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State/Territory Name: Wisconsin

State Plan Amendment (SPA) 21-0018

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



Financial Management Group

March 1, 2022

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) 21-0018

Dear Mr. Jones:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 21-0018. Effective for services on or after December 1, 2021, this amendment modifies inpatient hospital reimbursement. This amendment modifies inpatient hospital reimbursement through an updated APR-DRG grouper, disproportionate share hospital (DSH) reimbursement pool amounts, claimable graduate medical expense by identifying an existing and accredited residency programs, and institutions for mental disease (IMD) reimbursement settlement through settled cost reports.

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 21-0018 is approved effective December 1, 2021. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,



Rory Howe
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 21-0018	2. STATE WI
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT	
TO: CENTER DIRECTOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 12/01/2021	
5. FEDERAL STATUTE/REGULATION CITATION 47 CFR Part 447 Subparts C and F	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY 2022 \$90K \$90,000 b. FFY 2023 \$90K \$90,000	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A pages 1, 28, 37, 38, and 43.....	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Same	
9. SUBJECT OF AMENDMENT Inpatient hospital reimbursement modification		
10. GOVERNOR'S REVIEW (Check One) <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
11. SIGNATURE OF STATE AGENCY OFFICIAL [Redacted] 12/1/2021		DocuSigned by: Nathan Bollhorst 12/1/2021
12. TYPED NAME Jim Jones	15. RETURN TO Autumn Knudtson Director, Bureau of Benefits Policy Department of Health Services 1 W. Wilson St. P.O. Box 309 Madison, WI 53701-0309	
13. TITLE State Medicaid Director		
14. DATE SUBMITTED 12/17/2021		
FOR CMS USE ONLY		
16. DATE RECEIVED 12/2/2021	17. DATE APPROVED 3/1/2022	
PLAN APPROVED – ONE COPY ATTACHED		
18. EFFECTIVE DATE OF APPROVED MATERIAL 12/1/2021	[Redacted] APPROVING OFFICIAL	
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe	21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group	
22. REMARKS Box 6 Federal Budget Impact annotated without state concurrence to comport with Box 6 instructions for the revised CMS 179 form. Estimates of impact should not be rounded nor truncated.		

State: Wisconsin

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OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT

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

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

The WMP DRG reimbursement system uses the grouper that has been developed by 3MT™ that uses an all patient sample, the All Patient Refined (APR) DRG. The grouper classifies a patient's hospital stay into an established DRG based on the diagnosis of and procedures provided to the patient. A grouped claim is then assigned a weight that is intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with an APR DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with an APR DRG weight of 1.0, while the average hospitalization with a DRG with a weight of 0.5 would consume half the resources of the average hospitalization with a DRG weight of 1.0. APR DRG weights and average length of stay are established and maintained by 3MT™.

Each hospital is assigned a unique hospital-specific DRG base rate. This hospital-specific DRG base rate includes an adjustment for differences in wage levels between areas throughout the state. It also includes an amount for direct medical education costs.

Given a hospital's specific DRG rate and the weight for the APR DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined by multiplying the hospital's rate by the DRG weight and any applicable policy adjustor, and by taking into account the WMP's charge cap and transfer policies.

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

For additional information, contact:

Bureau of Rate Setting
Department of Health Services
1 W. Wilson Street, Room 318
P. O. Box 309
Madison, Wisconsin 53701-0309.

Telephone (608) 266-8922
FAX (608) 264-9847
E-mail DHSDMSBRS@dhs.wisconsin.gov

State: Wisconsin

8000
HOSPITALS PAID UNDER PER DIEM RATE

8100 Covered Hospitals

State-operated institutions for mental disease (IMDs), psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals will be paid under a rate per diem. Services described in §7000 are exempted from reimbursement under this section if reimbursement is requested by and approved for the hospital according to §7000.

8200 Payment Rates

This section describes how IMDs, psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals are reimbursed for services provided to WMP recipients. All services provided during an inpatient stay, except professional services described in §8420, will be considered inpatient hospital services for which payment is provided.

8210 State Owned and Operated IMDs

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

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

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

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

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

8220 All Other Psychiatric, Rehabilitation, and Long-Term Care Hospitals. Patient stays in a hospital covered by this section will be paid at a prospective per diem cost based rate. The prospective per diem rate will be based on the rate setting Medicare cost report. A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. WMP ancillary costs will be apportioned by deriving cost-to-charge ratios for each ancillary service. The total routine and ancillary WMP costs will be divided by total paid WMP days from the Medicaid Management Information System (MMIS). The cost per diem rate will be inflated to the current rate year by applying the "Hospital and Related Healthcare Costs Index" published by IHS. Final hospital-specific per diem payment rates are based on provider costs but are subject to a budget reduction factor to ensure compliance with the Department's annual budget. For rate year 2014 and subsequent years, the budget reduction factor used to ensure compliance with the Department's annual budget is 85.08%.

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

8300 Other Provisions Relating to Per Diem Rate System

TN #21-0018
Supersedes
TN #18-002

Approval date: 3/01/22

Effective date: 12/01/2021

State: Wisconsin

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

- a) The sum of all supplemental DSH payments made to hospitals equals the annual budget amount:
Annual Budget = Payment to Hospital 1 + Payment to Hospital 2 + ... + Payment to Hospital n
- b) The supplemental DSH payment made to each separately licensed, qualifying hospital for a given state fiscal year under this section is the lesser of 1) the product of its "DSH add-on percentage" and its "projected WMP inpatient fee-for-service payments" and 2) 6.77% of the \$47,500,000 in state share general purpose revenue (GPR) plus the matching federal share of payments:
Payment to Hospital i = min(DSH Add-On Percentage x Projected WMP IP FFS Payments, 6.77% of the \$47,500,000 in state share general purpose revenue (GPR) plus the matching federal share of 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 DSH add-on percentage is its "DSH add-on factor" minus 100% (in other words, the DSH add-on factor compares base payments to total (base + DSH) payments while the DSH add-on percentage compares base payments to DSH supplemental payments only):
DSH Add-On Percentage of Hospital i = DSH Add-On Factor of Hospital i - 1
- e) A hospital's DSH add-on factor is a function of the "base DSH add-on factor" and the amount by which its MIUR exceeds 6 percent, such that a hospital with a higher MIUR receives a higher DSH add-on factor:
DSH Add-On Factor of Hospital i = Base DSH Add-On Factor + ((MIUR of Hospital i - 0.06) x 0.75)
- f) A hospital's MIUR is the ratio of its Medicaid inpatient days to its total inpatient days, drawn from a data period two years prior to the given state fiscal year:
MIUR of Hospital i = Hospital i's Total Medicaid Inpatient Days / Hospital i's Total Inpatient Days
- g) The base DSH add-on factor is determined per the constraints provided by the equations above. Since one of those equations (for the DSH supplemental payment) is nonlinear, there is no clean formula for the base DSH add-on factor; rather, it can only be derived by iteratively solving the above system of equations. This is possible due to the fact that every other variable involved in the above equations has a known value.

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

State: Wisconsin

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.
- f) Hospitals that meet the Supplemental DSH payments qualifying criteria in §9232 (a) through (d) and (f) must be determined by the Department to be ineligible for Supplemental DSH payments under (e) in order to be eligible for the Critical Care Supplement under §9300.

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.

State: Wisconsin

9800 Graduate Medical Education Supplemental Payments for Hospitals

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

9810 Introduction

Hospitals located in the State of Wisconsin may receive supplemental payments of up to \$541,386 per state fiscal year to support new graduate medical education residents. §1900, 146.64 of Wisconsin Act 20 authorizes the Department to distribute such payments to hospitals to fund the addition of resident positions to existing accredited graduate medical education programs including any of the following family medicine, general internal medicine, general surgery, pediatrics and psychiatry.

9820 Qualifying Criteria

The hospital must meet the following criteria:

- a) The hospital serves rural and underserved communities in Wisconsin.
- b) The hospital serves as an approved training site for an accredited graduate medical education program in one or more of the following specialties including: family medicine, general internal medicine, general surgery, pediatrics or psychiatry.
- c) The hospital meets applicable, minimum requirements to be WMP-certified.
- d) Priority for funding will be given to hospitals that meet the following criteria: The hospital is located in the State of Wisconsin.
- e) The hospital and its' associated graduate medical education program has a retention rate of at least 30 percent of graduate residents remaining to practice in Wisconsin's rural and underserved communities.
- f) The hospital serves underserved areas with a population of less than 50,000; more rural areas, e.g., those with populations of less than 10,000 receive higher priority.
- g) The hospital includes a focus on physician training in working with team-based care, in prevention and public health, in cost effectiveness and health care economics, and in working in new service delivery models, e.g., Accountable Care Organizations or patient-centered medical homes.

9830 Amounts of Supplemental Payments

The amount of payment per hospital shall not exceed \$180,462 per resident per state fiscal year, and the hospital shall not receive more than \$541,386 per state fiscal year. It is the intention of the Department that payments be made annually for the duration of the residencies expanded under the supplemental payment program.

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

The Department sets forth a methodology as defined in §9840 for distributing the graduate medical education resident supplemental payments.

9840 Allocation Methodology

- a) The Department shall solicit competitive applications for supplemental payments for residents through a Request for Applications from qualified hospitals.
- b) The residency program at the hospital must be an existing, accredited residency program.
- c) Each separately participating qualifying hospital cannot receive more than \$180,462 per resident or \$541,386 per state fiscal year.