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State/Territory Name: WI

State Plan Amendment (SPA) #: 24-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 10, 2025

William Hannah
Medicaid Director
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

Dear Director Hannah,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wisconsin State Plan Amendment (SPA) to Attachments 4.19-A and 4.19-B TN: #24-0022, which was submitted to CMS on December 19, 2024. This plan amendment proposes a payment methodology update to modify the cost reporting periods and rates methodology for new psychiatric, rehabilitation, or long-term care hospitals for Wisconsin's Inpatient and Outpatient Hospital State Plans.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of November 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Matthew Klein at 214-767-4625 or via email at matthew.klein@cms.hhs.gov

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0022

2. STATE: WI

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
11/1/2024

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, page 28-29
Attachment 4.19-B, page 6

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A, page 28-29
Attachment 4.19-B, page 6

9. SUBJECT OF AMENDMENT
DHS will modify the Inpatient and Outpatient Hospital State Plans to require a Medicare cost report with a six month reporting period minimum to conclude the start-up period for new psychiatric rate payments. The default rate for per diem hospitals with insufficient claims to calculate a rate shall be based on the median for all hospitals of that type.

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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
William Hanna

13. TITLE
Medicaid Director

14. DATE SUBMITTED
12/19/2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
12/19/2024

17. DATE APPROVED
March 10, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
11/1/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Instructions on Back

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 Medicare cost report with at least a six-month reporting period 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 Medicare cost report with at least a six-month reporting period 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, with the exception that a budget reduction factor of 85.08 percent is applied to the cost settlement target, unless the hospital qualifies for an Inpatient Medicaid Deficit Funding settlement under §9100. If the startup period for a new psychiatric hospital includes a period not covered by the Medicare cost report submitted to CMS, the hospital will submit cost report data covering that period directly to the Department with sufficient detail to calculate the reimbursement settlement. For psychiatric, rehabilitation, and long-term care hospitals not in the startup period and without sufficient claims to establish a provider rate, hospitals will be paid the statewide median rate for the provider type.

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.

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 acute care and children's 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. The start-up period for new psychiatric, rehabilitation, or long-term care hospitals begins the date the hospital admits its first WMP recipient and ends when a Medicare cost report with at least a six-month reporting period is available in the HCRIS to the Department at time of rate calculation. 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. If the startup period for a new psychiatric hospital includes a period not covered by the Medicare cost report submitted to CMS, the hospital will submit cost report data covering that period directly to the Department with sufficient detail to calculate the reimbursement settlement. For psychiatric, rehabilitation, and long-term care hospitals not in the startup period and without sufficient claims to establish a provider rate, hospitals will be paid the statewide median rate for the provider type.