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State/Territory Name: WI

State Plan Amendment (SPA) #: 13-003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SEP 25 2013

Mr. Brett Davis
Administrator
Division of Health Care Access and Accountability
Department of Health Services
1 West Wilson St., Room 350
Madison, WI 53701-0309

RE: Wisconsin State Plan Amendment (SPA) 13-003

Dear Mr. Davis:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-003. Effective for services on or after February 1, 2013, this amendment revises reimbursement methodology for inpatient hospital services. Specifically this amendment changes the rate year; revises the methodology for reimbursement for capital costs; revises the methodology for reimbursement for direct medical education; increases the trimpoint amounts for purposes of determining qualification for a cost outlier payment; increases the per diems for ventilator-assisted patients and brain injury cases; reduces the aggregate amount of supplemental payments for essential access city hospitals (EACH).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 13-003 is approved effective February 1, 2013. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (312) 353-9860.

Sincerely,

[redacted]

Cindy Mann,
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-003

2. STATE: Wisconsin

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

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

4. PROPOSED EFFECTIVE DATE
02/01/2013

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
47 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 ..... $0K
b. FFY 2014 ..... $0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages i to iii and 1 to 45. .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages i to iii and 1 to 40.

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Brett Davis

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
March 26, 2013

16. RETURN TO:
Brett Davis
State Medicaid Director
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: SEP 25 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB - 1 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

Wisconsin Medicaid Program
Inpatient Hospital State Plan
Method and Standards For Determining Payment Rates
With Amendments Effective February 1, 2013

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Wisconsin Medicaid Program
Inpatient Hospital State Plan
Method and Standards For Determining Payment Rates

SECTION 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 which is based on Diagnosis Related Groupings (DRGs). The DRG system covers acute care, children, long term care and critical access hospitals. Excluded from the DRG system are rehabilitation hospitals, State Institutions for Mental Disease (IMDs) and psychiatric hospitals, which are reimbursed at rates per diem. Also, reimbursement for certain specialized services is exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases and brain injury cases. Special provisions for payment of each of these DRG exempted services are included in the 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 Medicaid supplemental or enhanced payments and Medicaid disproportionate share payments.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn and psychiatric cases. The grouper classifies a patient's hospital stay into an established diagnosis related group (DRG) based on the diagnosis of and procedures provided the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each DRG based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.

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

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

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

For additional information, contact:

Bureau of Fiscal Management
Department of Health Services
1 W. Wilson Street, Room 265
P. O. Box 309
Madison, Wisconsin 53701-0309.

Telephone (608) 266-9438
FAX Telephone (608) 266-1096
Voice/TDD 1-800-362-3002

SECTION 2000
STATUTORY BASIS

The Wisconsin inpatient hospital payment system is designed to promote the objectives of the 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 will comply with all applicable Federal and State laws and regulations and will reflect all adjustments required under these laws and regulations.

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SECTION 3000
DEFINITIONS

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective February 1 of each year based on more current cost reports. The February 1st through December 31st rate year is for rate year 2013 and effective January 1st, 2014 through September 30th, 2014 will be rate year 2014. For each subsequent rate year after that, the rate year is October 1st through September 30th.

Border Status Hospital. A hospital not located in Wisconsin which has been certified by the WMAP as a border-status hospital to provide hospital services to WMAP recipients. (Reference, HFS 105.48, Wis. Adm. Code) Border status hospitals are differentiated between major border status providers and minor border status providers as described in Section 3520.

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

Critical Access Hospital. A hospital that meets the federal definition of a Critical Access Hospital, including but not limited to the requirements of 42 CFR 485.600.

Department. The Wisconsin Department of Health Services (or its agent); the State agency responsible for the administration of the Wisconsin Medical Assistance Program (WMAP).

DRG. DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

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

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 (LTCH).

Medicaid Management Information System (MMIS). The system used to process provider claims for payment.

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

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

SECTION 3000
DEFINITIONS, continued

Psychiatric Hospital. A general psychiatric hospital for which the department has issued a certificate of approval under s.50.35 that applies only to the psychiatric hospital, and that is not a satellite of an acute care hospital.

Rate Year. The time period from February 1 through December 31 during which rates established under the annual rate update are to be effective for most, if not all, hospitals. The February 1st through December 31st rate year is for rate year 2013 and effective January 1st, 2014 through September 30th, 2014 will be rate year 2014. For each subsequent rate year after that, the rate year is October 1st through September 30th.

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. Hospital provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple trauma to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

WMAP. Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA), Title XIX, or Wisconsin Medicaid Program (WMP).

SECTION 3500
DIFFERENCES IN RATE SETTING BETWEEN IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS

3510 Hospitals Located in Wisconsin

General acute care hospitals, including children, critical access and long term care hospitals, located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays within these hospitals are reimbursed under the DRG based payment method with certain exceptions. These exceptions include AIDS patient care, ventilator patient care, unusual cases and brain injury care. Organ transplants are paid under the DRG based payment method.

Rehabilitation and psychiatric hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system.

Use of Cost Report In Rate Setting. A hospital's audited Medicare cost report (CMS - 2552) is required for establishing certain components of the hospital's specific payment. The specific components include the capital, direct medical education, and rural hospital components of the base rate per discharge. Cost reports are also used to establish the cost to charge ratio for outlier payments and individual hospital allotments for disproportionate share hospital (DSH) payments. The Department obtains audited Medicare cost reports through the Healthcare Cost Report Information System (HCRIS) maintained by the Center for Medicare and Medicaid Services (CMS).

3520 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin which provide inpatient services to WMAP recipients may be reimbursed for their services. Certain of these hospitals have been granted "border status" by the WMAP. Others do not have border status under the WMAP (non-border status hospitals).

Non-Border Status Hospitals. Out-of-state hospitals which *do not have border status* are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard portion of the DRG base rate only. The rate is not adjusted to recognize hospital specific capital and direct medical education costs, nor differences in wage areas or rural hospital adjustment factors.

All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals.

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

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

Use of Cost Report In Rate Setting. To establish hospital-specific rate components, the Department will use the most recently audited Medicare cost report available in the Healthcare Cost Report Information System (HCRIS) as of March 31 prior to the start of the rate year.

SECTION 3500
DIFFERENCES IN RATE SETTING BETWEEN IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS, continued

Criteria For Major Border Status. Major border status hospitals are those border status hospitals which have had 75 or more WMAP recipient discharges or at least $750,000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for: (1) stays which were paid in full or part by Medicare, (2) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital. For example, the following table shows the years used for a series of annual rate updates.

Annual Rate Update Effective Date	Rate Years Looked At for Discharges and Charges
July 1, 2006	July 2003 to June 2004 and July 2004 to June 2005
July 1, 2007	July 2004 to June 2005 and July 2005 to June 2006

Rehabilitation Hospitals With Border Status. A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem consistent with in-state rehabilitation hospitals.

Alternative Payments To Border Status Hospitals For Certain Services. For any out-of-state acute, children, critical access or long term care hospital, border status or not, all inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

SECTION 4000
COST REPORTING

4010 General

The Wisconsin Medical Assistance Program uses the Medicare cost report (CMS 2552 form) to establish Medicaid inpatient hospital rates on an annual basis. Medicare cost report data is obtained through the Healthcare Cost Report Information System (HCRIS) maintained by the Center for Medicare and Medicaid Services (CMS).

4020 In-State and Major Border Status Hospitals.

To establish hospital-specific rate components for in-state and major border status hospitals, the Department will use the most recently audited Medicare cost report available in the Healthcare Cost Report Information System (HCRIS) as of March 31 prior to the start of the rate year. If the most recently audited cost report available in HCRIS is a "no utilization" cost report, the Department may request an alternate cost report from the hospital. If the most recently audited cost report available in HCRIS is greater than five years old from the prior fiscal year, the Department may use an unaudited Medicare cost report. However, if an unaudited cost report is utilized, the Department will recalculate the inpatient rate once the unaudited cost report is audited to determine the final rate.

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SECTION 5000
DRG BASED PAYMENT SYSTEM FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS

5010 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. The rate is the result of adjusting a uniform "standard DRG group rate" to recognize the wage area of each hospital. In addition, hospital-specific rate supplements for capital, direct medical education, and rural hospital adjustment are added to the

"standard DRG group rate." This results in hospital-specific DRG base rates.

For each Medicaid recipient's stay, the hospital's specific DRG base rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result 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.

5020 HOSPITALS COVERED BY THE DRG-BASED PAYMENT SYSTEM

Acute care, children, critical access and long term care hospitals will be paid according to the DRG based payment system. Rehabilitation hospitals and psychiatric hospitals are not covered by the DRG-based payment system.

5030 SERVICES COVERED BY DRG PAYMENTS

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HS 107.08(3) and (4))

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

Organ transplants are covered by the DRG based payment method.

5040 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. The following services are excluded, when the professionals are functioning in the capacity of:

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

5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, February 1 through December 31. They include the DRG grouper and the DRG weights.

5120 DRG Grouper

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

Annually, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by CMS for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after February 1 of the subsequent calendar year.

5130 DRG Weights

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

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

5130.1 Claims Used. Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the February 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000. Also not used are claims from any hospital designated a critical access hospital (CAH) during the selected period of claims. This exclusion of claims applies to hospitals newly designated as a CAH or discontinued as a CAH anytime during the selected period of claims.

5130 DRG Weights, continued

5130.2 Cost Report Used.
The WMP uses the cost report for each hospital's most recently completed reporting period for which an audited Medicare cost report is available to the Department as of the July 1st date prior to the February 1st day on which the revised DRG weights are to be implemented. The Department will use the HCRIS database as the primary data source. Costs are inflated as described below for the calculation of weights.

5130.3 Weights Calculated.
The updated version of the Medicare grouper described is applied to the historical claims. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, accommodation services for the hospital stay are multiplied by the cost to charge ratio of accommodation services in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by the cost-to-charge ratio of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. Acquisition charges for transplanted organs are multiplied by cost-to-charge ratios for the respective organ. The resulting accommodation cost, ancillary service cost and organ acquisition costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, direct medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health-Care Cost Review" that is published quarterly by Global Insight, Inc.

The average cost of the claims by each DRG is calculated. Also, a combined overall average cost of all DRG claims is calculated. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the combined overall average cost.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

5130.4 Cochlear Implants.

A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus.

5140 DRG Weights For MDC 15 (Mental Diseases and Disorders)

The WMP has expanded the standard diagnosis related groupings (DRGs) of MDC 15 (Mental Diseases and Disorders). For each of the DRGs, separate weighting factors are constructed for two age ranges: (1) over age 17 and (2) age 17 and younger. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals. The DRG Weights do not apply to hospital institutions for mental disease (IMDs) including State operated, and Psychiatric hospital providers.

As noted in subsection 5130.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate.

5150 Provider Specific Payment Rates for Hospitals Located within the State of Wisconsin and Major Border Status Hospitals

5151 Calculation Of Hospital-Specific DRG Base Rate, General

The "hospital-specific DRG base rates" is calculated as follows:

First, a uniform "standard DRG group rate" is developed based on the projected WMP budget for DRG hospitals and projected inpatient utilization and case mix for the rate year. For rate year 2013, the standard DRG group rate is $3,397. In the process of developing hospital-specific DRG base rates, the "standard DRG group rate" was continually adjusted to accommodate capital, medical education, DSH payments, and rural hospital factors, as well as the projected WMP budget. The "standard DRG group rate" was also adjusted to accommodate critical access hospital base rates that are estimated to provide those hospitals with 100% cost-based reimbursement.

The labor portion of that group rate will be adjusted by the wage area index applicable to the hospital. The sum of the adjusted labor portion and non-labor portion is the total labor adjusted group rate. Section 5152 describes the wage area adjustment index for hospitals located within the State of Wisconsin and Section 5155 describes the wage area adjustment index for Major Border status hospitals. Added to this adjusted rate are hospital's specific base payments for capital and a hospital's specific base payment for direct costs of a medical education program, described in sections 5160 and 5165. The result is the "hospital-specific DRG base rate".

5152 Wage Area Adjustment Index for Hospitals Located within the State of Wisconsin

5153 Introduction. The standard DRG group rate applicable to a hospital will be adjusted by a wage index. This subsection describes how the Department develops the hospital specific wage index for hospitals located within the State of Wisconsin and the separate hospital specific wage index for major border status hospitals, and how the indices will be applied to a specific hospital's payment rate.

5154 Calculation of Hospital Specific Wage Index. The Department will develop hospital specific wage indices based on hospital wage data available through the federal Centers for Medicare & Medicaid Services (CMS) website. For hospitals for which CMS has no data, such as children hospitals, non acute care hospitals, or new providers, the Department may use data from other sources. Provider information needs to be submitted to the Department no later than January 1rst of the previous rate year for the subsequent rate year.

Only wage data from hospitals certified as providers for the WMAP will be used. For determining the index for border status hospitals, only major border status hospitals will be included in the wage area index calculation.

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

(1) Hospitals not covered by the DRG payment system.
(2) Hospitals in Wisconsin designated as critical access hospitals as of September 30 immediately preceding the beginning of the rate year. For example, for the rate year beginning July 1, 2003, hospitals designated CAH as of September 30, 2002 are excluded.
(3) Hospitals known to be closed or to have discontinued operating as a hospital as of September 30 immediately preceding the beginning of the rate year, not including hospitals combining or merging with another hospital.
(4) Out-of-state non-border status hospitals and minor border-status hospitals.

Wage data will be obtained through the CMS website from the most recent fiscal year Final Occupational Mix Factor by Provider file available at time of rate development. This file is organized by provider and includes occupational mix adjusted and unadjusted wages, occupational mix adjusted and unadjusted AHWs, the nurse occupational mix adjustment factor, and the CBSA nurse occupational mix adjustment factor. DHS will utilize the unadjusted wage data for the purposes of the creation of the hospital specific wage index for hospitals located within the State of Wisconsin, and the hospital specific wage index for major border status hospitals. The hospital specific wage index calculation for hospitals located within the State of Wisconsin will be developed by calculating a statewide average wage rate using wage data from WMAP certified hospitals located in Wisconsin. The hospital specific wage index for each hospital shall be the ratio of the hospital specific average wage to the statewide average wage. The statewide rate, in essence, has a 1.00 index. A hospital specific wage index of 1.05 indicates that the average wage rate for the provider is 5% greater than the statewide average. A hospital specific wage index of .90 means that the hospital's average wage rate is 10% lesser than the statewide average.

For providers in which wage data is not available and providers have not submitted hospital specific information for consideration, DHS will calculate an average wage index using data from those providers located in the same metropolitan statistical area (MSA) as defined by CMS. This process will be followed until wage area data is identifiable and published in the referenced CMS publication used for wage index classification.

5155 Calculation of Hospital Specific Wage Index for Major Border Status Hospitals

5156 Introduction. The standard DRG group rate applicable to a major border hospital will be adjusted by a wage index. This subsection describes how the Department develops the hospital specific wage index for major border status hospitals and how the index will be applied to a specific hospital's payment rate.

5157 Calculation of Hospital Specific Wage Index. The hospital specific wage index calculation for major border status hospitals will be developed by calculating an average wage rate using wage data from WMAP certified major border status hospitals. The hospital specific wage index for each hospital shall be the ratio of the hospital specific average wage to the average wage for major border status hospitals. The average wage for all major border status hospitals, in essence, has a 1.00 index. A hospital specific wage index of 1.05 indicates that the average wage rate for the major border status provider is 5% greater than the average wage for all major border status hospitals. A hospital specific wage index of .90 means that the hospital's average wage rate is 10% lesser than the average wage for all major border status hospitals.

For providers in which wage data is not available and providers have not submitted hospital specific information for consideration, DHS will calculate an average wage index using data from those providers located in the same metropolitan statistical area (MSA) as defined by CMS. This process will be followed until wage area data is identifiable and published in the referenced CMS publication used for wage index classification.

5160 CAPITAL COSTS PAYMENT UNDER DRG PAYMENT SYSTEM

5161 General

For hospitals reimbursed under the DRG system, an amount for capital costs is added to a hospital's specific base DRG rate. For Wisconsin hospitals and major border status hospitals, this capital payment amount is prospectively established based on an individual hospital's past capital costs.

5162 Calculation for Hospitals Located In Wisconsin and Major Border Status Hospitals

Base Cost Report. The capital cost payment is determined from a hospital's most recent audited Medicare cost report available in the Healthcare Cost Report Information System (HCRIS) as of the March 31st prior to the annual rate update.

Calculation. The capital payment for a hospital is determined from cost information from each individual hospital's base cost report.

1. The capital cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient capital costs to total allowed inpatient costs.

2. The resulting WMP capital cost from step 1 is limited to no more than 8% of a hospitals total cost of treating WMP recipients.

3. The amount from step 2 is inflated through the rate year using an inflation rate derived from the IHS Global Insight's Hospital and Related Services Individual Price Index.

4. The amount from step 3 is divided by the number of WMP recipient discharges for the period of the audited cost report.

5. The resulting amount per discharge is divided by the average DRG case mix index per discharge.

6. The result from step 5 is the hospital's specific base capital payment at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate.

5163 Calculation where No Audited Cost Report Available

For hospitals located in Wisconsin and Major Border Status hospitals for which there is no audited cost report available and who have not filed a previous appeal with the WMP in prior rate years, the Department will apply the statewide average capital cost payment adjustment.

For in-state acute care hospitals, this adjustment is determined by taking the total Medicaid capital costs (capped at 8% of a hospital's total cost) of all in-state acute care hospitals and dividing it by the total number of recipient

discharges for the period of the audited cost report of all in-state acute care hospitals. This average capital cost per discharge calculation results in the statewide average capital cost payment that is added onto the qualifying hospital's base rate.

For Major Border Status hospitals, the adjustment is determined by taking the total Medicaid capital costs (capped at 8% of a hospital's total cost) of all Major Border Status hospitals and dividing it by the total number of recipient discharges for the period of the audited cost report of all Major Border Status hospitals. This average capital cost per discharge calculation results in the average capital cost payment that is added onto the qualifying hospital's base rate.

5164 Cost Reports For Recent Hospital Combinings

A "hospital combining" is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited cost report available for the combined operation, the Department will calculate an average capital cost per discharge based upon the most recently available audited Medicare cost report of the combining hospitals prior to the combining.

5165 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM

5166 General

An amount is added to a hospital's specific base DRG rate for costs of its direct medical education program. This payment amount is prospectively established based on an individual hospital's past direct costs of its medical education program.

5167 Calculation for Hospitals Located In Wisconsin

Base Cost Report. For hospitals located in Wisconsin and Major Border Status hospitals, the direct medical education payment is determined from a hospital's most recent audited cost report available in the Healthcare Cost Report Information System (HCRIS) as of the March 31st prior to the annual rate update.

Calculation. The direct medical education payment for hospitals located in Wisconsin and Major Border Status hospitals is determined from cost information from each individual hospital's base cost report.

1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs.

2. The resulting amount is inflated through the rate year using an inflation rate derived from the IHS Global Insight's Hospital and Related Services Individual Price Index.

3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report.

4. The resulting amount per discharge is divided by the average DRG case mix index per discharge. For rate year July 1, 2004 through June 30, 2005, the result is also multiplied by budget factor of 1.00.

5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.

5168 Calculation where No Audited Cost Report is Available

For hospitals located in Wisconsin and Major Border Status hospitals for which there is no audited cost report available and who have not filed a previous appeal with the WMP in prior rate years, the Department will apply the statewide average direct medical education cost payment adjustment.

For in-state acute care hospitals, this adjustment is determined by taking the total Medicaid medical education costs of all in-state acute care hospitals and dividing it by the total number of recipient discharges for the period of the audited cost report of all in-state acute care hospitals. This average medical education cost per discharge calculation

results in the statewide average direct medical education cost payment that is added onto the qualifying hospital's base rate.

For Major Border Status hospitals, the adjustment is determined by taking the total Medicaid medical education costs of all Major Border Status hospitals and dividing it by the total number of recipient discharges for the period of the audited cost report of all Major Border Status hospitals. This average medical education cost per discharge calculation results in the average medical education cost payment that is added onto the qualifying hospital's base rate.

5169 Cost Reports For Recent Hospital Combinings

A "hospital combining" is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited cost report available for the combined operation, the Department will calculate an direct medical education per discharge payment amount based upon the most recently available audited Medicare cost report data of the combining hospitals prior to the combining.

5170 RURAL HOSPITAL ADJUSTMENT

5171 Qualifying Criteria.

A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Critical access hospitals are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin and is not located in a CMS defined metropolitan statistical area (MSA).

2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.

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

4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below:
   (a) total discharges excluding newborns,
   (b) the Medicare case-mix index, and
   (c) the Wisconsin Medicaid case-mix index.

5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

5172 Adjustment Percentage.

The amount of the rural hospital adjustment is based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report available in the Healthcare Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update.

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

NOTE: To clarify for the federal Center for Medicare and Medicaid Services (CMS), the adjustment described in the above section 5170, specifically subsections 5171 and 5172, is NOT a disproportionate share hospital (DSH) adjustment under Section 1923 of the Social Security Act.

5173 Lump Sum Rural Adjustment Payments

Hospitals that do not qualify for a rural hospital adjustment percentage, but are classified as rural under the Medicare wage index, are eligible for an annual lump sum payment of $300,000 per hospital per rate year.

5180 DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

5181 General.

The special payments described in this section 5180, specifically subsections 5181 through 5186, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

DSH payments are allocated to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

5182 Obstetrician Requirement.

In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP 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 adjustment.

5183 Medicaid Utilization Method

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) payment. The DSH payment under this "Medicaid utilization method" is provided to hospitals in the Department's annual inpatient rate update. A hospital's DSH payment is a lump sum payment distributed by the Department on an annual basis.

Statewide Amounts Calculated: The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid 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.

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

The DSH payment amount shall be limited by the budgetary restrictions as outlined in sections 5184.

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 Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

Medicaid inpatient days (the numerator) will include Medicaid HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital.

Medical Assistance patient days in the numerator shall not include any days of inpatient stays which were covered in full or part by Medicare. Paid in full means the amount received by the hospital equals or exceeds the amount WMAP would have paid for the stay.

Some MA recipient stays, which are <u>not</u> covered in full or part by Medicare, may be paid fully or partially by a third party insurance payor 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 an MA patient day. If the hospital is not paid in full and the WMAP reimburses the hospital for the unpaid balance, then all days of the stay will be included in the numerator as an MA patient day to the extent that the days of the stay were allowed by the WMAP.

Base Data For In-State Hospitals. For hospitals located in Wisconsin, the number of total inpatient days, MA inpatient days and MA HMO inpatient days will be from a hospital's most recent audited cost report available in the Healthcare Cost Report Information System (HCRIS) as of the March 31st prior to the annual rate update.

Base Data For Major Border Status Hospitals. For major border status hospitals, the number of inpatient days shall be from the hospital's most recent audited cost report on file in HCRIS as of the January 1st prior to the annual rate

update.

5184 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 has to specifically request the Department to be considered under this method for a disproportionate share hospital payment. However, if a hospital qualifies for a payment under the Medicaid utilization method but requests an adjustment under the low-income method, the hospital will only qualify for one DSH payment.

A hospital's "low income utilization rate" would be the sum of the following two percentages calculated as described below. The Department will designate the cost reporting period.

First Percentage. Total payments from Medicaid 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, Medicare or Blue Cross. Revenues shall also exclude recorded charges for charity care.

5184 Low-Income Utilization Method, continued

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 nonqualification 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 means 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.

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

The Department has determined that a total of $100,000 (for all hospitals combined) will be available for the DSH hospital payments per rate year.

5185 Which Method Allowed.

A hospital will only be allowed an adjustment either under the Medicaid utilization method of §5183 or under the low-income utilization method of §5184. 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.

5190 Payment Rates for New Acute Care, Children and Long Term Care Hospitals

The Department will establish payment rates for new acute care, children and long term care hospitals under a method other than that described above until cost reports are available for application of the above methodology.

5191 New Acute Care Hospital and Start-Up Period

The start-up period for a new acute care, children and long term care hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends when a full fiscal year Medicare audited cost report is available to the

Department at time of rate calculation.

5192 Rates for Start-Up Period

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

5200 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM

5210 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments are provided.

The Department may evaluate the medical necessity of services provided and appropriateness of outlier cases prior to the issuance of outlier payments or, if payment has been made, recoup the same.

5220 Cost Outliers

5221 Qualifying Criteria for a Cost Outlier Payment.

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

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

	----- Trimpoint Amount -----	
Type of Hospital / Bed Size	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	$ 10,000	$ 33,291
Critical Access Hospital	$300	N/A

4. Hospital stays for which payment is not 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 section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

5222 Charges Adjusted-To-Cost.

For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report available in the Hospital Cost Report Information System as of the January 1st prior to the annual rate update. For cost reports to be used for combining hospitals, see §5225.

For hospitals for which the Department does not have an audited cost report, then the cost-to-charge ratio to be used for the specific hospital will be the average state-wide cost-to-charge ratio, which is the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services.

For Major Border Status Hospitals. For a border-status hospital, the Department shall determine a cost-to-charge ratio applicable to inpatient services provided Wisconsin Medicaid recipients by the hospital based on the hospital's most recent audited cost report available in the Healthcare Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update. For cost reports to be used for combining hospitals, see §5225.
For hospitals for which the Department does not have an audited cost report, then the cost-to-charge ratio to be used for the specific hospital will be the average state-wide cost-to-charge ratio which is the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services.

5223 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 section 21000.

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

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

3. The outlier payment will be the result of multiplying the excess claim costs by the variable cost factor. The variable cost factors will be:

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

5224 Bed Count, Source and Changes.

The trimpoint amount for each hospital shall be established effective February 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.

5225 Cost Reports For Recent Hospital Combinings

A "hospital combining" is the result of 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. Data from the audited cost reports of each previous (i.e., before the combining) individual hospital will be combined to calculate the following components of the hospital payment rates which require the use of cost report data: the disproportionate payment amount and the cost-to-charge ratio used for outlier payments. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used for the subsequent annual rate update (for capital and medical education payments for combined hospitals, see 5164 and 5169).

5300 OTHER PROVISIONS RELATING TO DRG PAYMENTS

5310 Medically Unnecessary Stays, Defined

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 EQRO review section below regarding criteria.)

5313 Authority For Recovery

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 WMAP recipients and payments made to providers of such services. Wisconsin statute, section 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.

5316 Review by External Quality Review Organization (EQRO)

The Department contracts with an **External Quality Review Organization (EQRO)** to review selected hospitalizations of WMAP 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.

5319 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.

5323 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 section 4.19B of the Medicaid Hospital State Plan. If payment has been made, the difference between the payment and the outpatient rate-per-visit will be recovered.

5326 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.

5329 Transfers

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

5336 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 WMAP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-MR is delayed, not on the hospital's part, for completion of required pre-admission screening for mental illness and/or mental retardation (required under Subtitle C, Part 2 of PL 100-203, the Omnibus Budget Reconciliation Act of 1987), the hospital may request and receive a per diem payment for each allowed day identified as waiting placement due to the lack of the pre-admission screen. This payment shall be in addition to the DRG payment, not to exceed the estimated statewide average NF rate. Each allowed day awaiting placement must be adequately documented for review in the patient chart.

5339 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.

5343 IMD Hospital Transfers

An inpatient at an IMD may transfer to an acute care general 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.

5346 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.

5349 Obstetrical And Newborn Same Day Admission/Discharge

A hospital stay shall be considered an inpatient stay when a WMAP 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.

5353 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 cost reports will be used until the new owner's cost reports come due for use in the annual rate update.

5362 Provisions Relating to Organ Transplants

Prior Authorization and 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 WMAP for the type of transplant provided. A list of approved hospitals is available from the Department of Health Services, P.O. Box 309, Madison, WI 53701-0309.

b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.

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

Organ Procurement. Organs must be obtained in compliance with the requirements of federal and state statute and regulations.

Transplant Log. Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMAP 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 Medicaid cost report, so that the WMAP may document compliance.

5400 REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS, and is designated as a critical access hospital by the Department.

Critical access hospitals are reimbursed the lower of the hospital's allowable cost or charges for the services provided to Medicaid recipients.

The Department will calculate a prospective cost based rate per discharge based on a hospital's most currently audited cost report. The prospective cost per discharge rate will be based on the most recently available audited Medicare cost report as of March 31st prior to the annual rate update. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. Costs will be apportioned to the Medicaid program by multiplying the cost per day times Medicaid days from the Medicaid Management Information System (MMIS).

Medicaid ancillary costs will be calculated by deriving cost to charge ratios for each ancillary service cost center. The total ancillary Medicaid costs will be calculated by multiplying the cost to charge ratios by Medicaid ancillary charges from the Medicaid Management Information System (MMIS). Outlier payments will be projected based upon claims data corresponding to the cost report period and will be netted from Medicaid costs. In addition, costs associated with capital will be limited to no more than 8% of a hospitals total Medicaid. The Medicaid routine costs plus ancillary costs, net of outlier payments and capital cost reduction amounts, will be divided by the number of Medicaid discharges from MMIS corresponding to the cost report period. The cost per discharge rate will be inflated to the current rate year by applying the "Hospital and Related Healthcare Costs Index" published by Global Insight. The prospective cost based rate will not be subject to an annual Medicaid cost settlement.

If no audited cost report is available, the hospital will receive the statewide average payment rate.

Total inpatient payments may not exceed charges as described in section 9000.

5500 Performance-Based Payments

The Department will reserve $5 million All Funds in rate year 2012 for performance-based payments to acute care, children's hospitals and rehabilitation hospitals located in Wisconsin. Critical Access hospitals will not be included in the performance-based payment system 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 Department will continue performance-based payments in rate year 2012. The payment will consist of two different components.

The first component of the payment will be for reporting the 7 following measures of perinatal care to the Wisconsin CheckPoint (www.wicheckpoint.org) hospital quality reporting program. These measures include:

1. Pre-birth Steroids
2. Forceps Delivery
3. Vacuum Delivery
4. C-section with Labor
5. C-section without Labor
6. Breast Feeding
7. Infant Composite

The second payment component of the payment will be for scoring at or above the state wide average of each of five CheckPoint measures:

1) Perinatal Measures – Hospitals will be scored on the Pre-Birth Steroids measure, Breast Feeding measure and Infant Composite measures.
2) Patient Experience of Care – Hospitals will be scored on 10 measures based on patient completion of a 27-question Hospital Consumer Assessment of Healthcare Providers and Systems.
3) Surgical Infection Prevention Index – Hospitals will be scored on the percent of surgical patients that were given all the care they needed to prevent an infection based on selected measures.
4) Flu Vaccine for Pneumonia Patients – Hospitals will be scored on the percent of pneumonia patients, age 50 or older, that are asked if they had flu shot and, if not, are given the flu vaccine shot before they leave the hospital.
5) Surgical Care Improvement, Clot Prevention Medication Given – Hospitals will be scored on the percent of surgical patients that received venous thromboembolism prophylaxis within 24 hours of surgery.

For both the first and second components of the payment, the funds will be distributed based on the data submitted to *CheckPoint* as of April 15, 2012 update.

The department will calculate each payment for each hospital as follows:

1) Perinatal Measures – To qualify for funding for the first and second components, a hospital must have submitted their data to CheckPoint as of April 15, 2012 update. $0.5 million will be available for reporting the 7 perinatal measures and $0.5 million for scoring at or above the state average for each of the 3 perinatal measures: Pre-Birth Steroids, Breast Feeding and infant composite measures. The total aggregate funding pool for both components will be divided equally among the qualifying hospitals for each component to determine SFY 13 payments.
2) Patient Experience of Care – To qualify for funding for the second component, a hospital must have submitted their data to CheckPoint as of the April 15, 2012 update. $1.0 million will be available for scoring at or above the statewide average for the Patient Experience of Care Measure. The total aggregate funding pool will be divided equally among the qualifying hospitals to determine SFY 13 payments.

3) Surgical Infection Prevention Index – To qualify for funding for the second component, a hospital must have submitted their data to CheckPoint as of the April 15, 2012 update. $1.0 million will be available for scoring at or above the statewide average for the Surgical Infection Prevention Index. The total aggregate funding pool will be divided equally among qualifying hospitals to determine SFY 13 payments.

4) Flu Vaccine for Pneumonia Patients – To qualify for funding for the second component, a hospital must have submitted their data to CheckPoint as of the April 15, 2012 update. $1.0 million will be available for scoring at or above the statewide average for the Flu Vaccine for Pneumonia Patients Measure. The total aggregate funding pool will be divided equally among qualifying hospitals to determine SFY 13 payments.

5) Surgical Care Improvement, Clot Prevention Medication Given – To qualify for funding for the second component, a hospital must have submitted their data to CheckPoint as of the April 15, 2012 update. $1.0 million will be available for scoring at or above the statewide average for the Surgical Care Improvement, Clot Prevention Medication Given Measure. The total aggregate funding pool will be divided equally among qualifying hospitals to determine SFY 13 payments.

Payments will be made once annually by December 31, 2012.

5600 Withhold-Based Performance-Based Payments

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

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

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

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

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

In order to be eligible for P4P program payments, hospitals are required to report performance measure data and meet performance-based targets as specified in the Hospital Pay-for_Performance (P4P) Guide available at:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Provider/medicaid/hospital/P4P_FY2013.

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

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

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

c. qualifies to participate in four measures, each measure would be worth a maximum supplemental payment of $25,000)

d.

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

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

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

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

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

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

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

1) Thirty-day hospital readmission – Hospitals will be scored on the percent of patients that had a qualifying readmission within 30 days of a qualifying discharge. This measure will be applicable to a hospital that has at least 23 observations during the measurement year. To qualify for its earn back on this measure, a hospital must improve upon its past performance (since the Department is not using a risk adjustment methodology for this measure, it is not appropriate to compare a hospital's score to the statewide average). Past performance was calculated using calendar year 2010 data, or subsequent year thereafter.

2) Mental health follow-up visit within 30 days of discharge for mental health inpatient care – Hospitals will be scored on the percent of patients who had a mental health follow-up appointment within 30 days of qualifying mental health discharge. This measure will be applicable to a hospital that has at least 23 observations during the measurement year. To qualify for its earn back on this measure, a hospital must improve upon its past performance (since the Department is not using a risk adjustment methodology for this measure, it is not appropriate to compare a hospital's score to the statewide average). Past performance was calculated using calendar year 2010 data, or subsequent year thereafter.

3) Asthma care for children – Hospitals will be scored on the percent of children admitted to a hospital with a qualifying asthma diagnosis that were discharged with a Home Management Plan of Care (HMPC). This measure will be applicable to children's hospitals that have at least 30 observations during the measurement year. To qualify for its earn back on this measure, a hospital must submit their data to the Joint Commission by September 30 following the

measurement year and must exceed either the national average or their past performance on this measure.

4) Surgical infection prevention index (SCIP Index) - Hospitals will be scored on the percent of surgical patients that were given all the care they needed to prevent an infection based on selected measures. This measure will be applicable to a hospital that has at least 25 observations during the measurement year. To qualify for its earn back on this measure, a hospital must submit their data to the Wisconsin CheckPoint (www.checkpoint.org) by December 31 of the measurement year and must exceed either the state average or their past performance on this measure.
5) Initial antibiotic for community-acquired pneumonia (PN-6) – Hospitals will be scored on the percent of immunoincompetent patients with community-acquired pneumonia that receive an initial antibiotic within 24 hours of admission into the hospital. This measure will be applicable to a hospital that has at least 25 observations during the measurement year. To qualify for its earn back on this measure, a hospital must submit their data to CheckPoint by December 31 of the measurement year and must exceed either the state average or their past performance on this measure.
6) Healthcare personnel influenza vaccination (pay-for-reporting) – Hospitals will be evaluated based on their submission of the Health Care Personnel Influenza Vaccination data via the National Healthcare Safety Network (NHSN) module or to the Wisconsin Division of Public Health (WI DPH). To qualify for its earn back on this measure, a hospital must report its healthcare personnel influenza vaccination data to the NHSN module or WI DPH prior to August 15 following the measurement year.

P4P payments, including the additional bonus payments, are limited by the federal upper payment limit (UPL) regulations at 42 CFR 447.273. All P4P payments, including the additional bonus payments, are included in the UPL calculation for the measurement year regardless of when payments are actually made.

5700 Payment Adjustment for Provider Preventable Conditions

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

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 Medicaid beneficiaries.

SECTION 6000
HOSPITALS PAID UNDER PER DIEM RATE

6100 COVERED HOSPITALS

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

6200 PAYMENT RATES FOR STATE, PRIVATE AND NON-STATE PUBLIC MENTAL HEALTH INSTITUTES AND REHABILITATION HOSPITALS

This section describes how hospital institutions for mental disease owned and operated by the State, psychiatric hospitals and rehabilitation hospitals are reimbursed for services provided to Medicaid recipients. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided.

6210 Interim Per Diem Rate for State owned and Operated IMDs

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.

6220 Final Reimbursement Settlement for State owned and Operated IMDs

After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid 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 section 9000.

(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.

6230 Calculation of Per Diem Rates for All Other Psychiatric IMDs and Rehabilitation Hospitals

Patient stays in a hospital covered by this section will be paid at a prospective per diem cost based rate. The prospective per diem rate will be based on the most recently available audited Medicare cost report as of March 31st prior to the annual rate update. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. Medicaid ancillary costs will be apportioned by deriving cost to charge ratios for each ancillary service. The total routine and ancillary Medicaid costs will be divided by total paid Medicaid days from the Medicaid Management Information System (MMIS). The cost per diem rate will be inflated to the current rate year by applying the "Hospital and Related Healthcare Costs Index" published by Global Insight. 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 2013 and subsequent years, the budget reduction factor used to ensure compliance with the Department's annual budget is 85.08%.

6240 Rates for New Psychiatric and Rehabilitation Hospitals

The Department will establish payment rates for a new psychiatric and rehabilitation hospital under a method other than that described above until cost reports are available for application of the above methodology.

6241 New Psychiatric Hospitals and Rehabilitation Hospitals Start-Up Period

The start-up period for a new psychiatric and rehabilitation hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends when a full fiscal year Medicare audited cost report is available to the Department at time of rate calculation.

6242 Rates for Start-Up Period

The per diem rates to be paid during the start-up period shall be an average of the rates being paid to other psychiatric and rehabilitation hospitals in the state, not including rates being paid to new psychiatric or rehabilitation hospitals during a start-up period. The start-up rate being paid to a new psychiatric hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

6243 Rates After Start-Up Period Ends

Rates will be established according to the methodology described in §6230 above after the start-up period ends and an audited Medicare cost report is available.

6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM

6410 Medically Unnecessary Days, Defined (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 EQRO review section below regarding criteria.)

6413 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 WMAP recipients and payments made to providers of such services. Wisconsin statute, section 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.

6414 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.

6416 Review by Wisconsin Professional Review Organization (EQRO).

Section 5316 applies to hospitals under the per diem rate system.

6419 EQRO Control Numbers.

Section 5319 applies to hospitals under the per diem rate system.

6423 Inappropriate Inpatient Admission.

Section 5323 applies to hospitals having per diem rates.

6436 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 WMAP 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 WMAP. 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.

6443 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 general 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 WMAP for medically necessary stays.

6446 Outpatient Services Related to Inpatient Stay.

Section 5346 applies to hospitals under the per diem rate system.

6453 Changes of Ownership.

Section 5353 applies to hospitals under the per diem rate system.

6460 Cost Report Used For Recent Hospital Combinings (Under Per Diem Rate System)

Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP 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. Data from the audited cost reports of each previous individual hospital will be combined to calculate any per diem rate which requires the use of audited cost reports. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used in the subsequent annual rate update.

6470 SERVICES COVERED BY PER DIEM RATE PAYMENTS UNDER SECTION 6000

All covered services provided during an inpatient stay, except professional services described in §6480, shall be considered hospital inpatient services for which per diem payment is provided under this section 6000. [Reference: Wis. Admin. Code, HFS 107.08(3) and (4).]

6480 PROFESSIONAL SERVICES EXCLUDED FROM PER DIEM RATE PAYMENTS UNDER SECTION 6000

Certain professional and other services are not covered by the per diem payment rates under this section 6000. To be reimbursed by the Wisconsin Medicaid program, 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

SECTION 7000
SERVICES EXEMPTED FROM THE DRG PAYMENT SYSTEM

7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

7110 AIDS Acute Care and AIDS Extended Care Rates of Payment. (Rates listed in §7900)

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

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

7150 Patient Criteria For Approval To Receive AIDS Rate of Payment

7150.2 Acute Care.
Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria apply:

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

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

7150.3 Extended Care.
Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria must be met:

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

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

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

7160 No Outlier Payment and Administrative Adjustment

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

7170 If AIDS Exemption Discontinued

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

7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS

7210 Rate of Payment (Rates listed in §7900)

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

7250 Criteria For Approval To Receive Ventilator-Assistance Payment Rate

7250.2 Patient Criteria.
Payment of the ventilator-assistance rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP based on the following criteria. The request is to be submitted through the WMAP 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 WMAP 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.

7250.3 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.

7250.4 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.

7270 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.

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 WMAP determines that all of the following requirements are met:

1. The services are either:
    a. Necessary to prevent death of a recipient or
    b. Life threatening impairment of the health of a recipient or
    c. Grave and long lasting physical health impairment of a recipient or
    b. 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 WMAP recipients; or

b. Had not been a WMAP approved service provided for the particular purpose(s) intended; or

c. Had not been a WMAP 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 WMAP.

3. Existing payment methods are inadequate to ensure access to the services proposed for the recipient.
4. All applicable prior authorization requirements are met.

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

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

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

7500 BRAIN INJURY CARE

7520 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 WMAP. The hospital's brain injury care program must be approved by the WMAP and each recipient's participation in the program must be prior authorized by the WMAP. 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, section 100, page 1).

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

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

7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG 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 fiscal year 2013 and subsequent years.

Section	Services	Rate Per Diem Effective February 1, 2013
7100	AIDS Acute Care.....	$ 597
7100	AIDS Extended Care.....	$ 329
7200	Long-Term Ventilator Services.....	$ 1,564
7500	Brain Injury Care	

Neurobehavioral Program Care ..... $ 1,222
Coma-Recovery Program Care..... $ 2,182

7990 SERVICES COVERED BY PAYMENT RATES IN SECTION 7900 ABOVE

All covered services provided during an inpatient stay, except professional services described in §7992, 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)]

7992 PROFESSIONAL SERVICES EXCLUDED FROM PAYMENT RATES IN SECTION 7900 ABOVE

Certain professional and other services are not covered by the payment rates listed in §7900 above. To be reimbursed by the Wisconsin Medicaid program, 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

SECTION 8000
FUNDING OF INPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

8001 GENERAL INTRODUCTION

This is referred to as deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. This reimbursement is available for hospital fiscal years beginning on and after July 1, 2006 and is determined based on a hospital's cost report for its completed fiscal year.

8010 QUALIFYING CRITERIA

A hospital will qualify for deficit reduction funding if:

(a) The hospital is an acute care general hospital operated by the State or a local government in Wisconsin.
(b) It incurred a deficit from providing Medicaid inpatient services (described in §8020 below),
(c) The governmental unit that operates the hospital certifies it has expended public funds to fund the deficit.

8020 DEFICIT FROM PROVIDING MEDICAID INPATIENT SERVICES

The deficit from providing inpatient services to Wisconsin Medicaid recipients, that is, the Medicaid deficit, is the amount by which cost exceeds the payment for the Medicaid inpatient hospital services. The cost of Medicaid inpatient services is identified from the hospital's audited cost report for the hospital's fiscal year under consideration for the deficit reduction. Payment above refers to the total of the reimbursement provided under the provisions of section 5000 and sections 8200 to 8500 of this Attachment 4.19A of the State Plan for inpatient services for the respective fiscal year.

8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND THE FINAL RECONCILIATION

Wisconsin will identify the total amount of uncompensated Medicaid Fee-For-Service Inpatient (FFS) hospital costs as described in §8020 to determine interim Medicaid payments under this section until finalized hospital cost reports are available. For the payment 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 (CMS 2552), as filed with the Medicare Fiscal intermediary. The process for the Interim Medicaid Payment Calculation is as follows:

The following process is used to determine inpatient hospital costs:

Step 1

Total hospital room and board or routine costs are identified from Worksheet B Part I Column 27, line 25 through 33. These cost centers are specific to routine or room and board services and the cost calculations for routine or room and board service costs is calculated discretely from ancillary service costs. Total hospital patient days for inpatient routine costs are identified from Worksheet S-3 Part I Column 6.

Step 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.

Step 3

Total ancillary hospital costs are identified from Worksheet B Part I . These cost centers pertain to only ancillary service cost centers. The hospital's total charges by cost center are identified from Worksheet C Part I . These costs and charges are identified in order to determine the cost to charge ratios for ancillary cost centers.

Step 4

Costs for organs transplanted to Medicaid recipients will be calculated by first determining the organ acquisition cost to charge ratio using Worksheet D-6 cost data from the CMS 2552 form. The organ acquisition cost to charge ratio is then multiplied by Medicaid hospital Fee-for-Service (FFS) organ acquisition charges identified from MMIS records for the most recent completed state fiscal year ending June 30.

Step 5

The Department will calculate the cost per diem for each routine cost center. For each inpatient routine cost center a cost per diem is calculated by dividing total hospital costs identified from Step 1, Worksheet B Part I , line , by total days identified in Step 1 Worksheet S-3 Part I . The cost per diem is multiplied by Medicaid 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 CMS-2552 worksheet D-1, is computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

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

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

Step 6

To determine the inpatient hospital routine and ancillary cost center costs for the payment year, the hospital's projected Medicaid FFS inpatient charges by cost center are used. To project Medicaid hospital FFS charges as accurately as possible for the payment year, the projection will be based upon the hospital's actual experience of Medicaid FFS inpatient charges for the most recent 6-month period. The projected charges are multiplied by the inflation rate from the IHS Global Insight's Hospital and Related Services Individual Price Index. The projected charges are then multiplied by the cost to charge ratios from Step 5 for each respective ancillary cost center and the per diem cost is multiplied by the Medicaid hospital FFS inpatient days to determine the Medicaid FFS inpatient costs for each routine service cost center.

Step 7

The Medicaid hospital FFS costs eligible to be reimbursed under this section are determined by adding the Medicaid FFS inpatient costs from Step 6, and subtracting estimated Medicaid FFS inpatient payments. The payment estimate will be based on the hospital's Medicaid FFS payment experience for the most recent 6-month period.

Interim Reconciliation

The hospital costs determined through the methods described for the payment year are reconciled to the as-filed

CMS 2552 cost report for the payment year once the cost report has been filed with the Medicare fiscal intermediary. 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 CMS 2552 cost report are used.

Step 6

Medicaid hospital FFS charges and inpatient days from MMIS paid claims data are used subject to provider reconciliation.

Step 7

Medicaid hospital FFS payments subject to provider reconciliation are used.

Final Reconciliation

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare fiscal intermediary, reconciliation of the finalized amounts will be completed, including use of the Worksheet D apportionment process. In the final reconciliation, Medicaid FFS cost is computed using the methodology as prescribed by the CMS-2552

Worksheet D series including 1) computing a per diem for each routine cost center and applying the applicable Medicaid 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 Medicaid 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 Medicaid.

8030 LIMITATIONS ON THE AMOUNT OF DEFICIT REDUCTION FUNDING

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

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP is available under federal upper-payment limits at 42 CFR 447.272.

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

8035 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.

SECTION 8100
SUPPLEMENTAL DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR STATE, COUNTY AND PRIVATE HOSPITALS

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

8105 Introduction.

State, county and private acute care hospitals located in Wisconsin may receive a disproportionate share hospital (DSH) payment adjustment for the costs of uncompensated care as defined in section 1923(g)(1)(A) of the Social Security Act [42 U.S.C. 1396r-4(g)(1)(A)]. This amount shall not exceed the costs incurred by the hospital during the

applicable year of furnishing hospital services (net of payments under Title XIX, other than under section 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 year.

8110 Qualifying Criteria.

The hospital must meet the following criteria:

a) The hospital must meet the obstetrician requirements of §5182; and
b) The hospital must have a Medicaid inpatient utilization rate of at least 1% determined under §8130; and
c) The hospital must be owned and operated by the State of Wisconsin; or
d) The hospital must be owned and operated by a county government of the State of Wisconsin.
e) The hospital must be a private, acute care hospital located in the State of Wisconsin that is neither an IMD nor critical access hospital.

8120 Reimbursable Costs

Costs are reimbursable only if allowable under Medicare principles of cost reimbursement. The allowable costs incurred by the hospital during the applicable year of furnishing services will be determined for Medicaid recipients enrolled in Health Maintenance Organizations and individuals who had no health insurance or other third party health coverage for hospital services, using Medicare/Medicaid hospital cost reports required under section 4020.

Inpatient and outpatient hospital costs per unit of service for the applicable year will be compared to Medicaid HMO payments for inpatient and outpatient hospital services rendered in the applicable year and self-pay amounts collected from individuals without coverage for inpatient and outpatient hospital services rendered in the applicable year, to determine a total net Medicaid HMO inpatient payment shortfall, if any, and a total net cost to the hospital of uncompensated inpatient care for uninsured individuals for the applicable year. The sum of the Medicaid HMO inpatient and outpatient shortfall plus the net cost of uncompensated inpatient and outpatient care is the hospital-specific upper payment limit for disproportionate share hospital inpatient payment adjustments for the applicable year. This sum for each qualifying hospital may be subject to payment under section 8120 to the extent that the Wisconsin governmental entity that owns and operates the qualifying hospital submits in a timely manner, to the Wisconsin Medical Assistance Program, certified public expenditure forms supported by auditable documentation satisfying all requirements under 42 CFR 433.51, as amended.

8125 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 fiscal year, as published by CMS pursuant to § 1923(f) of the Social Security Act [42 USC § 1396r-4(f)]. The Department will establish a methodology for distributing the DSH allotment under this section among qualifying hospitals such that the amount of the DSH payment to each hospital in any year, when combined with any other DSH payment to the hospital, results in a total DSH payment that is not greater than the hospital's uncompensated costs for that year as determined under § 1923(g)(1)(A) of the Social Security Act [42 USC § 1396r–4(g)(1)(A)] or less than a hospital's minimum payment adjustment under the tests set forth in § 1923(c) of the Social Security Act [42 USC § 1396r–4(c)].

The Department shall determine the total allotment for hospitals under section 8100 after the Department determines the amounts of DSH payments under sections 5180. To the extent that there is a remaining State DSH allotment for Wisconsin for the relevant fiscal year, within the amounts determined by CMS pursuant to section 1923(f) of the Social Security Act, the remaining allotment may be distributed among qualifying section 8100 state hospitals taking into account the charges and costs of those hospitals using the following method:

First, total charges are tabulated for each respective state hospital for inpatient and outpatient services provided in the calendar year prior to the July 1 rate year.
Second, these charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific service cost.
Third, the hospital-specific service cost of all state hospitals qualifying under section 8100 is summed.
Fourth, the maximum DSH funding divided by this sum of hospital-specific service costs results in a ratio of funding-to-costs.
Fifth, the ratio of funding-to-costs multiplied by the service cost of each qualifying hospital results in the annual DSH allowance for each hospital and a proportional distribution of the DSH funding among

qualifying state hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the DSH allowances do not exceed total reimbursable service costs of the qualifying state hospitals.

Sixth, this annual amount is paid to the respective qualifying state hospitals.

After the distribution among qualifying section 8100 state hospitals has been calculated, to the extent that there is any remaining State DSH allotment for Wisconsin for the relevant fiscal year, within the amounts determined by CMS pursuant to section 1923(f) of the Social Security Act, that remaining amount may be distributed among qualifying section 8100 county hospitals taking into account the charges and costs of those hospitals using the following method:

First, total charges are tabulated for each respective county hospital for inpatient services provided in the calendar year prior to the July 1 rate year.

Second, these charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific service cost.

Third, the hospital-specific service cost of all county hospitals qualifying under section 8100 is summed.

Fourth, the maximum DSH funding divided by this sum of hospital-specific service costs results in a ratio of funding-to-costs.

Fifth, the ratio of funding-to-costs multiplied by the service cost of each qualifying hospital results in the annual DSH allowance for each hospital and a proportional distribution of the DSH funding among qualifying county hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the DSH allowances do not exceed total reimbursable service costs of the qualifying county hospitals.

Sixth, this annual amount is paid to the respective qualifying county hospitals.

Finally, after the distribution among qualifying section 8100 state and county hospitals has been calculated, to the extent that there is any remaining State DSH allotment for Wisconsin for the relevant fiscal year, within the amounts determined by CMS pursuant to section 1923(f) of the Social Security Act, that remaining amount may be distributed among qualifying section 8100 private acute care hospitals taking into account the charges and costs of those hospitals using the following method:

First, total charges are tabulated for each respective private acute care hospital for inpatient services provided in the calendar year prior to the July 1 rate year.

Second, these charges are multiplied by a ratio of cost-to-charges of the respective hospital resulting in a hospital-specific service cost.

Third, the hospital-specific service cost of all private acute care hospitals qualifying under section 8100 is summed.

Fourth, the maximum DSH funding divided by this sum of hospital-specific service costs results in a ratio of funding-to-costs.

Fifth, the ratio of funding-to-costs multiplied by the service cost of each qualifying hospital results in the annual DSH allowance for each hospital and a proportional distribution of the DSH funding among qualifying private acute care hospitals. The ratio of funding-to-costs is not to exceed 1.00 in order that the total of the DSH allowances do not exceed total reimbursable service costs of the qualifying private acute care hospitals.

Sixth, this annual amount is paid to the respective qualifying private acute care hospitals.

8130 Interim Payments Pending the Inpatient Final Settlement

A hospital's final settlement is not calculated until an audited cost report is available for the hospital's fiscal year. Qualifying DSH hospitals, as defined under §8110 may apply for an interim DSH payment amounts. Qualifying hospitals will provide an as filed Medicare cost report so that an interim payment amount can be determined in the same manner as is described in section 8125.

SECTION 8200
SUPPLEMENTAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)

NOTE: The supplement payment described in this section 8200, specifically subsections 8210 through 8230, is NOT a disproportionate share hospital (DSH) adjustment under Section 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).

8210 Qualifying Criteria for Level 1 EACH Supplement

A hospital qualifies for the Level 1 EACH supplement in the current rate 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 Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
3. More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
    a. Including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance
    b. Not including days of Medicaid recipients' stays that are covered in full or part by Medicare.
    c. The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

8215 Determination of Level 1 EACH Supplement

The Level 1 EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the Level 1 EACH supplement is limited to $2,988,700 per rate year. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's Level 1 EACH supplement will be determined as follows:

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

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

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

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

8220 Qualifying Criteria for Level 2 EACH Supplement

A hospital qualifies for the Level 2 EACH supplement in the current rate year if the hospital met the following criteria during the previous 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 Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
4. More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
    a. Including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance
    b. Not including days of Medicaid recipients' stays that are covered in full or part by Medicare.

c. The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

8225 Determination of Level 2 EACH Supplement

The Level 2 EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the Level 2 EACH supplement is limited to $996,200 per rate year. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's Level 2 EACH supplement will be determined as follows:

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

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

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

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 rate year, the monthly supplement of other qualify hospitals will not be recalculated to redistribute the total annual funding for the Level 2 EACH supplement.

SECTION 8500
Supplemental Payments

Supplemental payments are provided to acute care hospitals located in Wisconsin which provides a significant amount of services to specialty populations. The payments will be subject to the payment limitation of section 9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

8510 Qualifying Criteria for Pediatric Inpatient Supplement

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 rate year. For example, for the rate year beginning July 1, 1998, the hospital's fiscal year that ended in 1996 is used.

8515 Determination of Pediatric Inpatient Supplemental Payment

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

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

$$\text{Hospital's annual pediatric supplement} = \frac{\text{Medicaid pediatric days for hospital}}{\text{}} \times \$2{,}000{,}000 \text{ Statewide}$$

Sum of Medicaid pediatric days of all qualifying hospitals annual funding

Hospital's monthly pediatric supplement = Hospital's annual pediatric supplement / 12 Months

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

8520 Inpatient Access Payments

To promote WMP member access to acute care, children, rehabilitation hospitals, and critical access hospitals throughout Wisconsin, WMP will provide a hospital access payment amount per inpatient 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 acute care, children, 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 (UPL). This amount of funding is divided by the estimated number of paid inpatient discharges for the fiscal year. For rate year 2013, the inpatient hospital access payment amount for acute care, children and rehabilitation hospitals is $3,608 per discharge. For rate year 2013, the inpatient hospital access payment amount for critical access hospitals is $901 per discharge. This payment per discharge will be in addition to the base DRG and per diem payments for Wisconsin acute care, children, rehabilitation and critical access hospitals. Access payments per discharge are only provided until the fee-for-service hospital access payment budget has been expended for the rate year. The total fee-for-service hospital access payment budget for rate year 2013 is $268,811,479.

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

8525 Inpatient Supplement Payment for Adult Level One Trauma Centers

For services provided on or after July 1, 2012, the WMP will provide annual statewide funding of $4,000,000 per state fiscal year to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons. The payment is made to hospitals with an Adult Level One Trauma Center to assist with the high costs associated with operating a center with this designation. The trauma inpatient supplement is paid as a monthly amount established according to the following method. A total of $4,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of eligible hospitals as described below.

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

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

SECTION 9000
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 WMAP recipients. Overall payments from all sources includes, but are not necessarily limited to, WMAP payments, recipient co-payments, third party liability payments, local and related matching FFP amounts under §8000 and the indigent care allowance of §8230. The state fiscal year is July 1 through June 30. Disproportionate share (under sections 5180 and 8250) in the WMAP 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 WMAP will recoup payments in excess of charges-plus-disproportionate share.

SECTION 9100
LIMIT ON AMOUNT OF 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. Section 1923(g) of the federal Social Security Act.)

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 the State of Wisconsin Medicaid State Plan according to the provisions of the Social Security Act, Section 1902(a)(13)(A)(iv) and Section 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 Medicaid cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMAP 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 §9000) 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.

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, Section 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 Medicaid cost report on file with the Department.

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.

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

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

SECTION 10000
PAYMENT FOR SERVICES PROVIDED IN HOSPITALS OUT-OF-STATE
HOSPITALS NOT HAVING BORDER-STATUS AND MINOR BORDER STATUS HOSPITALS

10100 INTRODUCTION

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG based payment system described in this section 10000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under section 5000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals.

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

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

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

10200 DRG BASED PAYMENT SYSTEM (For Minor Border Status and Non-Border Status Hospitals)

10210 Base DRG Rate

The base DRG rate for all minor border status and non-border status hospitals shall be the standard DRG group rate which is determined under section 5151 for the hospital grouping entitled "acute care hospitals." There is no further adjustment for wage area, capital, medical education, DSH or rural hospital.

10230 Cost Outliers

Minor border status hospitals and non-border status hospital claims may qualify for cost outlier claims as described in Section 5200.

10300 PAYMENT NOT TO EXCEED CHARGES

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

payment for services exempt from the DRG payment system.

For minor border-status hospitals, payments are limited to charges according to the method described in section 9000. This method limits aggregate annual payments to charges, not by individual claims.

SECTION 10400
CORRECTION OF A RATE CALCULATION ERROR

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

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

(a) The application of the rate setting methodology or standards was applied to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or

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

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

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

APPENDIX SECTION 21000

EXAMPLE CALCULATION – State of Wisconsin Acute Care Hospital (over 100 beds)
COST OUTLIER PAYMENT

BASE DATA

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

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 123,550
2.	Cost-to-charge ratio (see above)	X .6139
3.	Claim charges adjusted to cost	$ 75,847.35
4.	DRG Payment	($ 18,419.91)
5.	Claim cost exceeding DRG payment	$ 57,427.44
6.	Applicable trimpoint for hospital bed size (Trimpoints applicable to current rate year are listed in section 5320.1.)	($ 33,291

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

8.	Claim cost exceeding DRG payment and trimpoint =	$ 24,136.44
9.	Disproportionate share adjustment percentage (Note A). X	1.043
10.	Adjusted variable cost factor X	1.043
11.	OUTLIER PAYMENT =	$ 25,174.31
12.	DRG PAYMENT +	$ 18,419.91
13.	TOTAL PAYMENT FOR CLAIM including outlier payment	**$ 43,594.22**

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

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

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

APPENDIX SECTION 21000

EXAMPLE CALCULATION – MAJOR BORDER STATUS HOSPITAL (over 100 beds) COST OUTLIER PAYMENT

Pursuant to Section 5220

BASE DATA

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

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 113,982
2.	Cost-to-charge ratio (see above)	X .6397
3.	Claim charges adjusted to cost	$ 72,914.29
4.	DRG Payment	($ 5,160.95)
5.	Claim cost exceeding DRG payment	$ 67,753.34
6.	Applicable trimpoint for hospital bed size (Trimpoints applicable to current rate year are listed in section 5320.1.)	($ 33,291)

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

8.	Claim cost exceeding DRG payment and trimpoint	=	$ 34,462.34
9.	Variable cost factor	.77	
10.	Disproportionate share adjustment percentage (Note A).	X 1	
11.	Adjusted variable cost factor		X .77
12.	OUTLIER PAYMENT	=	$ 26,536.00
13.	DRG PAYMENT	+	$ 5,160.95
14.	TOTAL PAYMENT FOR CLAIM including outlier payment		**$ 31,696.95**

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

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

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

APPENDIX SECTION 25000

RURAL HOSPITAL ADJUSTMENT PERCENTAGES PURSUANT TO SECTION 5170

The following table lists the rural hospital adjustment percentages that are applied under section 5170. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls. For example, a Medicaid utilization rate of 7.34% falls in the "5.0% through 9.99%" range that has a corresponding 11% rural hospital percentage. Similarly, an 11.23% utilization rate corresponds to a 17% rural hospital percentage.

EFFECTIVE ON and AFTER JULY 1, 2001

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

EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

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