem payment.

Full DRG payment is calculated as:

[provider-specific rate x DRG weight x applicable policy adjuster]

Calculated DRG per diem payment is calculated as:

[Full DRG Base Payment] ÷ DRG Average Length of Stay x [Actual Length of Stay + 1]

DRG average length of stay is maintained by 3M™ and calculated during APR DRG weight development. One day is added to the WMP member's actual length of stay to recognize the additional relative resources used during the admission process. After selecting the appropriate transfer base payment, the claim is reviewed for any applicable outlier payment. Transfer base payment review is applied to all acute care providers paid via DRG. A receiving provider is paid via standard DRG unless they too transfer the WMP member.

6272 DRG Transfer Payment Policy Exclusions

DRGs specific to a neonate transfer [580 and 581] are not subject to transfer payment policy review. Weights for neonate transfer DRGs include only transfer claims and therefore appropriately reflect relative resources.

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 a provider and claim-specific, cost-based amount paid on an individual stay in addition to the DRG payment. 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 current rate year trimpoint applicable to the hospital. The applicable trimpoint will depend on the provider type and size and can be found on the ForwardHealth portal here: https://www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/hospital/drg/drg.htm.spage#.

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 inpatient services. For Acute Care Hospitals the cost-to-charge ratio published in the CMS Provider Specific File (PSF) is used. When a CCR is not published within the PSF, a hospital specific cost-to-charge ratio is calculated using the following formula: estimated Medicaid costs are divided by actual Medicaid charges for the provider's claims. The claim set used to calculate this information will be the same as the rate setting base year data.

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. An example of a cost outlier calculation is presented in appendix §21000.

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

2. The allowed excess claim cost is calculated by subtracting the DRG payment (provider-specific rate × DRG weight × applicable policy adjuster) and the hospital's trimpoint from the claim cost. (Claim cost – 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:

Provider	APR DRG SOI	
	Level 1 or 2	Level 3 or 4
Non Critical Access Hospital	80%	95%
Critical Access Hospital	100%	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.

6360 Outlier Trimpoint for 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, the applicable trimpoint will depend on the type and size of the combined operation. One trimpoint will apply to all individual combining hospitals under the combined operation, regardless of the type and size of the individual combining hospitals.

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 ancillary service cost centers. 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. The WMP routine costs plus ancillary costs will be inflated to the current rate year using the CMS Market Basket for hospitals.
5. Claims used to estimate cost will be priced under current rate year APR DRG pricing parameters until the sum of simulated payment (base DRG plus outlier) is equal to the inflated, estimated cost of the claim period. The final base rate that results in simulated payments equal to the estimated claim costs will serve as the rate year provider-specific base rate.

The prospective cost based rate will not be subject to an annual WMP cost settlement. If no submitted 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 and Children's Hospitals

The Department will establish payment rates for new acute care and children's 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 or children's hospital begins the date the hospital admits its first WMP recipient. The start-up period ends when a submitted 12-month Medicare cost report is available to the Department at time of rate calculation.

6422 Rates for Start-Up Period. New acute care and children's 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 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-IDD 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, 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 Charge Cap Payment Policy

All claims paid via DRG are subject to a charge cap payment policy. Under the policy, claims are paid lesser of the submitted charges or DRG calculated payment amount. The DRG calculated payment amount is the allowed amount (DRG base payment + outlier payment) minus other healthcare coverage and copayment. DRG calculated payment does not include P4P or access payment adjustments.

6700 Performance-Based Payments

6710 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 children's, rehabilitation, and acute care, including long term care, 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 January 1 through December 31. Payments for each MY are made annually by the September 30 following the conclusion of the MY.

The remainder of this section describes the program's design and requirements for the current measurement year. 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, which is effective January 1 and published on the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/hospital/resources_01.htm.spage.

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 two sub-measures (Cesarean Section and Newborn Screening Turnaround Time). 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 both of the sub-measures.

2) Patient Experience of Care ($1.5 million) – Hospitals are scored on 10 sub-measures drawn from the -31 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 June 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.

6720 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, and critical access hospital services. Psychiatric, long term care, and rehabilitation hospitals are exempt from the HWP4P program.

The Department administers the HWP4P program on a measurement year (MY) basis. MYs are on a 12-month cycle, from January 1 through December 31.

For each MY, the Department pays FFS inpatient claims at the rate of 97% of the reimbursement in effect during the MY. The HWP4P pool amount is the remaining 3% 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 by the end of the calendar year that follows the HWP4P 12-month cycle.

The remainder of this section describes the program's design and requirements for the current measurement year. In order to earn eligibility for HWP4P program payments, hospitals are required to meet performance-based targets as specified in the Hospital Pay-for-Performance (P4P) Guide, which is effective January 1 and published on the Wisconsin ForwardHealth Portal here:
https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/hospital/resources_01.htm.spage.

The HWP4P program consists of the Potentially Preventable Readmissions (PPR) measure, which focuses on identifying inpatient admissions that occur within 30 days after an initial inpatient visit and could have been potentially prevented through a variety of discharge planning, outpatient or professional services, or other preventative care. Wisconsin Medicaid uses 3M™ software to identify these potentially preventable readmissions, as well as to generate an expected number of PPR chains based on the historic Wisconsin inpatient hospital experience. The Department compares each provider's number of PPR chains in the measurement year to the number of PPR chains expected from that provider, based on historical data evaluated by the 3M™ software, to create the methodology for performance standards and returns.

Providers that meet the requirements are eligible to receive payments from the HWP4P pool as follows:

1) If a hospital meets all of its performance targets for all applicable measures, it receives a payment equal to its individual HWP4P pool amount.

2) If a hospital does not meet or surpass its performance targets, it receives either no return, or a partial return calculated in a graduated manner as specified in the Hospital P4P Guide.

3) 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.

4) 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, up to 10% of their total fee for service inpatient reimbursement.

Each eligible hospital may review the performance measure requirements to receive the HWP4P pool payment prior to the MY in the ForwardHealth P4P Guide, here:
https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/hospital/resources_01.htm.spage. The data provided includes criteria for which claims are excluded from the measure.

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.

6800 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

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 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 a percent of their usual and customary charges equal to the average in-state, acute hospital cost-to-charge ratio.

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, 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 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.

7600 Long-Acting Reversible Contraception

7610 In-State and Border-Status Hospitals

An additional payment will be made to a hospital when a long-acting contraceptive (LARC) is provided immediately postpartum to a WMP member in the inpatient setting, effective for dates of service on and after January 1, 2017. Costs associated with LARC device are to be billed separately from the inpatient visit (which is paid via DRG).

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
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

State-operated institutions for mental disease (IMDs), psychiatric hospitals, rehabilitation hospitals, and long-term care 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 IMDs, psychiatric hospitals, rehabilitation hospitals, and long-term care 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, Rehabilitation, and Long-Term Care 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 new rate year 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, rehabilitation, and long-term care 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, rehabilitation, or long-term care hospital begins the date the hospital admits its first WMP recipient. The start-up period ends when a 12- month Medicare cost report is available in the HCRIS to the Department at time of rate calculation. New rehabilitation or long-term care hospitals during a start-up period will be paid an average of the rates being paid to other rehabilitation or long-term care hospitals, not including rates being paid to new rehabilitation or long-term care hospitals. The start-up rate being paid to a new rehabilitation, or long-term care hospital is prospective without a retroactive payment adjustment. New psychiatric hospitals during a start-up period will be paid the highest per diem rate paid to other psychiatric hospitals within the last 12 months, not including rates paid to new psychiatric hospitals. The start-up rate being paid to a new psychiatric

hospital will be paid on an interim basis. Rates will be established according to the methodology described in §8220 above after the start-up period ends and a submitted 12-month Medicare cost report is available in the HCRIS. In addition, for new psychiatric hospitals, the Department will conduct a reimbursement settlement for the start-up period using the methodology described in §8212 above, unless the hospital qualifies for an Inpatient Medicaid Deficit Funding settlement under §9100.

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 §9800 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 26, Lines 30 through 43 for the CMS 2552-10 (Worksheet B Part I, Column 27, Lines 25 through 33 for the CMS 2552-96). 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 8 for the CMS 2552-10 (Worksheet S-3 Part I, Column 6 for the CMS 2552-96).
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 for both the CMS 2552-10 and the CMS 2552-96. 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 for both the CMS 2552-10 and the CMS 2552-96. 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-4 from the CMS 2552-10 (Worksheet D-6 from the CMS 2552-96). 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, by total days identified in Step 1. 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 for both the CMS 2552-10 and the CMS 2552-96, 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 days and 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 and inflated to the payment year. 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 (for both the CMS 2552-10 and the CMS 2552-96) 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 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 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.

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. Per 49.45(3m)(a) the annual aggregate DSH pool amount is equal to $47,500,000 in state share general purpose revenue (GPR) plus the matching federal share of payments; 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) $7,950,000:
Payment to Hospital i = min(DSH Add-On Percentage x Projected WMP IP FFS Payments, $7,950,000)

c) A hospital's projected WMP inpatient fee-for-service payment for a given calendar year is the projected payment developed through the rate setting process from one year prior; for example, the projected payments for SFY 2020 are drawn from CY 2019 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 Critical Care Supplement

NOTE: The supplemental payment described in this §9300 is NOT a disproportionate share hospital (DSH) adjustment under §1923 of the Social Security Act.

9310 Introduction. The following section establishes critical care supplement (CCS) payments for qualifying critical access hospitals located in the State of Wisconsin. The CCS pool amount is equal to $2,250,000 GPR plus the matching federal share of payments; qualifying providers will receive a proportion of this pool. To qualify for CCS payments under this section, hospitals must not qualify for any disproportionate share hospital (DSH) payments as specified in §9200 and must meet the criteria outlined in §9311.

9311 Qualifying Criteria. To be eligible for CCS payments, a hospital must meet the following criteria:

a) The hospital is recognized as a hospital by DQA.
b) The hospital meets the definition of "Critical Access Hospital" under 42 C.F.R. 485, subpart F and under §3000 of this Inpatient Hospital State Plan.
c) The hospital is located in the State of Wisconsin.
d) The hospital provides a wide array of services, including services provided through an emergency department recognized by DQA.
e) In the most recent year for which information is available, charged at least 6 percent of overall charges for services to the Medical Assistance program for services provided to Medical Assistance recipients.

9312 CCS Allocation Methodology. The Department distributes CCS payments in accordance with an annual budget set on a state fiscal year basis. To distribute this CCS money among the qualifying hospitals, the Department performs a series of calculations using the following formulas:

a) The sum of all CCS 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 CCS payment made to each separately licensed, qualifying hospital for a given state fiscal year under this section is the product of its "CCS add-on percentage" and its "projected WMP inpatient fee-for-service payments":
Payment to Hospital i = (CCS Add-On Percentage x Projected WMP IP FFS Payments)

c) A hospital's projected WMP inpatient fee-for-service payment for a given calendar year is the projected payment developed through the rate setting process from one year prior; for example, the projected payments for SFY 2020 are drawn from CY 2019 projected payments.

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

e) A hospital's CCS add-on factor is a function of the "base CCS add-on factor" and the amount by which its percentage of overall charges for Medical Assistance services exceeds 6 percent, such that a hospital with a higher percentage of overall charges for Medicaid services receives a higher CCS add-on factor:
CCS Add-On Factor of Hospital i = Base CCS Add-On Factor + ((Percentage of Overall Charges for Medical Assistance Services of Hospital i – 0.06) x 0.75)

f) The base CCS add-on factor is determined per the constraints provided by the equations above. Since one of those equations (for the CCS payment) is nonlinear, there is no clean formula for the base CCS 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 CCS add-on factor for a given state fiscal year, the Department employs the above formulas to calculate the CCS supplemental payment to each qualifying hospital.

9400 Supplemental Payments for Essential Access City Hospitals (EACH)

NOTE: The supplement payment described in this §9400, specifically §9410 through §9420, 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).

9410 Level 1 EACH Supplement

9411 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.

9412 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 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.

9420 Level 2 EACH Supplement

9421 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.

9422 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. 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.

9423 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.

9500 Pediatric Supplement

9510 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, 2008, the hospital's fiscal year that ended in 2006 is used.

9520 Amount of Payment

The pediatric inpatient supplement is paid as an 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, 2008 the state fiscal year July 1, 2006 through June 30, 2007 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.

9600 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 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:

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

9700 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.

The access payment per discharge amounts are effective July 1 of the current fiscal year and are identified on the hospital reimbursement rate web page of the Wisconsin ForwardHealth Portal, here: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm.spage#IHDRGR. 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, described in 42 CFR §447.321. 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.

9800 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.

9810 Introduction

Hospitals located in the State of Wisconsin may receive supplemental payments of up to $541,386 per state fiscal year 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.

9820 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.

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

9830 Amounts of Supplemental Payments

The amount of payment per hospital shall not exceed $180,462 per resident per state fiscal year, and the hospital shall not receive more than $541,386 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 §9840 for distributing the graduate medical education resident supplemental payments.

9840 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 $180,462 per resident or $541,386 per state fiscal year.

9900 Rural Hospital Supplement

A hospital classified as rural under the Medicare wage index but not classified as a critical access hospital, are eligible for a rural hospital supplemental payment. The annual payment is equally divided among qualifying providers, not to exceed $300,000 per provider or a grand total payout of $5,000,000. Provider payments shall be equally adjusted to ensure total rural hospital supplemental payments do not exceed $5,000,000.

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.

10105 Reallocation of Recovered Disproportionate Share Funds. The Department will reallocate funds recovered per §10103 and §10104 to other eligible disproportionate share hospitals that were not paid up to their hospital-specific DSH UPL.

10106 Reallocation Limitations. After the final payment during the fiscal year has been issued, no adjustment will be given on DSH payments except to recover and reallocate funds per §10103-10105, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital.

11000
PAYMENT TO OUT-OF-STATE HOSPITALS

11100 Introduction

Out-of-state hospitals which do not have border status will be paid according to the DRG-based payment system described in this §6100. This payment system provides a single base DRG base rate for all non-border status hospitals. This rate is applied to the DRG weights used for in-state hospitals and border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and 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 ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: DHSDMSBFM@dhs.wisconsin.gov.

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 Non-Border Status Hospitals)

11210 Base DRG Rate

The base DRG rate for all 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 direct graduate medical education or DSH.

11220 Cost Outliers

Non-border status hospital claims may qualify for cost outlier claims as described in §6300.

11230 DRG-Based Payments

Non-border status hospital claims are subject to all payment policies as described in §6000

12000
ADMINISTRATIVE ADJUSTMENT ACTIONS

12100 Introduction

The Department provides an administrative adjustment procedure through which an in-state or 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 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) a clerical error in calculating the hospital's inpatient payment rate; or
b) 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
c) the most recently submitted 12-month Medicare cost report used as outlined in §5200 is incorrect per the HCRIS report record number.

21000
APPENDIX 1: COST OUTLIER PAYMENT EXAMPLE

BASE DATA

APPROVED BEDS	250
T-19 INPATIENT COSTS	$2,669,763
T-19 INPATIENT CHARGES	$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)	× 0.6139
3.	Claim charges adjusted to cost	$ 75,847.35
4.	DRG Payment [Hospital Base Rate x DRG Weight]	($10,154.95)
5.	Decision: Is this claim a transfer:	
	☐ Yes – Compute transfer payment	
	☒ No – Continue to line 6	
6.	Claim cost exceeding DRG payment	$ 65,692.40
7.	Applicable trimpoint for hospital bed size (Trimpoint dollar value for demonstration purposes only)	($32,000)
8.	Decision: Does Line 5 exceed the hospital's trimpoint at Line 6?	
	☒ Yes – Continue to line 8	
	☐ No – No outlier payment in addition to DRG payment	
9.	Claim cost exceeding DRG payment and trimpoint	= $33,692.40
10.	Variable cost factor (Variable cost factor for demonstration purposes only)	× 0.80
11.	OUTLIER PAYMENT	= $ 26,953.92
12.	DRG PAYMENT	+$ 10,154.95
13.	TOTAL PAYMENT FOR CLAIM including outlier payment	**$ 36,098.10**

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

	Total
Hospital-Specific Base Rate	$ 3,605.52
Times: DRG Weight	2.8165
Times: Policy Adjuster	1.00
Base DRG Payment	**$ 10,154.95**