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State/Territory Name: WI

State Plan Amendment (SPA) #: 14-0018

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CENTERS FOR MEDICARE & MEDICAID SERVICES

March 4, 2015

Kevin E. Moore, Administrator
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Moore:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #14-0018 --Outpatient Hospital Rates and Methodologies
--Effective July 1, 2014

If you have any additional questions, please have a member of your staff contact Charles Friedrich at (608) 441-5344 or Charles.Friedrich@cms.hhs.gov.

Sincerely,

/s/

Alan Freund
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Al Matano, Wisconsin Department of Health Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-018

2. STATE: Wisconsin

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

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

4. PROPOSED EFFECTIVE DATE
07/01/2014

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart F, §§447.300, 447.302, 447.304, 447.321, and 447.325.

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 2 to 6 and 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Outpatient 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:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Kevin Moore

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED:
September 30 2014

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 30, 2014

18. DATE APPROVED:
March 4, 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Alan Freund

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

SECTION 3000 DEFINITIONS

Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible outpatient claim. See §4250 for further details.

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

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

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

Capital (component of the rate). Already-produced durable goods or any non-financial asset that is used in production of goods or services. Hospitals incur real and significant capital costs to provide services for Medicaid patients. In the outpatient weight recalibration setting, capital statistics are used in the calculation to standardize provider costs across the state.

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

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

Clinical Diagnostic Laboratory Reimbursement. The lower of the laboratory fee schedule amounts of the WMP and the hospital's laboratory charges for services provided. This payment shall not exceed the Medicare rate on a per-test basis.

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

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

EAPG Base Rate. The dollar value that is multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable WMP operating payment for a visit.

Enhanced Ambulatory Patient Grouping (EAPG). A group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization, and which incorporate the use of ICD-9-CM (before October 1, 2014) and ICD-10-CM (after October 1, 2014) diagnosis and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

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

Final EAPG Weight. The allowed EAPG weight for a given visit as calculated by the EAPG software using the logic in the EAPG definitions manual, including all adjustments applicable to bundling, packaging, and discounting.

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

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

Hospital Outpatient Extended Nursing Services (HOENSs). Nursing services and respiratory care provided by nurses, for part of a day, in a group setting, on the site of an acute care hospital or in a building physically connected to an acute care hospital. See §5700 for further details.

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

Hospital Withhold Pay-for-Performance (HWP4P) Program. A performance-based reimbursement system in which the WMP withholds 1.5% of payment for outpatient hospital services and allows hospitals to earn back those dollars by meeting various quality benchmarks. See §4300 for further details.

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

IHS Hospital Costs Index. The "Hospital and Related Healthcare Costs Index" published by IHS.

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

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

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

Medicaid Deficit. The amount by which the cost of providing outpatient services to WMP recipients exceeds the WMP payment for those services. See §7000 for further details.

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

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

Outpatient Visit. The provision of services by an outpatient department located within an inpatient hospital licensed facility on a given calendar day, regardless of the number of procedures or examinations performed or departments visited, which does not include or lead to an inpatient admission to the facility. Services provided at a facility operated by the University of Wisconsin Hospitals and Clinics Authority need not occur within an inpatient hospital licensed facility to qualify for outpatient status under this definition. Services provided at a facility operated by a free-standing pediatric teaching hospital need not occur within an inpatient hospital licensed facility to qualify for outpatient status under this definition if the facility was added to the hospital's certificate of approval on or after July 1, 2009.

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

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

Rate Year (RY). The time period from January 1 through December 31 for which prospective outpatient rates are calculated under §4200.

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

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

Upper Payment Limit (UPL). The maximum amount the WMP may reimburse a hospital for services provided to WMP members. This is formally specified in 42 CFR 447.321.

Wage (component of the rate). Net reimbursement to staff and employees. Statewide wage data and wage data by individual providers are used to create the wage index, which in turn is intended to account for regional differences in the cost of wages across providers.

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

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

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

SECTION 4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS

4100 Introduction

This section describes the methodology for reimbursing all acute care, psychiatric, rehabilitation, and critical access hospitals located in the State of Wisconsin for outpatient hospital services provided in outpatient departments of inpatient hospital licensed facilities to persons eligible for FFS medical coverage by the WMP. The EAPG system, described in §4200 through §4240, is used to classify and calculate reimbursement for outpatient visits. EAPGs categorize the amount and type of resources used in various outpatient visits. The WMP base rates and EAPG weights have been updated as of January 1, 2014, effective for services provided on or after that date.

4200 EAPG Reimbursement Methodology

4210 Establishing Wisconsin-Specific EAPG Weights. The EAPG relative weight calculations are performed using line level charges from the three most recent complete SFYs of WMP outpatient hospital adjudicated claims, paid through MMIS, and converted to cost using a ratio of cost to charges methodology. The State calculates hospital-specific, cost center-specific cost-to-charge ratios using the most recent audited 12-month Medicare cost reports. The cost-to-charge ratios are cross-walked to the three most recent complete SFYs of WMP outpatient claims data using line level revenue codes and are then multiplied by the line level charges.

The line level costs are normalized across providers and time periods to determine the average cost of each EAPG by adjusting the cost-to-charge ratios as follows:

- Wage: Adjust the wage portion of costs using the published wage index from CMS;
- Capital: Adjust costs to account for only 95% of capital costs;
- Medical Education: Adjust costs to remove medical education costs; and
- IHS Hospital Costs Index: Inflate costs from the time period associated with the most recent audited 12-month Medicare cost report for each hospital to the current RY.

The EAPG weight is calculated by dividing the cost of an individual EAPG by the average cost of all EAPGs. For EAPGs that lack sufficient volume (less than 30 occurrences), the EAPG weight defaults to the national weight for the EAPG (as calculated by the proprietor of the EAPG software, 3M). The current EAPG weights can found on the Wisconsin ForwardHealth Portal.

4211 Cost Reports for Recent Hospital Combinings. A "hospital combining" is the result of two or more hospitals combining into one operation, under one WMP provider certification, either through merger or consolidation, or a hospital absorbing a major portion of the operation of another hospital through purchase, lease, or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited 12-month Medicare cost report available for the combined operation, the Department will perform calculations based upon the most recent audited 12-month Medicare cost reports of the combining hospitals prior to the combining.

4212 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 EAPG base rate of the prior owner. Subsequent changes to the hospital-specific EAPG base rate for the new owner will be determined as if no change in ownership had occurred; that is, the prior owner's Medicare cost reports will be used until the new owner's Medicare cost reports come due for use in the annual rate update.

4220 Calculating EAPG Base Rates. CAHs each have a provider-specific EAPG base rate calculated by taking the outpatient WMP costs from the most recent audited 12-month Medicare cost report and dividing by the total hospital final EAPG weights. All other hospitals use a statewide EAPG base rate that is calculated by taking the Department's outpatient budget, less projected CAH payments, and dividing this amount by the total final EAPG weights for all other hospitals. The current EAPG base rates can be found on the Wisconsin ForwardHealth Portal.

4221 Direct Graduate Medical Education Add-On. For non-CAH providers that have a GME program, the Department adds an amount to a hospital's specific EAPG base rate for costs directly associated to the program. The Department determines the direct GME add-on to the EAPG base rate from a hospital's Medicare cost report. The Department performs the calculation as follows:

1. The Department determines the direct GME costs attributable to WMP outpatient services by multiplying the projected outpatient costs attributable to WMP recipients by the ratio of total allowed direct GME costs to total allowed hospital costs.
2. The Department divides the resulting amount by the total hospital-specific final EAPG weights for the current RY to form the direct GME add-on for that hospital.

4222 Approved Nursing and Allied Health Activities Add-On. For non-CAH providers that engage in approved nursing and allied health (ANAH) activities, the Department adds an amount to a hospital's specific EAPG base rate for costs directly associated to the activities. The Department determines the ANAH add-on to the EAPG base rate from a hospital's Medicare cost report. The Department performs the calculation as follows:

1. The Department determines the ANAH activities costs attributable to WMP outpatient services by multiplying the projected outpatient costs attributable to WMP recipients by the ratio of total allowed ANAH activities costs to total allowed hospital costs.
2. The Department divides the resulting amount by the total hospital-specific final EAPG weights for the current RY to form the ANAH activities add-on for that hospital.

4230 Calculating Final EAPG Payment. Each line of an outpatient hospital claim is assigned to an EAPG and therefore has a distinct weight. These weights are multiplied by the hospital's specific EAPG base rate. The total reimbursement for an outpatient hospital claim is the sum of these multiplications, with the following exceptions:

- Clinical Diagnostic Laboratory Services are paid on a fee schedule basis.

4240 Exclusions from the EAPG Reimbursement System. The following services are not included within the EAPG reimbursement system:

- Therapy Services
- Clinical Diagnostic Laboratory Services
- Durable Medical Equipment (DME)
- Provider-Based End Stage Renal Disease (ESRD) Services

4250 Outpatient Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible outpatient FFS claim. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per claim are not differentiated by hospital based on acuity or individual hospital cost. However, critical access hospitals receive a different access payment per claim than do acute care, children's, and rehabilitation hospitals.

The amount of the hospital access payment per claim is based on an available funding pool appropriated in the state budget and aggregate hospital UPLs. This amount of funding is divided by the estimated number of paid outpatient FFS claims for the SFY to develop the per claim access payment rate.

For SFY 2015, the FFS access payment funding pool amount for outpatient acute care, children's, and rehabilitation hospitals is $98,820,391, resulting in a projected access payment amount of $329 per claim; the FFS access payment funding pool amount for outpatient critical access hospitals is $2,199,772, resulting in a projected access payment amount of $36 per claim. These access payment per claim amounts are identified on the hospital reimbursement rate web page of the Wisconsin ForwardHealth Portal. This payment per claim is in addition to the EAPG base payment described in §4230. Access payments per claim are only provided until the FFS access payment funding pool amount has been expended for the SFY.

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

SECTION 6000 ADMINISTRATIVE ADJUSTMENT ACTIONS FOR IN-STATE HOSPITALS

6100 Introduction

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

An in-state hospital may appeal its outpatient reimbursement for one of the reasons listed in §6200 within 60 days of the date of its rate notification letter. If the appeal results in a new rate determination, the rate will apply to all claims with dates of service in the RY.

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

6200 Criteria for Administrative Adjustment

Allowable reasons for an outpatient payment rate appeal include:

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

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