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**State/Territory Name: Wisconsin**

**State Plan Amendment (SPA) 22-0005**

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



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**Financial Management Group**

June 14, 2022

Ms. Lisa Olson  
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) 22-0005

Dear Ms. Olson:

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) 22-0005. Effective for services on or after January 1, 2022, 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, 2022.

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 22-0005 is approved effective January 1, 2022. 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,

A black rectangular box redacting the signature of Rory Howe.

Rory Howe  
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM APPROVED  
OMB No. 0938-0193

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <b>WI 2 2-0005</b>	2. STATE <b>Wisconsin</b>
	3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <b>01/01/2022</b>	
5. TYPE OF PLAN MATERIAL (Check One) <input checked="" type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		

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

6. FEDERAL STATUTE/REGULATION CITATION <b>47 CFR Part 447 Subparts C and F</b>	7. FEDERAL BUDGET IMPACT a. FFY 2022 <b>\$1,644,704</b> b. FFY 2023 <b>\$1,644,704</b>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <b>State Plan Attachment 4.19-A: Pages 1, 9-10, 28-29, &amp; 32</b> <b>State Plan Attachment 4.19-B: Pages 1 &amp; 5-6</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <b>Same</b>

10. SUBJECT OF AMENDMENT <b>Inpatient and Outpatient Hospital Reimbursement Modification</b>
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11. GOVERNOR'S REVIEW (Check One)
<input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED

3/14/2022

12. SIGNATURE OF STATE AGENCY OFFICIAL DocuSigned by: [Redacted] 3/14/2022	16. RETURN TO <b>Autumn Knudtson</b> <b>—Bureau Director, Bureau of Benefits Policy</b> <b>Interim State Plan Amendment</b> <b>Department of Health Services</b> <b>1 W. Wilson St.</b> <b>P.O. Box 309</b> <b>Madison, WI 53701-0309</b>
13. TYPED NAME <b>Coordinator <u>Lisa Olson</u></b>	
14. TITLE <b><u>State Medicaid Director</u></b>	
15. DATE SUBMITTED <b>03/30/2022</b>	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED <b>March 30, 2022</b>	18. DATE APPROVED <b>June 14, 2022</b>
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL <b>January 1, 2022</b>	REGIONAL OFFICIAL [Redacted]
21. TYPED NAME <b>Rory Howe</b>	22. TITLE <b>Director, FMG</b>

## 1000 OVERVIEW OF INPATIENT HOSPITAL REIMBURSEMENT

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

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

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

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

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

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

For additional information, contact:

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

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

E-mail [DHSDMSBRS@dhs.wisconsin.gov](mailto:DHSDMSBRS@dhs.wisconsin.gov)

## 6200 Standardized DRG Payment Factors

Certain standard factors are used in determining the amount of payment hospitals receive for services covered by the DRG-based payment method. The Department adjusts these standard factors for each RY. These include the DRG grouper, DRG weights and policy adjusters.

### 6210 DRG Grouper

The DRG grouper is a classification system that sorts each patient stay into one DRG. The WMP DRG reimbursement system uses the grouper developed by 3M™ for an all patient population, the All Patient Refined (APR) DRG grouper. The version of the APR DRG grouper used by the WMP is updated for each RY.

### 6220 DRG Weights

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

### 6230 Policy Adjusters

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

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

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

*6230 Hospital-Specific DRG Base Rate*

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

The Department determines hospital-specific DRG base rates by inflating the standard DRG group rate from the prior rate year to the new rate year, and then adjusting for differences in the wage area index and direct graduate medical education costs for each hospital. The labor portion of the standard DRG group rate is adjusted by the wage area adjustment index applicable to the hospital; the sum of the adjusted labor portion and the unadjusted non-labor portion forms the "total labor-adjusted group rate." §6240 describes the wage area adjustment index. To form the hospital-specific DRG base rate, the Department adds to the hospital's total labor-adjusted group rate its specific base payment add-on amounts for graduate medical education costs (if applicable), described in §6250 through §6270.

Finally, the Department adjusts the standard DRG group rate to account for the impact of including wage index adjustments and direct graduate medical education in the development of the hospital-specific DRG base rates. This action, in turn, serves to adjust the hospital-specific DRG base rates as well.

## 8000 HOSPITALS PAID UNDER PER DIEM RATE

### 8100 Covered Hospitals

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

### 8200 Payment Rates

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

#### *8210 State Owned and Operated IMDs*

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

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

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

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

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

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

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

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

### **8300 Other Provisions Relating to Per Diem Rate System**

8310 Review by External Quality Review Organization (EQRO). §6510 applies to hospitals under the per diem rate system.

8311 EQRO Control Numbers. §6511 applies to hospitals under the per diem rate system.

8320 Medically Unnecessary Days (Under Per Diem Rate System). Medically unnecessary days are those days that are not reasonably expected to improve the patient's condition, that are not for diagnostic study, or that do not require the intensive therapeutic services normally associated with inpatient care. (See §8310 regarding criteria.)

8321 Authority for Recovery (Under Per Diem Rate System). The Department will recover payments previously made or deny payments for medically unnecessary hospital stays or days and/or inappropriate services based on determinations by the Department, the Wisconsin Peer Review Organization (EQRO) or other organizations under contract with the Department. The Department is required by federal law to monitor the medical necessity and appropriateness of services provided to WMP recipients and payments made to providers of such services. Wisconsin statute, §49.45(3)(f)2m, authorizes the Department to adopt criteria on medical necessity and appropriateness and to deny claims for services failing to meet these criteria.

8322 Calculation of Recoupment (Under Per Diem Rate System). The amount to be recouped for medically unnecessary stays or days is calculated by multiplying the rate per diem times the number of denied days, less any co-payment or third-party payment.

8330 Inappropriate Admissions. §6530 applies to hospitals having per diem rates.

8340 Temporary Hospital Transfers (Under Per Diem Rate System). When an inpatient in a hospital paid under the prospective rate per diem system is transferred to an acute care hospital and transferred back, no per diem payment shall be provided to the hospital for the days of absence. The acute care hospital, to which the patient temporarily transferred, will be reimbursed by the WMP for medically necessary stays.

8350 Days Awaiting Placement (Under Per Diem Rate System). Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. Payment under the prospective rate-per-diem will be adjusted for days a WMP recipient patient is awaiting placement to an alternative living arrangement. For those days identified as awaiting placement, payment shall be adjusted to an amount not to exceed the statewide average skilled care per diem rate for nursing facilities (NFs). Each allowed day awaiting placement shall be documented through patient chart review and subject to criteria established by the WMP. The amount to be recouped is calculated by subtracting the skilled care rate from the rate per diem and multiplying by the days awaiting placement. The amount to be recouped is also reduced by the applicable amount of co-pay and third-party liability (TPL) payments.

8360 Outpatient Services Related to Inpatient Stay. §6560 applies to hospitals under the per diem rate system.

8380 Changes of Ownership. §6580 applies to hospitals under the per diem rate system.



5. The Department will calculate the cost per diem for each routine cost center. For each inpatient routine cost center a cost per diem is calculated by dividing total hospital costs identified from Step 1, by total days identified in Step 1. The cost per diem is multiplied by WMP hospital Fee-for-Service (FFS) days identified from MMIS records for the most recent completed state fiscal year ending June 30. Long-term care cost centers and other non-hospital related cost centers are excluded from this process. The Adults & Pediatrics (A&P) routine per diem, in accordance with the Medicare cost report worksheet D-1 for both the CMS 2552-10 and the CMS 2552-96, is computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and private room differential costs from the A&P costs.

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

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

6. To determine the inpatient hospital routine and ancillary cost center costs for the payment year, the hospital's projected WMP FFS inpatient days and charges by cost center are used. To project WMP hospital FFS charges as accurately as possible for the payment year, the projection will be based upon the hospital's actual experience of WMP FFS inpatient charges for the most recent 6-month period and inflated to the payment year. The projected charges are then multiplied by the cost-to-charge ratios from Step 5 for each respective ancillary cost center and the per diem cost is multiplied by the WMP hospital FFS inpatient days to determine the WMP FFS inpatient costs for each routine service cost center.
7. The WMP hospital FFS costs eligible to be reimbursed under this section are determined by adding the WMP FFS inpatient costs from Step 6, and subtracting estimated WMP FFS inpatient payments. The payment estimate will be based on the hospital's WMP FFS payment experience for the most recent 6-month period.

#### *9140 Interim Reconciliation*

The hospital costs determined through the methods described for the payment year are reconciled to the as-filed Medicare cost report for the payment year once the Medicare cost report has been made available on HCRIS. For purposes of this reconciliation, the same steps as outlined for the payment year method are carried out except for the changes noted below:

- Steps 1 – 5: Hospital costs and charges and patient days from the as-filed Medicare cost report are used.
- Step 6: WMP hospital FFS charges and inpatient days from MMIS paid claims data are used subject to provider reconciliation.
- Step 7: WMP hospital FFS payments subject to provider reconciliation are used.

#### *9150 Final Reconciliation*

Once the Medicare cost report for the payment year has been finalized on HCRIS, reconciliation of the finalized amounts will be completed, including use of the Worksheet D (for both the CMS 2552-10 and the CMS 2552-96) apportionment process. In the final reconciliation, WMP FFS cost is computed using the methodology as prescribed by the Medicare cost report.

Worksheet D series including 1) computing a per diem for each routine cost center and applying the applicable WMP inpatient days from MMIS records for the completed state fiscal year ending June 30 to the per diem amount; 2) using the appropriate Worksheet D-1 lines to compute the per diem for the routine cost centers, particularly the Adults & Pediatrics cost center; and 3) applying Worksheet C cost center-specific cost-to-charge ratios to the applicable WMP hospital charges for each ancillary cost center. Use of Worksheet D series also includes the application of all Medicare cost report adjustments (including swing bed and private room differential adjustments) unless expressly exempt for WMP.

## SECTION 1000 OVERVIEW

This section is an overview of how the Wisconsin Medicaid Program (WMP) establishes payment rates for hospital outpatient care provided to persons eligible for fee-for-service (FFS) coverage under the WMP. The payment is for outpatient medical services provided by a hospital in its inpatient hospital licensed facility, for which the patient does not need to be admitted for an overnight stay, and for which the WMP does not pay another certified WMP provider.

Effective April 1, 2013, all hospitals that qualify for payment under the WMP are reimbursed for outpatient services under the Enhanced Ambulatory Patient Grouping (EAPG) system. No final cost settlement is done for these hospitals, as EAPG payments are considered final and are not subject to cost settlement.

For additional information, contact:

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

Telephone (608) 266-8922  
FAX (608) 264-1096  
E-mail [DHSDMSBRS@dhs.wisconsin.gov](mailto:DHSDMSBRS@dhs.wisconsin.gov)

## SECTION 2000 STATUTORY BASIS

The Wisconsin outpatient hospital payment system is designed to promote the objectives of the Wisconsin state statutes regarding payment for hospital services (Chapter 49, Wis. Stats.) and to meet the criteria for Title XIX hospital payment systems contained in the federal Social Security Act and federal regulations (Title 42 CFR, Subpart C). The outpatient payment system shall comply with all current and future applicable federal and state laws and regulations and reflect all adjustments required under said laws and regulations. Federal regulations (42 CFR §447.321) require that the payment system not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

## 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, long-term care, 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 of the current rate year, effective for services provided on or after that date.

### **4200 EAPG Reimbursement Methodology**

**4210 EAPG Weights.** EAPG relative weights effective January 1 of the current rate year are based on 3M's EAPG national weights, scaled to result in the same modeled aggregate case mix as the EAPG weights in the prior rate year. EAPG national weights are published by 3M for each EAPG grouper version, and are calculated based on the average cost per visit using national Medicare Provider and Analysis Review (MEDPAR) data. DHS adjusts the national weight for each EAPG by a single statewide factor such that the aggregate modeled EAPG case mix for the rate year is equal to the aggregate modeled case mix under the EAPG weights used in the prior rate year. The EAPG grouper version and associated weights are updated annually, and are effective January 1 of the current rate year. EAPG relative weights can be found on the Wisconsin ForwardHealth Portal here: <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm#page#>

**4211 Calculating EAPG Base Rates for Critical Access Hospitals (CAHs).** CAHs each have a provider-specific EAPG base rate calculated by estimating the outpatient WMP claim costs using Medicare cost report data, inflating costs to the new rate year, and dividing by the total hospital final EAPG weights. The calculation results in a prospective, provider-specific EAPG base rate at 100 percent of Medicaid cost for EAPG qualifying services. The CAH EAPG base rates are effective January 1 of the current rate year and can be found on the Wisconsin ForwardHealth Portal here: <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm#page#>.

**4212 Calculating EAPG Base Rates for Psychiatric Hospitals.** Psychiatric hospitals each have a provider-specific EAPG base rate calculated by estimating the outpatient WMP claim costs using Medicare cost report data, inflating costs to the new rate year, and dividing by the total hospital final EAPG weights. Final hospital-specific base rates are subject to a budget reduction factor of 85.08 percent to ensure compliance with the Department's annual budget. The psychiatric hospital EAPG base rates are effective January 1 of the current rate year and can be found on the Wisconsin ForwardHealth Portal here: <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm#page#>.

**4213 Calculating EAPG Base Rates for Hospitals that are not CAHs nor Psychiatric Hospitals.** Hospitals that do not qualify as Critical Access Hospitals or as Psychiatric Hospitals use a statewide EAPG base rate that is calculated by inflating the statewide EAPG base rate from the prior rate year to the new rate year. Qualifying hospital EAPG base rates also include a Direct Graduate Medical Education (GME) add on, as described in section 4221. The EAPG base rates are effective January 1 of the current rate year and can be found on the Wisconsin ForwardHealth Portal here: <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Provider/medicaid/hospital/drg/drg.htm#page#>.

**4214 Use of Cost Reports in Rate Setting.** The WMP uses the Medicare cost report to establish certain components of an in-state hospital's specific payment for direct graduate medical education. Cost reports are

also used to establish critical access hospitals' estimated costs. The Department obtains Medicare cost reports through the Healthcare Cost Report Information System (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS).

*4215 Selection of Cost Reporting Period.* The Department uses the most recently submitted 12-month Medicare cost report available in HCRIS as of the March 31 prior to the start of the RY. For example, rates effective January 1, 2015 (i.e. RY '15) would use the most recently submitted 12-month Medicare cost report available in HCRIS as of March 31, 2014. If the most recently submitted 12-month Medicare cost report available is a "no utilization" cost report, the Department may request an alternate 12-month cost report from the hospital.

*4216 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, the Department will perform calculations based upon the most recently submitted 12-month Medicare cost reports of the combining hospitals prior to the combining.

*4217 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.

*4218 Rates for New Hospitals.* The start-up period for new hospitals begins the date the hospital admits its first WMP recipient and ends when a 12-month Medicare cost report is available in the HCRIS to the Department at time of rate calculation. New acute care and children's hospitals are paid prospectively the statewide EAPG base rate effective for the rate year, without retrospective settlement. New psychiatric hospitals during a start-up period will be paid the highest rate paid to other psychiatric hospitals within the last 12 months, not including rates paid to new psychiatric hospitals. The start-up rate being paid to a new psychiatric hospital will be paid on an interim basis. The Department will also conduct a reimbursement settlement for new psychiatric hospitals for the start-up period following the interim reconciliation methodology described in steps 1-5 of §7125 below (unless the hospital already qualifies for an outpatient Medicaid deficit funding settlement), with the exception that a budget reduction factor of 85.08 percent is applied to the cost settlement target, no inflation is applied, and the costs are not considered a certified public expenditure.