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State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: 20-0001

This file contains the following documents in the order listed:

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

Financial Management Group

June 24, 2020

Mr. Jim Jones
State Medicaid Director
Department of Health Services
1 West Wilson St.
P.O. Box 309
Madison, WI 53701-0309

RE: Wisconsin State Plan Amendment (SPA) 20-0001

Dear Mr. Jones:

We have reviewed the proposed amendment to Attachment 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 20-0001. Effective for services on or after January 1, 2020, this amendment modifies inpatient and outpatient reimbursement rates, including for critical care supplements, wage area adjustment indices for border status hospitals, cost-to-charge ratios, and outpatient access payments effective January 1, 2020.

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 19-0017 is approved effective January 1, 2020. We are enclosing the HCFA-179 and the amended plan pages.

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

Sincerely,

[redacted]

Karen Shields
Acting 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: **WI-20-0001**

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
01/01/2020

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 Part 447 Subparts C and F

7. FEDERAL BUDGET IMPACT
a. FFY 2020 $2,465K
FFY 2021 $3,286K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A Inpatient Hospital State Plan
pages ii, iii, 6, 11, 14, 18, 38.....
Attachment 4.19-B Outpatient Hospital State Plan
page 8.....

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 NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Same

Same

10. SUBJECT OF AMENDMENT
This amendment modifies inpatient and outpatient reimbursement rates, including for critical care supplements, wage area adjustment indices for border status hospitals, cost-to-charge ratios, and outpatient access payments.

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

7/25/20

[redacted]
TITLE
State Medicaid Director

15. DATE SUBMITTED

16. RETURN TO
Laura Brauer
State Plan Amendment Coordinator
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
6/24/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/20

20. [redacted]

21. TYPED NAME:
Karen Shields

22.
FMG, Acting Director

23. REMARKS:

FORM CMS-179 (07-92)

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

4100 Hospitals Located in Wisconsin

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

4200 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin but which provide inpatient services to WMP recipients may be reimbursed by the WMP for their services. Some such hospitals may be granted "border status" by the WMP. Others will not have border status under the WMP (i.e. non-border status hospitals). All out of state hospitals regardless of border status do not receive add-on payments for direct graduate medical education costs.

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

4230 Border Status Hospitals
Border status hospitals are reimbursed according to the DRG-based payment method. This is the same DRG method as is used for in-state hospitals and contains a wage area adjustment.

4240 Criteria for Border Status
Border status hospitals are hospitals providing essential and substantive services to WMP recipients. To be considered for border status, the provider must demonstrate an average of 100 or more inpatient claims annually over three consecutive years. Not included in the count of claims are (1) stays which were paid in full or part by Medicare and (2) stays paid in full by a payer other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMP would have paid for the stay. Border status is reviewed on a periodic basis by the WMP.

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

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

6240 Wage Area Adjustment Indices

6241 Introduction. The Department adjusts the portion of the standard DRG group rate attributable to labor by a wage area adjustment index specific to the local of each hospital. The following sections describe how the Department applies these wage indices. The Department applies two distinct sets of wage indices, one for in-state hospitals and one for border status hospitals including non-border out of state hospitals. Providers receiving a cost-based reimbursement method have no wage index adjustment.

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

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

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

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

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

6300 Outlier Payments under DRG-Based Payment System

6310 General

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

6320 Qualifying Criteria for a Cost Outlier Payment

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

1. The charges for a given case must be usual and customary.

2. The services provided must be medically necessary and the level of care appropriate to the medical needs of the patient.

3. The claim's cost, that is, charges-adjusted-to-cost, must exceed the DRG payment by the amount of the current rate year trimpoint applicable to the hospital. The applicable trimpoint will depend on the provider type and size and can be found on the ForwardHealth portal here: https://www.forwardhealth.wi.gov/WIPortal/content/provider/medicaid/hospital/drg/drg.htm.spage#.

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

6330 Charges Adjusted-To-Cost
Claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for inpatient services. For Acute Care Hospitals the cost-to-charge ratio published in the CMS Provider Specific File (PSF) is used. When a CCR is not published within the PSF, a hospital specific cost-to-charge ratio is calculated using the following formula: estimated Medicaid costs are divided by actual Medicaid charges for the provider's claims. The claim set used to calculate this information will be the same as the rate setting base year data.

6540 Transfers

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

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

6550 Days Awaiting Placement

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

6560 Outpatient Services Related to Inpatient Stays

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

6570 Obstetrical and Newborn Same Day Admission/Discharge

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

6580 Changes of Ownership

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

9300 Critical Care Supplement

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

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

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

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

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

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

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

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

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

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

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

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

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.

The access payment per claim amounts are identified on the hospital reimbursement rate web page of the Wisconsin ForwardHealth Portal here: https://www.forwardhealth.wi.gov/wiportal/content/provider/medicaid/hospital/resources_01.htm.spage. 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, described in 42 CFR §447.321. Access payment amounts are not interim payments and are not subject to settlement. Psychiatric hospitals are not eligible for access payments because of the unique rate setting methods used to establish rates for those hospitals.