Wisconsin Medicaid Program
Inpatient Hospital State Plan

Method and Standards For Determining Payment Rates
With Amendments Effective July 1, 2009

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Wisconsin Medicaid Program
Inpatient Hospital State Plan
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SECTION 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 which is based on Diagnosis Related Groupings (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) and psychiatric hospitals, which are reimbursed at rates per diem. Also, reimbursement for certain specialized services are exempted from the DRG system. These include acquired immunodeficiency syndrome (AIDS), ventilator-assisted patients, unusual cases and brain injury cases. Special provisions for payment of each of these DRG exempted services are included in the 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 Medicaid supplemental or enhanced payments and Medicaid disproportionate share payments.

The WMP DRG reimbursement system uses the grouper that has been developed for and used by Medicare, with enhancements for certain perinatal, newborn and psychiatric cases. The grouper classifies a patient's hospital stay into an established diagnosis related group (DRG) based on the diagnosis of and procedures provided the patient. The WMP applies the Medicare grouper and its enhancements to Wisconsin-specific claims data to establish a relative weight for each DRG based on statewide average hospital costs. These weights are intended to reflect the relative resource consumption of each inpatient stay. For example, the average hospitalization with a DRG weight of 1.5 would consume 50 percent more resources than the average hospitalization with a weight of 1.0, while a hospital stay assigned a DRG with a weight of .5 would require half the resources.

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 rural and metropolitan areas throughout the state. This rate includes an amount, based on a hospital's most recently audited cost report, for capital and direct medical education programs. For some hospitals, the rate also includes additional amounts for serving a disproportionate share of low incomes persons of for the hospital being located in a rural area.

Given a hospital's specific DRG rate and the weight for the DRG into which a stay is classified by the grouper, payment to the hospital for the stay is determined in multiplying the hospital's rate by the DRG weight.

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. A length-of-stay outlier payment is available upon a hospital's request for children under six years of age in disproportionate share hospitals and for children under age one in all hospitals.

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SECTION 2000
STATUTORY BASIS

The Wisconsin inpatient hospital payment system is designed to promote the objectives of the 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 inpatient payment system will comply with all applicable Federal and State laws and regulations and will reflect all adjustments required under these laws and regulations.

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SECTION 3000
DEFINITIONS

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective July 1 of each year based on more current cost reports and/or other information relevant to hospital reimbursement.

Border Status Hospital. A hospital not located in Wisconsin which has been certified by the WMAP as a border-status hospital to provide hospital services to WMAP recipients. (Reference, HFS 105.48, Wis. Adm. Code) Border status hospitals are differentiated between major border status providers and minor border status providers as described in Section 3520.

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

Critical Access Hospital. A hospital that meets the federal definition of a Critical Access Hospital, including but not limited to the requirements of 42 CFR 485.600.

Department. The Wisconsin Department of Health Services (or its agent); the State agency responsible for the administration of the Wisconsin Medical Assistance Program (WMAP).

DRG. DRG means Diagnosis Related Groups which is a patient classification system that reflects clinically similar groupings of services that can be expected to consume similar amounts of hospital resources.

Hospital-Specific DRG Base Payment Rate. The payment rate per discharge which will be calculated for and assigned to each hospital by the Department for the rate year. This is the rate by which a DRG weight is multiplied to establish the amount of payment for an individual inpatient stay.

IMD. Institution for Mental Disease, as defined in 42 CFR 435.1009.

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

Medicaid Management Information System (MMIS). The system used to process provider claims for payment.

Non-Border Status Hospital. A hospital not located in Wisconsin and which has not been certified by the WMAP as a border status hospital.

Prospective Rate per Diem. The hospital-specific rate for each day of service.

Psychiatric Hospital. A general psychiatric hospital for which the department has issued a certificate of approval under s.50.35 that applies only to the psychiatric hospital, and that is not a satellite of an acute care hospital.

Rate Year. The twelve month period from July 1 through June 30 during which rates established under the annual rate update are to be effective for most, if not all, hospitals.

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

WMAP. Wisconsin Medical Assistance Program, also referred to as Medicaid, Medical Assistance (MA) or Title XIX.

SECTION 3500
DIFFERENCES IN RATE SETTING BETWEEN
IN-STATE HOSPITALS AND OUT-OF-STATE HOSPITALS

3510 Hospitals Located in Wisconsin

General acute care hospitals, including children's, critical access and long term care hospitals, located in Wisconsin (in-state hospitals) are reimbursed according to the DRG based payment method described in section 5000 herein. All inpatient stays within these hospitals are reimbursed under the DRG based payment method with certain exceptions. These exceptions include AIDS patient care, ventilator patient care, unusual cases and brain injury care.. Organ transplants are paid under the DRG based payment method.

Rehabilitation and psychiatric hospitals are reimbursed under a rate per diem methodology, not the DRG based payment system.

Use of Cost Report In Rate Setting. A hospital's audited Medicare cost report (CMS - 2552) is required for establishing certain components of the hospital's specific payment. The specific components include the capital, direct medical education, disproportionate share hospital (DSH) and rural hospital components of the base rate per discharge. Cost reports are also used to establish the cost to charge ratio for outlier payments..The Department obtains audited Medicare cost reports through the Health Cost Reporting Information System (HCRIS) maintained by the Center for Medicare and Medicaid Services (CMS).

3520 Hospitals Not Located In Wisconsin and Border Status Hospitals

Hospitals not located in Wisconsin which provide inpatient services to WMAP recipients may be reimbursed for their services. Certain of these hospitals have been granted "border status" by the WMAP. Others do not have border status under the WMAP (non-border status hospitals).

Non-Border Status Hospitals. Out-of-state hospitals which *do not have border status* are reimbursed under the DRG based payment method described in section 10000 herein. Payment is based on a standard portion of the DRG base rate only. The rate is not adjusted to recognize hospital specific capital and direct medical education costs, as well as differences in wage areas and disproportionate share or rural hospital factors.

All non-emergency services at out-of-state hospitals which do not have border status require prior authorization from the WMAP. This differs from the prior authorization requirements for in-state and border status hospitals.

Minor Border Status Hospitals. Border status hospitals are divided into minor and major border status hospitals. Minor border status hospitals are those border status hospitals which do not meet the criteria described below for a major border status hospital. Minor border status hospitals are reimbursed using the same methodology as a non-border status hospital..

Major Border Status Hospitals. Major 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; it provides a rate that is adjusted to recognize hospital specific capital and direct medical education costs as well as disproportionate share factors. Major border status hospitals do not receive a wage area adjustment..

> *Use of Cost Report In Rate Setting.* To establish hospital-specific rate components, the Department will use the most recently audited Medicare cost report available in the Health Cost Report Information System (HCRIS) as of January 1 prior to the start of the rate year.
>
> *Criteria For Major Border Status.* Major border status hospitals are those border status hospitals which have had

75 or more WMAP recipient discharges or at least $750,000 or greater inpatient charges for services provided to WMAP recipients for the combined two rate years ending in the calendar years preceding the current annual rate update. Not included in these amounts are discharges and charges for: (1) stays which were paid in full or part by Medicare, (2) stays paid in full by a payor other than Medicare or Medicaid. Paid in full means the amount received by the hospital equals or exceeds the amount the WMAP would have paid for the stay. For each rate year, the Department will assess the discharges and charges of each border status hospital and notify the hospital of its standing as a major or minor border status hospital. For example, the following table shows the years used for a series of annual rate updates.

Annual Rate Update Effective Date	Rate Years Looked At for Discharges and Charges
July 1, 2006	July 2003 to June 2004 and July 2004 to June 2005
July 1, 2007	July 2004 to June 2005 and July 2005 to June 2006

Rehabilitation Hospitals With Border Status. A major border status hospital which the Department determines qualifies as a rehabilitation hospital, as defined in section 3000, will be reimbursed on a prospective rate per diem consistent with in-state rehabilitation hospitals..

Alternative Payments To Border Status Hospitals For Certain Services. For any out-of-state acute, children's, critical access or long term care hospital, border status or not, all inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

SECTION 4000
COST REPORTING

4010 General

The Wisconsin Medical Assistance Program uses the Medicare cost reporting form as its Title XIX cost report.

4020 In-State and Major Border Status Hospitals.

To establish hospital-specific rate components for in-state and major border status hospitals, the Department will use the most recently audited Medicare cost report available in the Health Cost Report Information System (HCRIS) as of January 1 prior to the start of the rate year. If the most recently audited cost report available in HCRIS is a "no utilization" cost report, the Department may request an alternate cost report from the hospital..

SECTION 5000
DRG BASED PAYMENT SYSTEM
FOR IN-STATE HOSPITALS AND MAJOR BORDER STATUS HOSPITALS

5010 INTRODUCTION

A hospital is paid a prospectively established amount for each discharge under the DRG based payment system. In the Department's annual rate update, a "hospital-specific DRG base rate is calculated for each hospital. The rate is the result of adjusting a uniform "standard DRG group rate" to recognize the wage area of each hospital. In addition, hospital-specific rate supplements for capital, direct medical education, disproportionate share hospital and rural hospital adjustment are added to the "standard DRG group rate." This results in hospital-specific DRG base rates.
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For each Medicaid recipient's stay, the hospital's specific DRG base rate is multiplied by the relative weighting factor for the diagnosis related group (DRG) which applies to the hospital stay. The result is the DRG payment to the hospital for the specific stay. In addition to the DRG payment, an "outlier" payment may be made to the hospital for very high cost cases.

5020 HOSPITALS COVERED BY THE DRG-BASED PAYMENT SYSTEM

Acute care, children's, critical access and long term care hospitals will be paid according to the DRG based payment system. Rehabilitation hospitals and , psychiatric hospitals are not covered by the DRG-based payment system.

5030 SERVICES COVERED BY DRG PAYMENTS

All covered services provided during an inpatient stay, except professional services described in §5040, shall be considered hospital inpatient services for which payment is provided under this DRG based payment system. (Reference: Wis. Admin. Code, HS 107.08(3) and (4))

All covered hospital inpatient stays are reimbursed under the DRG based payment method except AIDS patient care, ventilator patient care, unusual cases and brain injury care will be reimbursed under the alternative payment methods described in section 7000 if the hospital requests and qualifies for the alternative reimbursement according to section 7000.

Organ transplants are covered by the DRG based payment method.

5040 PROFESSIONAL SERVICES EXCLUDED FROM DRG PAYMENTS

Certain professional and other services are excluded from the DRG payment system. Professional services must be billed by a separately certified provider and billed on the CMS - 1500 claim form. The following services are excluded, when the professionals are functioning in the capacity of:

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

5100 STANDARDIZED DRG PAYMENT FACTORS

Certain standard factors are used in the determining the amount of payment hospitals receive for services covered by the DRG based payment method. The Department adjusts these standard factors for each rate year, July 1 through June 30. They include the DRG grouper and the DRG weights.

5120 DRG Grouper

The DRG grouper is a classification system which results in a patient stay being classified into one "diagnosis related group" (DRG). The WMP DRG reimbursement system uses the grouper developed for Medicare based on "major diagnostic categories" (MDCs). For newborns, WMP has enhanced the grouper's MDC 15 (Newborns and Other Neonates with Conditions Originating in the Perinatal Period). For psychiatric stays, the grouper's MDC 19 (Mental Diseases and Disorders), is also enhanced.

Annually, updated versions of the Medicare grouper will be used by the WMP. The Medicare grouper version, which is released by CMS for use by Medicare beginning on October 1 of each calendar year, will be implemented for MA discharges occurring on and after July 1 of the subsequent calendar year.

5130 DRG Weights

DRG weights reflect the relative resource consumption of each inpatient stay. The weights are determined from an analysis of past services provided by hospitals, the claim charges for those services and the relative cost of those services. WMP recipient inpatient hospital claims are used in order that the weights which are developed are relevant to the types and scope of services provided to WMP recipients.

Annually, revised DRG weights will be established based on (1) the updated version of the Medicare grouper, (2) more current claims information and (3) more current inpatient hospital cost report information.

5130.1 Claims Used. Claims for a period of at least three years for WMP certified hospital providers in Wisconsin are used. The selected period of claims is not to end more than twenty-four months nor less than nine months prior to the

July 1st day on which the revised DRG weights are to be implemented. Claims not covered by WMP's DRG based payment system are not used. These are claims for which payment is made at rates determined under Sections 6000 and 7000. Also not used are claims from any hospital designated a critical access hospital (CAH) during the selected period of claims. This exclusion of claims applies to hospitals newly designated as a CAH or discontinued as a CAH anytime during the selected period of claims.

5130.2 Cost Report Used. The WMP uses the cost report for each hospital's most recently completed reporting period for which an audited Medicare cost report is available to the Department as of the January 1st date prior to the July 1st day on which the revised DRG weights are to be implemented. The Department will use the HCRIS database as the primary data source. Costs are inflated as described below for the calculation of weights.

5130.3 Weights Calculated.

The updated version of the Medicare grouper described is applied to the historical claims. Each claim is classified to and assigned its appropriate diagnosis related grouping (DRG) by the grouper.

The cost of each inpatient hospital claim is calculated. This is a hospital-specific claim cost that requires correlating the services charged on the claim to related cost centers of the hospital's cost report. For each claim, accommodation services for the hospital stay are multiplied by the per diem cost of accommodation services in the respective hospital's cost report. The result is the cost of accommodations for the hospital stay. Ancillary service charges are multiplied by the cost-to-charge ratio of ancillary cost centers in the respective hospital's cost report providing a cost for ancillary services. Acquisition charges for transplanted organs are multiplied by cost-to-charge ratios for the respective organ. The resulting accommodation cost, ancillary service cost and organ acquisition costs of each claim is summed resulting in the total cost of the inpatient stay.

The cost of each inpatient stay is further standardized (or adjusted) for area wage differentials and reduced for the cost attributed to capital costs, direct medical education costs and outlier costs.

Each claim's cost is inflated by an inflation multiplier to the current rate year. The inflation multiplier is derived from indices in the publication, "Health-Care Cost Review",that is published quarterly by Global Insight, Inc.

The average cost of the claims by each DRG is calculated. Also, a combined overall average cost of all DRG claims is calculated. The weight for each respective DRG is the average cost of the respective DRG's claims divided by the combined overall average cost.

Random anomalies and incongruities in the resulting weights are reviewed and analyzed in the light of the prior year weights and the cost and volume of claims involved. The questioned DRG weights are adjusted, if considered appropriate, to a reasonable amount based on the analysis. It should be noted that low-volume DRGs are especially vulnerable for significant year-to-year swings in their weight. A significant decrease in the weight of any individual DRG is limited unless cost, volume and central tendency and deviation data justify the significant decrease. A listing of the resulting proposed and final DRG weights are disseminated to in-state and major border status hospitals.

5130.4 Cochlear Implants.
A separate weighting factor is provided for inpatient hospital stays for cochlear implants. Payment is available upon written request by the hospital for payment at this weight and is only available for a claim that covers cochlear implant surgery and the cost of the apparatus.

5140 DRG Weights For MDC 15 (Mental Diseases and Disorders)

The WMP has expanded the standard diagnosis related groupings (DRGs) of MDC 15 (Mental Diseases and Disorders). For each of the DRGs, separate weighting factors are constructed for two age ranges: (1) over age 17 and (2) age 17 and younger. These weighting factors apply to hospital stays for mental diseases and disorders in acute care hospitals. The DRG Weights do not apply to hospital institutions for mental disease (IMDs) including State operated, and Psychiatric hospital providers.

As noted in subsection 5130.3, random anomalies and incongruities in the resulting weights are reviewed and adjustments made if considered appropriate.

5150 Provider Specific Payment Rates for Hospitals Located within the State of Wisconsin

5151 Calculation Of Hospital-Specific DRG Base Rate, General

The "hospital-specific DRG base rates" is calculated as follows:

First, a uniform “standard DRG group rate” is developed, based on the projected WMP budget for DRG hospitals and projected inpatient utilization and case mix for the rate year. In the process of developing hospital-specific DRG base rates, the “standard DRG group rate” is continually adjusted to accommodate capital, medical education, DSH and rural hospital factors.. The “standard DRG group rate” must also be adjusted to accommodate critical access hospital base rates that are estimated to provide those hospitals with 100% cost-based reimbursement.

The labor portion of that group rate will be adjusted by the wage area index applicable to the hospital. The sum of the adjusted labor portion and non-labor portion is the total labor adjusted group rate. Section 5152 describes the wage area adjustment index. Added to this adjusted rate is a hospital’s specific base payment for capital and a hospital’s specific base payment for direct costs of a medical education program, described in sections 5160 and 5165. The result is the "hospital-specific DRG base rate".

5152 Wage Area Adjustment Index

5153 Introduction.
The standard DRG group rate applicable to a hospital will be adjusted by a wage index. This subsection describes how the Department develops hospital specific wage index and how the index will be applied to a specific hospital’s payment rate.

5154 Calculation of Hospital Specific Wage Index. The Department will develop hospital specific wage index based on hospital wage data available through the federal Centers for Medicare & Medicaid Services (CMS) website. For hospitals for which CMS has no data, such as children’s hospitals or new providers, the Department may use data from other sources. Provider information needs to be submitted to the Department no later than January 1rst of the previous rate year for the subsequent rate year.
Only wage data from hospitals certified as providers for the WMAP will be used. For determining indices for border status hospitals, only major border status hospitals will be included in the wage area index calculation.

The following hospitals are not included in the calculation of the wage index.

(1) Hospitals not covered by the DRG payment system.
(2) Hospitals in Wisconsin designated as critical access hospitals as of September 30 immediately preceding the beginning of the rate year, For example, for the rate year beginning July 1, 2003, hospitals designated CAH as of September 30, 2002 are excluded.
(3) Hospitals known to be closed or to have discontinued operating as a hospital as of September 30 immediately preceding the beginning of the rate year, not including hospitals combining or merging with another hospital.
(4) Out-of-state hospitals, including major and minor border-status hospitals..

Wage data will be obtained through the CMS website from the most recent fiscal year Final Occupational Mix Factor by Provider file available at time of rate development, This file is organized by provider and includes occupational mix adjusted and unadjusted wages, occupational mix adjusted and unadjusted AHWs, the nurse occupational mix adjustment factor, and the CBSA nurse occupational mix adjustment factor. DHS will utilize the unadjusted wage data for the purposes of the creation of the hospital specific wage index. The hospital specific wage index calculation will be developed by calculating a statewide average wage rate using wage data from WMAP certified hospitals located in Wisconsin. The hospital specific wage index for each hospital shall be the ratio of the hospital specific average wage to the statewide average wage. The statewide rate, in essence, has a 1.00 index. A hospital specific wage index of 1.05 indicates that the average wage rate for the provider is 5% greater than the statewide average. A hospital specific wage index of .90 means that the hospital's average wage rate is 10% lesser than the statewide average.

For providers in which wage data is not available and providers have not submitted hospital specific information for consideration, DHS will calculate an average wage index using data from those providers located in the same metropolitan statistical area (MSA) as defined by CMS. This process will be followed until wage area data is identifiable and published in the referenced CMS publication used for wage index classification.

5160 CAPITAL COSTS PAYMENT UNDER DRG PAYMENT SYSTEM ------

5161 General

For hospitals reimbursed under the DRG system, an amount for capital costs is added to a hospital's specific base DRG rate. For Wisconsin hospitals and major border status hospitals, this capital payment amount is prospectively established based on an individual hospital's past capital costs.

5162 Calculation for Hospitals Located In Wisconsin

Base Cost Report. The capital cost payment is determined from a hospital's most recent audited Medicare cost report available in the Health Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update.

Calculation. The capital payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report.

1. The capital cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient capital costs to total allowed inpatient costs.

2. The resulting WMP capital cost from step 1 is limited to no more than 8% of a hospitals total cost of treating WMP recipients.

3. The amount from step 2 is inflated through the rate year by the Global Insights CMS Hospital Market Basket inflation rate..

4. The amount from step 3 is divided by the number of WMP recipient discharges for the period of the audited cost report.

5. The resulting amount per discharge is divided by the average DRG case mix index per discharge.

6. The result from step 5 is the hospital's specific base capital payment at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate.

5163 Calculation where No Audited Cost Report Available

For hospitals for which there is no audited cost report available, the hospital may submit equivalent data such as an unaudited cost report or financial statements for consideration, by January 1 preceding the start of the rate year. If no data is provided or if the Department deems that the data supplied is insufficient, the hospital will receive no capital cost payment adjustment in the rate year.

5164 Cost Reports For Recent Hospital Combinings

A "hospital combining" is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited cost report available, for the combined operation, the hospital may submit equivalent data such as an unaudited cost report or financial statements for consideration, by January 1 preceding the start of the rate year..

5165 DIRECT MEDICAL EDUCATION PAYMENT UNDER DRG PAYMENT SYSTEM

5166 General

An amount is added to a hospital's specific base DRG rate for costs of its direct medical education program. This payment amount is prospectively established based on an individual hospital's past direct costs of its medical education program.

5167 Calculation for Hospitals Located In Wisconsin

Base Cost Report. For hospitals located in Wisconsin, the direct medical education payment is determined from a hospital's most recent audited cost report available in the Health Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update.

Calculation. The direct medical education payment for a hospital located in Wisconsin is determined from cost information from each individual hospital's base cost report.

1. The direct medical education cost attributable to WMP inpatient services is determined by multiplying the allowed inpatient cost attributable to WMP recipient inpatients by the ratio of total allowed inpatient direct medical education costs to total allowed inpatient costs.

2. The resulting amount is inflated through the rate year by the DRI/McGraw Hill, Inc. CMS Hospital Market Basket inflation rate.

3. The resulting gross amount is divided by the number of WMP recipient discharges for the period of the audited cost report.

4. The resulting amount per discharge is divided by the average DRG case mix index per discharge. For rate year July 1, 2004 through June 30, 2005, the result is also multiplied by budget factor of 1.00.

5. The result is the hospital's specific base payment for its direct medical education program at a 1.00 DRG weight. This amount is added to the hospital's specific DRG base rate described in section 5210.

Payment for a specific patient's stay is determined by multiplying the base payment amount by the DRG weighting factor for a specific patient's stay.

5168 Calculation where No Audited Cost Report is Available

For hospitals located in Wisconsin for which there is no audited cost report available, the hospital may submit equivalent data such as an unaudited cost report or financial statements for consideration, by January 1 preceding the start of the rate year. If no data is provided or if the Department deems that the data supplied is insufficient, the hospital will receive no direct medical education payment in the rate year.

5169 Cost Reports For Recent Hospital Combinings

A "hospital combining" is the result of hospitals combining into one operation, under one WMAP provider certification, either through merger or consolidation or a hospital absorbing a major portion of the operation of another hospital through purchase, lease or donation of a substantial portion of another hospital's operation or a substantial amount of another hospital's physical plant. For combining hospitals for which there is not an audited cost report available for the combined operation, the hospital may submit equivalent data such as an unaudited cost report or financial statements for consideration, by January 1 preceding the start of the rate year. If no data is provided or if the Department deems that the data supplied is insufficient, the hospital will receive no direct medical education payment in the rate year. The direct medical education adjustment is effective the first day of the month following the month in which the combination was effective.

5170 Rural Hospital Adjustment

5171 Qualifying Criteria.
A hospital may qualify for a rural hospital adjustment if it meets the following conditions. Critical access hospitals are not eligible to receive an adjustment under this section.

1. The hospital is located in Wisconsin, is not located in a CMS defined metropolitan statistical area (MSA), and has the WMP's Wisconsin rural area wage index.
2. As of January 1, 1991, the hospital was classified in a rural wage area by Medicare.
3. The hospital is not classified as a Rural Referral Center by Medicare.
4. The hospital did not exceed the median amount for urban hospitals in Wisconsin for each of the following operating statistics for the statistical years described below: (a) total discharges excluding newborns, (b) the Medicare case-mix index, and (c) the Wisconsin Medicaid case-mix index.
5. For rate years beginning on and after July 1, 1998, the combined Medicare and Medicaid utilization rate of the hospital is determined to be equal to or greater than 50.0%. For rate years beginning prior to July 1, 1998, the combined Medicare and Medicaid utilization rate has been equal to or greater than 55.0%.

5172 Adjustment Percentage.

The amount of the rural hospital adjustment is based on a qualifying hospital's Medicaid utilization rate. The Medicaid utilization rate is determined by dividing the total Medicaid inpatient days by the total inpatient days from the individual hospital's most recent audited cost report available in the Hospital Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update.

The Department has determined that a total of $5,000,000 will be available for the Rural Hospital adjustment percentage (for all hospitals combined) in FY2008 and years thereafter.

NOTE: To clarify for the federal Center for Medicare and Medicaid Services (CMS), the adjustment described in the above section 5170, specifically subsections 5171 and 5172, is NOT a disproportionate share hospital (DSH) adjustment under Section 1923 of the Social Security Act.

5173 Lump Sum Rural Adjustment Payments

Hospitals that do not qualify for a rural hospital adjustment percentage, but are classified as rural under the Medicare wage index, are eligible for an annual lump sum payment of $300,000 per hospital per rate year.

5180 Disproportionate Share Hospital Adjustment Percentage

5181 General.

The special payment adjustment described in this section 5180, specifically subsections 5181 through 5186, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Rate adjustments are allocated to hospitals that provide a disproportionate share of services to Medicaid and low-income patients. A hospital may qualify for a disproportionate share adjustment if the hospital's Medicaid utilization rate is at least 1% and if either (1) the hospital's *Medicaid utilization rate* is at least one standard deviation above the mean Medicaid utilization rate for hospitals in the State, or (2) has a *low-income utilization rate* of more than 25%.

5182 Obstetrician Requirement.

In order for a qualifying hospital to receive its adjustment, it must have at least 2 obstetricians who have staff privileges and who have agreed to provide obstetrical care to WMAP recipients. Hospitals may substitute any physician with staff privileges to perform obstetrical care and who has agreed to provide care to WMAP recipients. If a hospital serves patients predominantly under age 18, or if the hospital did not offer non-emergency obstetrical care as of December 21, 1987, it need not comply with this obstetrical requirement in order to receive the adjustment.

5183 Medicaid Utilization Method

A hospital with high Medicaid utilization may qualify for a disproportionate share hospital (DSH) adjustment. The DSH adjustment under this "Medicaid utilization method" is provided to hospitals in the Department's annual DRG rate update. A hospital's DSH adjustment is incorporated into the hospital's specific DRG base rate and ultimately into the payment a hospital receives for each Medicaid recipient's stay.

Statewide Amounts Calculated: The Department annually calculates a "Medicaid inpatient utilization rate" for each hospital in the state that receives Medicaid payments. This is M in the following formula. From the compilation of the individual hospital utilization rates, the statewide mean average and standard deviation from the mean are calculated. The mean rate <u>plus</u> the amount of one standard deviation is S in the following formula.

Qualifying Hospital Under Medicaid Utilization Method: A hospital qualifies for a DSH adjustment if its Medicaid inpatient utilization rate (M) is equal to or greater than the mean-plus-one-standard-deviation (S) and is at least 1%.

Hospital Specific Adjustment Calculated: A "DSH adjustment percentage" is calculated according to the following formula: for a hospital that qualifies under the Medicaid utilization method.

[(M minus S) x F] + 3% where M = Hospital's Medicaid inpatient utilization rate
S = Statewide mean-plus-one-standard-deviation
F = Proportional increase factor

This adjustment factor will be applied to either the DRG base rate or per diem rate, depending on the method of payment Medicaid uses for the eligible hospital type. The amount of the DSH add-on shall be limited by the.budgetary restrictions as outlined in sections 5184

Adjustment for Certain IMDs. The above 3% factor is increased to 11% for any hospital institution for mental disease (IMD) which qualifies for a disproportionate share hospital adjustment and has an average length of stay that exceeds 35 days for Wisconsin Medicaid recipients. Any days of a Medicaid recipient's stay that are covered in whole or part by Medicare are excluded from the calculation of the average length of stay. The average length of stay is based on the rate year that ended in the calendar year preceding the calendar year in which the current rate year begins. For example, for rates effective July 1, 2006, the base will be the rate year July 1, 2004 to June 30, 2005.

Medicaid Inpatient Utilization Rate. For purposes of the above calculation, the term "Medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for Medicaid, and the denominator of which is the total number of the hospital's inpatient days.

Medicaid inpatient days (the numerator) will include Medicaid HMO recipient days and recipient days of other states' Medicaid programs reported by a hospital.

Medical Assistance patient days in the numerator shall not include any days of inpatient stays which were covered in full or part by Medicare. Paid in full means the amount received by the hospital equals or exceeds the amount WMAP would have paid for the stay.

Some MA recipient stays, which are not covered in full or part by Medicare, may be paid fully or partially by a third party insurance payor and\or by a recipient's MA eligibility spend-down funds. If the hospital stay is paid in full, then the days of the recipient's stay will not be included in the numerator as an MA patient day. If the hospital is not paid in full and the WMAP reimburses the hospital for the unpaid balance, then all days of the stay will be included in the numerator as an MA patient day to the extent that the days of the stay were allowed by the WMAP.

Base Data For In-State Hospitals. For hospitals located in Wisconsin, the number of total inpatient days, MA inpatient days and MA HMO inpatient days will be from a hospital's most recent audited cost report available in the Health Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update.

Base Data For Major Border Status Hospitals. For major border status hospitals, the number of inpatient days shall be from the hospital's most recent audited cost report on file in HCRIS as of the January 1st prior to the annual rate update.

5184 Low-Income Utilization Method.

A hospital with a low-income utilization rate exceeding 25% may also qualify for a disproportionate share hospital adjustment. A hospital has to specifically request the Department to be considered under this method for a disproportionate share hospital adjustment. However, if a hospital qualifies for an adjustment under the Medicaid utilization method but requests an adjustment under the low-income method, the resulting lower adjustment percentage will be used. (See section 5246)

A hospital's "low income utilization rate" would be the sum of the following two percentages calculated as described below. The Department will designate the cost reporting period.

First Percentage. Total payments from Medicaid to the hospital and total county general assistance program payments to the hospital for inpatient and outpatient services plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient and outpatient services (including the amount of such cash subsidies) in the same cost reporting period. Revenues shall be net revenues after deducting bad debts, contractual allowances and discounts, that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross. Revenues shall also exclude recorded charges for charity care.

Second Percentage. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in a cost reporting period, less the portion of any cash subsidies described above in the period reasonably attributable to inpatient hospital services in the same period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period.

Charity Care. Charity care means health care a hospital provides to a patient who, after an investigation of the circumstances surrounding the patient's ability to pay, including nonqualification for a public program, is determined by the hospital to be unable to pay all or a portion of the hospital's normal billed charges. Charity care does not include any of the following: (1) care provided to patients for which a public program or public or private grant funds pay for any of the charges for the care; (2) contractual adjustments in the provision of health care services below normal billed charges; (3) differences between a hospital's charges and payments received for health care services provided to the hospital's employees, to public employees or to prisoners; (4) hospital charges associated with health care services for which a hospital reduces normal billed charges as a courtesy; or (5) bad debts. Bad debts means claims arising from rendering patient care services that the hospital, using a sound credit and collection policy, determines are uncollectible, but does not include charity care.

Adjustment Factors. The following table lists the disproportionate share adjustment factor for each threshold percentage of the low-income utilization method.

Low-Income Utilization Rate	*Adjustment Percentage*
25.0% through 43.99%	3.0%
44.0% through 62.99%	3.5%
63.0% through 81.99%	4.0%
82.0% & greater	4.5%

The Department has determined that a total of $100,000 (for all hospitals combined) will be available for the DSH rate-based hospital adjustments per rate year. The adjustment percentage to the hospital specific DRG base rate shall be proportionately reduced to comply with this DSH rate-based hospital budget. For example, if all DSH rate-based adjustments must be reduced by 10% to comply with the $100,000 limit, a 5% rate add-on will be reduced to a 4.5% rate add-on. This reduction to the rate add-on may result in rate adjustments that are less than 3%.

5185 Which Method Allowed.

A hospital will only be allowed an adjustment either under the Medicaid utilization method of §5183 or under the low-income utilization method of §5184. If the Department determines a hospital qualifies for a disproportionate share adjustment under the Medicaid utilization method but the hospital requests an adjustment under the low-income method, the method which provides the lower disproportionate share adjustment percentage shall be used.

5190 Payment Rates for New Acute Care, Children’s and Long Term Care Hospitals

The Department will establish payment rates for new acute care, children’s and long term care hospitals under a method other than that described above until cost reports are available for application of the above methodology.

5191 New Acute Care Hospital and Start-Up Period

The start-up period for a new acute care, children’s and long term care hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends when a full fiscal year Medicare audited cost report is available to the Department at time of rate calculation.

5192 Rates for Start-Up Period

New acute care, children’s and long term care hospitals are paid a statewide average "DRG payment rate adjusted by case mix.”. New Hospitals are eligible to receive an "outlier" payment for very high cost cases. The statewide average cost to charge ratio will be used in determining outlier payments during the start-up period. The statewide average cost to charge ratio will be calculated by summing the total cost of treating Wisconsin Medicaid patients in existing in-state acute care hospitals divided by total Medicaid charges associated with Wisconsin Medicaid patients in the rate year.

5200 OUTLIER PAYMENTS UNDER DRG PAYMENT SYSTEM

5210 General

An outlier payment to the hospital provides a measure of relief from the financial burden presented by extremely high cost cases. It is an amount paid on an individual stay in addition to the DRG payment.

Cost based outlier adjustments are provided.

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.

5220 Cost Outliers

5221 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 trimpoint applicable to the hospital. The applicable trimpoint will depend on the type and size of the hospital as follows:

	----- Trimpoint Amount -----	
Type of Hospital / Bed Size	Less than 100 Beds	100 Beds or Greater
General Medical & Surgical Hospitals	$ 5,235	$ 31,410
Critical Access Hospital	$300	

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 section 7000. Claims for chronic, stable ventilator-dependant hospital patients shall be reimbursed under the ventilator rate and, therefore, are not eligible for a cost outlier payment.

5222 Charges Adjusted-To-Cost.

For Wisconsin Hospitals. For a hospital located in Wisconsin, claim charges are adjusted to costs using the hospital's specific cost-to-charges ratio for WMAP inpatient services. The cost-to-charges ratio to be used will be from a hospital's most recent audited cost report available in the Hospital Cost Report Information System as of the January 1st prior to the annual rate update. For cost reports to be used for combining hospitals, see §5360.

For hospitals for which the Department does not have an audited cost report, the cost-to-charge ratio from the most recent unaudited cost report available to the Department will be used. This unaudited cost-to-charge ratio will be used until the Department receives an audited cost report.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average state-wide cost-to-charge ratio which is the ratio of the total state-wide inpatient hospital costs for WMAP services to the total charges for those services.

For Major Border Status Hospitals. For a border-status hospital, the Department shall determine a cost-to-charge ratio applicable to inpatient services provided Wisconsin Medicaid recipients by the hospital based on the hospital's most recent audited cost report available in the Hospital Cost Report Information System (HCRIS) as of the January 1st prior to the annual rate update. Cost reporting requirements are described in §4022. For cost reports to be used for combining hospitals, see §5360.

If an audited and an unaudited cost report is not available, then the cost-to-charge ratio to be used for the specific hospital will be the average Wisconsin state-wide cost-to-charge ratio which is the ratio of the total Wisconsin state-wide inpatient hospital costs for WMAP services to the total charges for those services. This statewide mean will be used until the Department acquires a cost report from which, if unaudited, the cost-to-charge ratio will be used until the Department gets an audited cost report.

5223 Outlier Payment Calculation.

Variable costs in excess of the DRG payment and the trimpoint will be paid. Following are the steps for calculation of an outlier payment. An example of a cost outlier calculation is presented in appendix section 21000.

1. Allowed claim charges are adjusted to cost by multiplying the charges by the hospital's Medicaid cost-to-charge ratio.

2. The allowed excess claim costs will be calculated by subtracting the case-mix adjusted DRG payment and the hospital's trimpoint from the claim costs. (Claim cost – case-mix adjusted DRG payment - Trimpoint = Excess cost, must be positive to qualify).

3. The outlier payment will be the result of multiplying the excess claim costs by the variable cost factor. The variable cost factors will be:

Type of Hospital	Variable Cost Factor
General Medical & Surgical Hospitals	77%
Major Border Status Hospitals	77%
Non-Border Status and Minor Borders Status Hospitals	77%
Critical Access Hospitals	100%

5224 Bed Count, Source and Changes.

The trimpoint amount for each hospital shall be established effective July 1 of the rate year based on the bed count on file with the Department's Division of Quality Assurance, as of January 1 of the preceding rate year.

If a hospital changes its bed count after January 1, any change in the trimpoint amount will not be effective until July 1 of the subsequent rate year.

5280 Cost Reports For Recent Hospital Combinings

A “hospital combining” is the result of 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. Data from the audited cost reports of each previous (i.e., before the combining) individual hospital will be combined to calculate the following components of the hospital payment rates which require the use of cost report data: the disproportionate share hospital adjustment and the cost-to-charge ratio used for outlier payments.. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used for the subsequent July 1 annual rate update.

5300 OTHER PROVISIONS RELATING TO DRG PAYMENTS

5310 Medically Unnecessary Stays, Defined

Medically unnecessary stays are those stays 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 EQRO review section below regarding criteria.)

5313 Authority For Recovery

The Department will recover payments previously made or deny payments for medically unnecessary hospital stays and/or inappropriate services based on determinations by the Department, the External Quality 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 WMAP recipients and payments made to providers of such services. Wisconsin statute, section 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.

5316 Review by External Quality Review Organization (EQRO)

The Department contracts with an **External Quality Review Organization (EQRO)** to review selected hospitalizations of WMAP recipients for medical necessity and appropriateness. The process to select those hospitalizations which are reviewed is approved by the Department. The EQRO review criteria are premised on objective clinical signs of patient illness and documentation that intensive hospital services were being provided. The EQRO review process represents a highly professional, clinically sound approach for assuring that hospital services are used only when medically necessary. EQRO criteria is approved by the federal Center for Medicare and Medicaid Services (CMS). The review criteria and periodic updates to it are disseminated to all hospitals in the state.

5319 EQRO Control Number

The hospital must contact the EQRO and acquire a unique case-specific control number from the EQRO for each of the following types of inpatient admissions:

- urgent/emergent admissions to hospital IMDs for recipients under 21 years of age,
- medical elective admissions, and
- admissions for ambulatory/outpatient procedures identified by the Department as needing control numbers.

Payment of inpatient claims for these admissions will be denied if the claims do not include the required case-specific control number from the EQRO.

5323 Inappropriate Inpatient Admission

Payment for inpatient care which could have been performed on an outpatient basis shall not exceed the facility's outpatient rate-per-visit paid under section 4.19B of the Medicaid Hospital State Plan. If payment has been made, the difference between the payment and the outpatient rate-per-visit will be recovered.

5326 Inappropriate Discharge And Readmission

If the EQRO determines that it was medically inappropriate for a patient to have been discharged from a hospital and as a result, that patient needed to be readmitted to a hospital, no payment will be made for the first discharge. If payment has been made, it will be recouped.

5329 Transfers

Patient transfers may be reviewed by the EQRO or the Department for medical necessity. If the transfer is determined to have been medically necessary, then both the transferring and the receiving hospital will be paid the full amount for the respective stay. 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.

5336 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 WMAP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-MR 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.

5339 DRG Validation Review

As part of the EQRO review process, the information provided on the hospital claim are verified with the medical record documentation. This review may determine that the DRG initially assigned to the hospital stay was inappropriate. The Department may adjust DRG payment pursuant to the result of EQRO reviews and recover any overpayment which has been made.

5343 IMD Hospital Transfers

An inpatient at an IMD may transfer to an acute care general 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.

5346 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.

5349 Obstetrical And Newborn Same Day Admission/Discharge
A hospital stay shall be considered an inpatient stay when a WMAP 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 is transferred to another hospital.

5353 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 cost reports will be used until the new owner's cost reports come due for use in the annual rate update.

5362 Provisions Relating to Organ Transplants
Prior Authorization and Criteria. In order for a hospital to receive payment for transplant services, the following criteria must apply:

a. The transplant must be performed at an institution approved by the WMAP for the type of transplant provided. A list of approved hospitals is available from the Department of Health Services, P. O. Box 309, Madison, WI 53701-0309.
b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.
c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization.

Organ Procurement. Organs must be obtained in compliance with the requirements of federal and state statute and regulations.

Transplant Log. Hospitals which perform organ transplants must maintain a log for every organ transplant performed for a WMAP recipient (except bone marrow) indicating the organ procurement organization or agency or source of the organ and all costs associated with procurement. A copy of this log must be submitted along with the transplant hospital's Medicaid cost report, so that the WMAP may document compliance.

5400 Reimbursement for Critical Access Hospitals

Definition: A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS, and is designated as a critical access hospital by the Department.

Critical access hospitals are reimbursed the lower of the hospital's allowable cost or charges for the services provided to Medicaid recipients.

If payments exceed costs, the Department will recover excess payments from the hospital.

If costs exceed interim payments, the Department will reimburse the hospital the amount by which a hospital's costs exceed payments.

The Department will calculate an interim discharge rate based on a hospital's most currently audited cost report. If no cost report is available, the best available data will be used to set an interim rate.

Interim reimbursement may be adjusted to minimize the expected amount of excess payments that will need to be recovered from a CAH or the amount of expected additional payments the Department will need to make to a CAH. A CAH may request an adjustment to its interim payments until a final cost settlement can be calculated. No more than two such adjustment requests will be recognized by the Department for any fiscal year of the hospital. Upon consultation with the Department, the hospital must provide the Department sufficient information so that the interim adjustment is a reasonable and reliable estimate of the final cost settlement. The Department may deny an adjustment that is not significant.

Total inpatient payments may not exceed charges as described in section 9000.

SECTION 6000
HOSPITALS PAID UNDER PER DIEM RATE

6100 COVERED HOSPITALS

Rehabilitation hospitals, state-operated IMD Hospitals and psychiatric hospitals will be paid under a rate per diem. Services described in section 7000 are exempted from reimbursement under this section if reimbursement is requested by and approved for the hospital according to section 7000.

6200 PAYMENT RATES FOR STATE, PRIVATE AND NON-STATE PUBLIC MENTAL HEALTH INSTITUTES

This section describes how hospital institutions for mental disease owned and operated by the State and psychiatric hospitals are reimbursed for services provided to Medicaid recipients. Reimbursement for inpatient hospital services will be a final reimbursement settlement for each hospital's fiscal year based on the hospital's allowable cost incurred in its fiscal year. All services provided during an inpatient stay, except professional services described in section 6480, will be considered inpatient hospital services for which payment is provided. Professional services described in section 6480 may be included in the final reimbursement settlement if a waiver or variance is approved under the procedures described in section 6258.

6210 Interim Rate Per Diem for State owned and Operated IMDs

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.

6220 Final Reimbursement Settlement for State owned and Operated IMDs

After a hospital completes each of its fiscal years, a final reimbursement settlement will be completed for Medicaid inpatient services provided during the year. The allowable costs a hospital incurred for providing Medicaid inpatient services during its fiscal year will be determined from the hospital's audited Medicaid 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 δ413.85. Covered education activities include those allowed under δ413.85 and approved residency programs, allowed under 42 CFR δ413.86, in medicine, osteopathy, dentistry and podiatry.

A disproportionate share hospital (DSH) adjustment will be determined according to section 5180 if the hospital meets the qualifying criteria of that section. The DSH adjustment percentage will be applied to the allowable cost of Medicaid inpatient services for the fiscal year to determine the hospital's DSH payment. To calculate the adjustment percentage, the formulae and related fixed variables of section 5180, that were in effect on the July 1 date in the hospital's fiscal year, will be applied to the patient utilization incurred by the hospital in its fiscal year.

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

(1) Total final reimbursement may not exceed charges according to section 9000.
(2) Compliance with the federal upper payment limit of 42 CFR δ447.272, 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.
(3) The hospital's disproportionate share payment may not exceed the limits of section 9100 which will be determined based on the hospital's fiscal year cost report used for the final settlement.
(4) Disproportionate share payment in the final reimbursement will be reduced, if necessary, to not exceed the State's limitations on aggregate payments for disproportionate share hospitals under 42 CFR 447.297.

If the total amount of final reimbursement, including DSH payment, for the hospital's fiscal year exceed 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, including DSH payment, is less than the total interim payments.

6230 Calculation of Per Diem Rates for All Other Psychiatric IMDs

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 most recently available audited Medicare cost report as of January 1st prior to the annual rate update . A cost per day will be calculated for routine inpatient services using Medicare and Medicaid cost principles. Medicaid ancillary costs will be apportioned by deriving cost to charge ratios for each ancillary service. The total ancillary Medicaid costs will be divided by total paid Medicaid days from the Medicaid Management Information System (MMIS) to calculate an ancillary Medicaid cost per day. The routine plus the ancillary cost per day will serve as the Medicaid prospective payment rate. The Medicaid cost per diem will be adjusted by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5180. 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.

6250 New All Other Psychiatric IMDs and Start-Up Period

The start-up period for a new psychiatric hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends when a full fiscal year Medicare audited cost report is available to the Department at time of rate calculation.

6260 Rates for Start-Up Period

The per diem rates to be paid during the start-up period shall be an average of the rates being paid to other psychiatric hospitals in the state, not including rates being paid to new psychiatric hospitals during a start-up period. The start-up rate being paid to a new psychiatric hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

In calculating the statewide average rate, any disproportionate share adjustments which are provided to the other psychiatric hospitals will not be included.

6300 CALCULATION METHODOLOGY FOR REHABILITATION HOSPITALS

6310 Calculation of Per Diem Rates for Established Rehabilitation Hospitals

The following is the methodology to be followed for calculating a per diem payment rate for rehabilitation hospitals which are not new rehabilitation hospitals.

1) The Medicaid allowable costs from the audited cost reports for the hospitals' three base cost reporting years shall be indexed to June 30th of the earliest year of the three years by the DRI/McGraw Hill, Inc. HCFA Hospital Market Basket inflation rate. The "three base cost reporting years" for a hospital shall be the hospital's fiscal years which ended in the second, third and fourth calendar years preceding the calendar year of each annual rate update (defined §3000). (For example, for a July 1, 2007 annual rate update, the three base cost reporting years are a hospital's fiscal years which ended in 2005, 2004 and 2003 with costs being indexed to June 30, 2003, the earliest year of the three base years.) If needed audited cost reports are not available prior to a new rate year in order to calculate the annual rate update, then an interim rate shall be established for the new rate year until the audited cost reports are available.
2) Divide the total direct medical education costs for the three years by the total hospital costs for the three years to get the average percentage of direct medical education costs.
3) Divide the total capital related costs for the three years by the total hospital costs for the three years to get the

average percentage of capital costs.

4) Multiply the total Medicaid allowable costs (step 1) by the percentage of direct medical education costs (step 2) to arrive at Medicaid direct education costs.
5) Multiply the total Medicaid allowable costs (step 1) by the percentage of capital costs (step 3) to arrive at Medicaid capital costs.
6) Subtract the Medicaid education costs (step 4) and the Medicaid capital cost (step 5) from the total Medicaid costs (step 1).
7) Multiply the Medicaid capital costs (step 5) by . 95.
8) Add the Medicaid costs (step 6), the Medicaid direct medical education costs (step 4) and the reduced capital cost (step 7). This is the total adjusted Medicaid costs.
9) Divide the adjusted Medicaid costs (step 8) by the total Medicaid days from the three audited cost reports to get an adjusted Medicaid cost per diem.
10) Index the adjusted Medicaid cost per diem by the legislatively authorized Medicaid hospital budget for the current rate year and increase the per diem by the disproportionate share adjustment factor if applicable. The disproportionate share adjustment factor will be determined pursuant to section 5240.

6320 Rates for New Rehabilitation Hospitals

The Department will establish payment rates for new rehabilitation hospitals under a method other than that described above until cost reports are available for application of the above methodology.

6322 New Rehabilitation Hospital and Start-Up Period

The start-up period for a new rehabilitation hospital begins the date the hospital admits its first WMAP recipient. The start-up period ends the June 30th date following completion of the hospitals fourth full (12 month) fiscal year after the fiscal year in which the first WMAP recipient was admitted. (For example, a hospital’s fiscal year ends each September. It admitted its firs WMAP recipient on March 10, 1994. Its fourth full fiscal year after the admission ends September 30, 1998. The next rate year begins July 1, 1999. Therefore, the hospital's start-up period is March 10, 1994 through June 30, 1999.)

6324 Rates for Start-Up Period

The rates per diem to be paid during the start-up period shall be an average of the rates being paid to other rehabilitation hospitals in the state, not including rates being paid new rehabilitation hospitals during a start-up period. If a rate being paid to a rehabilitation hospital is adjusted as is called for in step 1 of §6310, the statewide average rate will be recalculated. The start-up rate being paid to a new rehabilitation hospital will be adjusted prospectively based on the recalculated statewide average rate without a retroactive payment adjustment.

In calculating the statewide average rate, any disproportionate share adjustments which are provided to the other rehabilitation hospitals will not be included. The new hospital may request an 'administrative adjustment action' for disproportionate share adjustments to be applied to its start-up rates. Section 6328 below describes the criteria for the administrative adjustment action.

6326 Rates After Start-Up Period Ends

Rates will be established according to the methodology described in §6310 above after the start-up period ends. Two base cost reporting periods, not three as called for in step 1 of §6310, will be used for establishing rates for the initial rate year after the start-up period. (A rate year is July 1 to June 30.) For the subsequent rate years, three base cost reporting periods will be used as is specified in §6310.

6400 OTHER PROVISIONS RELATING TO PER DIEM RATE SYSTEM

6410 Medically Unnecessary Days, Defined (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 EQRO review section below regarding criteria.)

6413 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 WMAP recipients and payments made to providers of such services. Wisconsin statute, section 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.

6414 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

6416 Review by Wisconsin Professional Review Organization (EQRO). Section 5316 applies to hospitals under the per diem rate system.

6419 EQRO Control Numbers. Section 5319 applies to hospitals under the per diem rate system.

6423 Inappropriate Inpatient Admission. Section 5323 applies to hospitals having per diem rates.

6436 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 WMAP 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 WMAP. 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.

6443 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 general 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 WMAP for medically necessary stays.

6446 Outpatient Services Related to Inpatient Stay. Section 5346 applies to hospitals under the per diem rate system.

6453 Changes of Ownership. Section 5353 applies to hospitals under the per diem rate system.

6460 Cost Report Used For for Recent Hospital Combinings (Under Per Diem Rate System)
Hospital combinings result from in-state or major border status hospitals combining into one operation, under one WMAP 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. Data from the audited cost reports of each previous individual hospital will be combined to calculate any per diem rate which requires the use of audited cost reports. When an audited cost report for a full fiscal year of the combined operation becomes available to the Department, that cost report will be used in the subsequent July 1 annual rate update. Under section 11900, item S, the combined or absorbing hospital may request the administrative adjustment to have its payments retroactively adjusted based on its audited cost report when they become available.

6470 SERVICES COVERED BY PER DIEM RATE PAYMENTS UNDER SECTION 6000
All covered services provided during an inpatient stay, except professional services described in §6480, shall be considered hospital inpatient services for which per diem payment is provided under this section 6000. (Reference: Wis. Admin. Code, HFS 107.08(3) and (4))

6480 PROFESSIONAL SERVICES EXCLUDED FROM PER DIEM RATE PAYMENTS UNDER SECTION 6000
Certain professional and other services are not covered by the per diem payment rates under this section 6000. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the per diem payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

SECTION 7000
SERVICES EXEMPTED FROM THE DRG PAYMENT SYSTEM

7100 PAYMENT FOR ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

7110 AIDS Acute Care and AIDS Extended Care Rates of Payment. (Rates listed in §7900)

The current payment rates per diem for AIDS acute care and for AIDS extended care are listed in section 7900. These per diem rates apply for instate hospitals, major and minor border-status hospitals and non-border status hospitals.

Total payment is calculated as the sum of the acute care per diem times the number of approved acute care days plus the extended care per diem times the number of approved extended care days. Payment will not exceed total covered charges.

7150 Patient Criteria For Approval To Receive AIDS Rate of Payment

7150.2 Acute Care. Payment of the acute care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria apply:

a. The patient must have an established diagnosis of AIDS.
b. Clinical findings and other relevant medical information must substantiate the medical necessity and appropriateness of the hospitalization and its payment at the AIDS acute care rate.
c. Medical record documentation supporting the medical necessity and appropriateness of acute inpatient care must be submitted with the request for approval.

Approval for the acute care per diem is granted for a specified period of time. If the patient still meets the intensity and severity criteria for acute care, the provider must submit a subsequent request for extension of the payment approval.

7150.3 Extended Care. Payment of the extended care rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP. The request is to be submitted through the WMAP prior authorization (PA) process. The following criteria must be met:

a. The patient must have an established diagnosis of AIDS.
b. The patient must be medically stable per discharge indicators appropriate for the system involved.
c. The patient must require infection control procedures and isolation techniques.
d. Reasonable attempts at securing alternative living situations that allow for correct infection control procedures and isolation techniques must have been unsuccessful and an appropriate plan of care and discharge plan must have been established.
e. The degree of debilitation and amount of care required must equal or exceed the level of skilled nursing care provided in a nursing facility (NF).
f. Sufficient documentation supporting these criteria must be submitted with the request for approval.

Approval for the extended care rate is granted for a specified period of time, after which if the patient still meets the intensity and severity criteria for extended care, the provider must submit a subsequent request for extension of the payment approval.

The progression of illness may require acute care services during the period established for extended care. Therefore, during an "extended care" period, the acute care payment rate will be approved for payment after the hospital has provided an acute level of care for at least five days and the WMAP determines the above acute care criteria are met.

7160 No Outlier Payment and Administrative Adjustment.
AIDS cases paid under the per diem rate of this section do not qualify for outlier payments. AIDS reimbursement rates are not subject to administrative adjustment.

7170 If AIDS Exemption Discontinued
In the event that the AIDS payment rate is discontinued, the Department is obligated to pay for services at the latest rate adjusted annually for inflation until alternative placement for these patients can be found. The hospital will provide care to these patients at this latest rate until such time that an alternative placement can be found.

7200 PAYMENT FOR VENTILATOR-ASSISTED PATIENTS

7210 Rate of Payment (Rates listed in §7900)

The per diem payment rate for long-term ventilator services is listed in section 7900. Hospitals are required to bill at least on a monthly basis. This rate applies to instate hospitals, major and minor border-status hospitals and non-border status hospitals.

7250 Criteria For Approval To Receive Ventilator-Assistance Payment Rate

7250.2 Patient Criteria. Payment of the ventilator-assistance rate for a patient's hospital stay must be requested by the hospital and approved by the WMAP based on the following criteria. The request is to be submitted through the WMAP prior authorization (PA) process. If one or more of the following criteria are not met, payment of the ventilator-assistance rate may be approved by the WMAP if it is determined that payment of such rate to the hospital for the patient's stay is expected to be less costly than alternative ventilator assistance services.

a. The patient must have been hospitalized continuously in one or more hospitals for at least thirty consecutive days;
b. The ventilator-assisted patient must be in a medically stable condition requiring an inpatient level of care;
c. Attempts at weaning the patient from the ventilator are inappropriate or must have failed;
d. The ventilator-assisted patient must require ventilator assistance six or more hours per day;
e. Home care must be an unacceptable alternative because of financial/economic hardship or because of the lack of adequate support system; and
f. Nursing home placement must be inappropriate because of the high level or type of care required or non-availability.

7250.3 Dedicated Unit Provisions. If a hospital has a specialized nursing unit dedicated to the care of ventilator-assisted patients, the Department will allow the hospital to be reimbursed retroactive to the first day of the stay in the dedicated unit even if that date is prior to the date of approval for payment at the ventilator-assistance rate.

7250.4 Transfers. Hospitals will continue to be paid the ventilator rate when ventilator-assisted patients are transferred to acute care or intensive care units within the hospital for complications associated with their ventilator dependency. Hospitals will be paid the prospective DRG rate for transfers and/or admissions to acute care settings for medical problems unrelated to their ventilator dependency, provided the acute care stay lasts more than five days.

7270 Ventilator-Assistance Exemption Discontinued.

In the event that the Department discontinues the ventilator-assisted payment rate, the Department is obligated to pay for services at the most current rate adjusted annually for inflation until such time as an alternate placement for patients is found. The hospital will continue to provide care to these patients at this rate until alternative placement is found.

7400 NEGOTIATED PAYMENTS FOR UNUSUAL CASES

Notwithstanding other reimbursement provisions of this plan, the Department may allow an alternative payment for non-experimental inpatient hospital services if the WMAP determines that all of the following requirements are met:

1. The services are either:
   a. Necessary to prevent death of a recipient or
   b. Life threatening impairment of the health of a recipient or
   c. Grave and long lasting physical health impairment of a recipient or
   b. Cost effective compared to an alternative service or alternative services.
2. At the time this plan was submitted, the service(s) as proposed:
   a. Was not reasonably accessible for WMAP recipients; or
   b. Had not been a WMAP approved service provided for the particular purpose(s) intended; or
   c. Had not been a WMAP approved service provided under similar medical circumstances; or
   d. Required performance in the hospital which, given the circumstances of the recipient's case, is the only feasible provider or one of the only feasible providers known to the WMAP.
3. Existing payment methods are inadequate to ensure access to the services proposed for the recipient.
4. All applicable prior authorization requirements are met.

This §7400 applies to in-state hospitals, major and minor border status hospitals, and out-of-state hospitals not having border status. Alternative payments made under this provision shall be set on a case by case basis and shall not exceed the hospital's charges.

Requests for alternative payments under this provision are to be made to the: Office of the Administrator, Department of Health Services, 1 West Wilson Street, Suite 350, P.O. Box 309, Madison WI 53701-0309 (telephone 608-266-2522 or FAX 608-266-1096).

Requests must be submitted prior to admission, during the hospital stay or not later than 180 days after the WMAP recipient's discharge from the requesting hospital in order for an alternative payment to apply, at the discretion of the WMAP, beginning with the admission date (if applicable prior authorization requirements have been met to allow retroactive payment).

7500 BRAIN INJURY CARE

7520 In-State and Border-Status Hospitals. A per diem rate is provided for prior authorized care of MA recipients in a hospital's brain injury care program which has been approved by the WMAP. The hospital's brain injury care program must be approved by the WMAP and each recipient's participation in the program must be prior authorized by the WMAP. The criteria for approval of a program and for prior authorization of an MA recipient's participation in the program is available from the Department of Health Services (see address, section 100, page 1).

Periodic payment will be made to the hospital at the applicable rate per diem specified below. After completion of the hospital's fiscal year, total payments at the per diem rates in effect for brain injury care of prior authorized MA recipient services during its fiscal year will be determined. These total payments will be compared to the hospital's charges for the services and to the hospital's audited cost of providing the services. If the total payments exceed the total charges or the total costs, whichever is lesser, then the excess amount of payments will be recovered from the hospital.

The rates per diem for brain injury care programs for in-state and major and minor border status-hospitals are listed in section 7900. The WMAP may determine and approve additional rates for brain-injury care programs which provide significantly different services than are provided in the types of programs listed in section 7900.

7900 PAYMENT RATES FOR SERVICES EXEMPTED FROM DRG PAYMENT SYSTEM

These payment rates are established by applying the general payment rate increase provided by the state's biennial budget to the rate in effect for the prior rate year.

For Section	Services	Rate Per Diem Effective July 1, 1996	Effective July 1, 1997	Effective July 1, 1998
7100	AIDS Acute Care..	$ 570	$ 582	$ 597
7100	AIDS Extended Care..................................	$ 314	$ 321	$ 329
7200	Long-Term Ventilator Services...................	$ 444	$ 453	$ 465
7500	Brain Injury Care			
	Neurobehavioral Program Care.......	$ 780	$ 796	$ 816
	Coma-Recovery Program Care.......	$ 937	$ 957	$ 981

7990 SERVICES COVERED BY PAYMENT RATES IN SECTION 7900 ABOVE

All covered services provided during an inpatient stay, except professional services described in §7992, are considered hospital inpatient services for which payment is provided under the payment rates listed in section 7900 above. (Reference: Wis. Admin. Code, HS 107.08(3) and (4))

7992 PROFESSIONAL SERVICES EXCLUDED FROM PAYMENT RATES IN SECTION 7900 ABOVE

Certain professional and other services are not covered by the payment rates listed in section 7900 above. To be reimbursed by the Wisconsin Medicaid program, professional services must be billed by a separately certified provider and billed on a claim form other than the UB-92 hospital claim form. The following services are excluded from the above payment rates and may be billed separately when the professionals are functioning in a capacity listed below.

Physicians	Optometrists	Pharmacy, for take home drugs on the date of discharge
Psychiatrists	Hearing aid dealers	
Psychologists	Audiologists	Durable medical equipment and supplies for non-hospital use
Physician assistants	Podiatrists	
Nurse midwives	Independent nurse practitioners	Specialized medical vehicle transportation
Chiropractors	Anesthesia assistants	
Dentists	Certified registered nurse anesthetists	Air, water and land ambulance

SECTION 8000
FUNDING OF INPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS

8001 GENERAL INTRODUCTION

This is referred to as deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. This reimbursement is available for hospital fiscal years beginning on and after July 1, 2006 and is determined based on a hospital's cost report for its completed fiscal year.

8010 QUALIFYING CRITERIA

A hospital will qualify for deficit reduction funding if:

(a) The hospital is an acute care general hospital operated by the State or a local government in Wisconsin.

(b) It incurred a deficit from providing Medicaid inpatient services (described in §8020 below),

(c) The governmental unit that operates the hospital certifies it has expended public funds to fund the deficit.

8020 DEFICIT FROM PROVIDING MEDICAID INPATIENT SERVICES

The deficit from providing inpatient services to Wisconsin Medicaid recipients, that is, the Medicaid deficit, is the amount by which cost exceeds the payment for the Medicaid inpatient hospital services. The cost of Medicaid inpatient services is identified from the hospital's audited cost report for the hospital's fiscal year under consideration for the deficit reduction. Payment above refers to the total of the reimbursement provided under the provisions of section 5000 and sections 8200 to 8500 of this Attachment 4.19A of the State Plan for inpatient services for the respective fiscal year.

8025 INTERIM PAYMENT, INTERIM RECONCILIATION, AND THE FINAL RECONCILIATION

Wisconsin will identify the total amount of uncompensated Medicaid Fee-For-Service Inpatient (FFS) hospital costs as described in Section 8020 to determine interim Medicaid payments under this section until finalized hospital cost reports are available. For the payment year, the per diem costs for routine cost centers and cost to charge ratios for ancillary cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552), as filed with the Medicare Fiscal intermediary. The process for the Interim Medicaid Payment Calculation is as follows:

The following process is used to determine inpatient hospital costs:

Step 1

Total hospital costs are identified from Worksheet B Part I Column 27, line 25 through 58.02. Total hospital patient days for inpatient routine costs are identified from Worksheet S-3 Part I Column 6.

Step 2

The cost and total hospital patient days from Step 1 represent the total hospital costs and days for purposes of determining the cost to charge ratios for ancillary cost centers and a calculated per diem cost for routine cost centers.

Step 3

The hospital's total charges by cost center are identified from Worksheet C Part I Column 8.

Step 4

The total hospital charges are included on Worksheet C Part I Column 8 lines 25 through 58.02. Organ acquisition costs for organs transplanted to Medicaid recipients will be calculated by applying Worksheet D-6 cost data from the CMS 2552 form.

Step 5
The state will calculate a per diem for each routine cost center. For each inpatient routine cost center a per diem cost is calculated by dividing total hospital costs from Step 1, Worksheet B Part I Column 27, line 25 through 26.06, divided by total days identified in Step 1 Worksheet S-3 Part I Column 6, line 12 multiplied by Medicaid hospital FFS days identified from MMIS records for the most recent completed state fiscal year ending June 30. Long term care cost centers are excluded from this process. The A&P routine per diem, in accordance with CMS-2552 worksheet D-1, 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 state 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 2 by the total hospital charges from Step 4.

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

Step 6

To determine the inpatient hospital routine and ancillary cost center costs for the payment year, the hospital's projected Medicaid FFS inpatient charges by cost center are used. To project Medicaid hospital FFS charges as accurately as possible for the payment year, the projection will be based upon the hospital's actual experience of Medicaid FFS inpatient charges for the most recent 6-month period. The projected charges are multiplied by the CMS Hospital Market Basket inflation rate published by DRI. 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 Medicaid hospital FFS inpatient days to determine the Medicaid FFS inpatient costs for each routine service cost center.

Step 7

The Medicaid hospital FFS costs eligible to be reimbursed under this section are determined by adding the Medicaid FFS inpatient costs from Step 6, and subtracting estimated Medicaid FFS inpatient payments. The payment estimate will be based on the hospital's Medicaid FFS payment experience for the most recent 6-month period.

Final Reconciliation

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare fiscal intermediary, reconciliation of the finalized amounts will be completed, including use of the Worksheet D apportionment process. In the final reconciliation, Medicaid FFS cost is computed using the methodology as prescribed by the CMS-2552 Worksheet D series including 1) computing a per diem for each routine cost center and applying the applicable Medicaid 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 Medicaid 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 excepted for Medicaid.

8030 LIMITATIONS ON THE AMOUNT OF DEFICIT REDUCTION FUNDING

The combined total of: (a) the deficit reduction funding, and (b) all other payments to the hospital for inpatient Medicaid services, will not exceed the hospital's total charges for the services for the settlement year. If necessary, the deficit reduction funding will be adjusted so the combined total payments do not exceed charges.

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP is available under federal upper-payment limits at 42 CFR 447.272.

There can be no Medicaid fee-for-service deficit for inpatient hospital services used to calculate any Disproportionate Share Hospital (DSH) payment.

8035 PAYMENT IN EXCESS OF COST

If hospital payments exceed hospital costs, the financial gain from MA payments or payments for the uninsured will be applied against the unrecovered cost of uninsured patients/MA shortfall.

SECTION 8200
SUPPLEMENTAL DISPROPORITONATE SHARE HOSPITAL PAYMENTS FOR ESSENTIAL ACCESS CITY HOSPITALS (EACH)

The special payments described in this section 8200, specifically subsections 8210 through 8230, are disproportionate share hospital payments provided in accord with the federal Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923.

Supplemental disproportionate share hospital payments are provided for any hospital located in Wisconsin which meets the following criteria for an "essential access city hospital" (EACH).

8210 Qualifying Criteria for EACH Disproportionate Share Hospital Supplement

A hospital qualifies for an EACH supplement in the current rate year if in the current rate year the hospital qualifies for a disproportionate share hospital adjustment under section 8200 and if the hospital met the following criteria during the year July 1, 1995 through June 30, 1996.

1) The hospital is located in the inner city of a city of the first class in Wisconsin as identified by the following U.S. Postal Service Zip Code areas. As of July 1, 1997, the following contiguous U.S. Postal Service Zip Code areas identify one inner city area covered by this supplement: 53202, 53203, 53205, 53206, 53208, 53209, 53210, 53212, 53216 and 53233.
2) At least 30% of the hospital's Medicaid recipient inpatient stays are for Medicaid recipients who reside in an inner city zip code area listed above.
3) More than 30% of the hospital's total inpatient days are Medicaid covered inpatient days.
   (a) including Medicaid HMO covered days and Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as hospitalization insurance
   (b) but not including days of Medicaid recipients' stays that are covered in full or part by Medicare.
4) The hospital is an acute care general hospital providing medical and surgical, neonatal ICU, emergency and obstetrical services.

8215 Determination of EACH Disproportionate Share Hospital Supplement

The EACH supplement is paid in a prospectively established monthly amount based on the past Medicaid utilization of the hospital. The amount of a qualifying hospital's supplement is recalculated annually for the upcoming rate year. The total statewide funding for the EACH supplement is limited to $4,748,000 per rate year.. This amount is distributed proportionately among qualifying hospitals based on Medicaid inpatient days of the qualifying hospitals.

A qualifying hospital's EACH supplement will be determined as follows:

$$\text{Hospital's Annual EACH Supplement} = \frac{\text{Medicaid days for hospital}}{\text{Sum of Medicaid days of qualifying hospitals}} \times \text{Statewide Annual Funding}$$

Listed in Appendix 27100

The monthly amount is the above annual amount divided by 12 months.

Medicaid days are a hospital's total covered inpatient days for Medicaid recipients for the calendar year prior to the rate year for which the EACH supplement is being calculated. The days include Medicaid HMO covered days and Medicaid covered days on which Medicaid made no payment due to the days being covered by some other payer such as hospitalization insurance but do not include days of Medicaid recipient stays that are covered in full or part by Medicare.

<u>Sanction on Not Continuing To Meet Qualifying Criteria</u>
A hospital receiving an EACH supplement is expected to maintain its effort to serve MA recipients including recipients and residents in the inner city area. If the Department finds a hospital fails to meet the above qualifying criteria above for any three month period, then payment of the supplement will be discontinued for the hospital and payments made for the three month period will be recovered. If the hospital shows it subsequently meets the criteria for any three-month period, then the supplemental payment will be reinstated at, and retroactive payment made since, the beginning of the three-month period in which the criteria were again met. If any qualifying hospital is sanctioned in a rate year, the monthly supplement of other qualify hospitals will not be recalculated to redistribute the total annual funding for the EACH supplement.

SECTION 8500
Supplemental Payments

Supplemental payments are provided to acute care hospitals located in Wisconsin which provide a significant amount of services to specialty populations. The payments will be subject to the payment limitation of section 9000 by which the total of the overall payments to an individual hospital during the rate year may not exceed the hospital's total charges for the covered services.

8510 Qualifying Criteria for Pediatric Inpatient Supplement

A hospital qualifies for this pediatric supplement if the hospital meets the following criteria.

1) The hospital is an acute care hospital located in Wisconsin.
2) During the hospital's fiscal year described here, inpatient days in the hospital's acute care pediatric units and intensive care pediatric units of the licensed facility totaled more than 12,000 days. Days for stays in neonatal intensive care units are not included in this determination. The inpatient days are counted for the hospital's fiscal year that ended in the second calendar year preceding the beginning of the rate year. For example, for the rate year beginning July 1, 1998, the hospital's fiscal year that ended in 1996 is used.

8515 Determination of Pediatric Inpatient Supplemental Payment

The pediatric inpatient supplement is paid as a monthly amount established according to the following method. A total of $2,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of Medicaid pediatric days as described below.

A qualifying hospital's pediatric inpatient supplement will be determined as follows:

$$\text{Hospital's annual pediatric supplement} = \frac{\text{Medicaid pediatric days for hospital}}{} \times \text{\$2,000,000 Statewide}$$

Sum of Medicaid pediatric days of all qualifying hospitals   annual funding

$$\text{Hospital's monthly pediatric supplement} = \frac{\text{Hospital's annual pediatric supplement}}{\text{12 Months}}$$

Medicaid pediatric days for the above calculation are a hospital's total covered inpatient days for pediatric Medicaid recipients, including HMO covered pediatric Medicaid recipients, for patient discharges occurring in the rate year that began two years prior to the beginning of the current rate year. (For example, for a current rate year beginning July 1, 1998 the rate year July 1, 1996 through June 30, 1997 is used.) A pediatric patient is a patient that has not attained 18 years of age as of the day of admission. Medicaid pediatric days <u>do not include: (a)</u> days of Medicaid recipient stays that are covered in full or part by Medicare; and (b) days of Medicaid covered stays on which Medicaid made no payment due to the stay being covered by some other payer such as private hospitalization insurance.

8520 Inpatient Access Payments

To promote WMP member access to acute care, children's and rehabilitation hospitals throughout Wisconsin, WMP will provide a hospital access payment amount per inpatient discharge. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per discharge are not differentiated by hospital based on acuity or individual hospital cost.

The amount of the hospital access payment per visit is based on an available funding pool appropriated in the state budget and aggregate hospital upper payment limites (UPL). This amount of funding is divided by the estimated number of paid outpatient visits for the fiscal year. This payment per discharge will be in addition to the base DRG and per diem payments for Wisconsin acute care, children's and rehabilitation hospitals. Access payments per discharge are only provided until the fee-for-service hospital access payment budget has been expended for the rate year.

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

SECTION 9000
PAYMENT NOT TO EXCEED CHARGES

The total of the overall payments to an individual hospital from all sources during the period of the state fiscal year may not exceed allowable charges-plus-disproportionate share, in aggregate, for inpatient hospital services provided to WMAP recipients. Overall payments from all sources includes, but are not necessarily limited to, WMAP payments, recipient co-payments, third party liability payments, local and related matching FFP amounts under §8000 and the indigent care allowance of §8230. The state fiscal year is July 1 through June 30. Disproportionate share (under sections 5180 and 8250) in the WMAP payment rates will be added to the allowable charges.

If an individual hospital's overall payments for the period exceed charges-plus-disproportionate share, the WMAP will recoup payments in excess of charges-plus-disproportionate share.

SECTION 9100
LIMIT ON AMOUNT OF DISPROPORTIONATE SHARE PAYMENT TO A HOSPITAL

A hospital's disproportionate share payments during its fiscal year may not exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients. The amount of disproportionate share payments which exceed this limit shall be determined retrospectively after a hospital completes its fiscal year. (Statutory Background. Section 1923(g) of the federal Social Security Act.)

Payment Shortfall for MA Recipient Services. The payment shortfall for MA recipient services is the amount by which the costs of inpatient and outpatient services provided MA recipients <u>exceed</u> the payments made to the hospital for those service excluding disproportionate share hospital payments. Disproportionate share hospital payments are payments provided a hospital under the State of Wisconsin Medicaid State Plan according to the provisions of the Social Security Act, Section 1902(a)(13)(A)(iv) and Section 1923. If payments exceed costs, the financial gain from MA payments will be applied against the uncompensated care costs for the uninsured.

The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department. Services provided MA recipients covered by an HMO under the WMAP will be included.
For outpatient MA services, interim outpatient payments limited to charges for the hospital's fiscal year will be used. For inpatient MA services, payments limited to charges will be also used. Payments limited to charges will be the lesser of (a) charges made by the hospital during its fiscal year for MA services, or (b) overall payments from all sources (as defined in §9000) for MA services during its fiscal year, excluding disproportionate share payments. This charge limit will be applied separately to payments for inpatient services and payments for outpatient services for the period of the hospital's fiscal year.

Unrecovered Cost of Uninsured Patients. The unrecovered cost of uninsured patients is the amount by which the costs of inpatient and outpatient services provided to uninsured patients exceed any cash payments made by them. However, as provided in the Social Security Act, Section 1923(g)(1)(A), “For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government with a State shall not be considered to be a source of third party payment.”

If payments exceed costs, the financial gain from payments for the uninsured will be applied against the MA shortfall. An uninsured patient is an individual who has no health insurance or source of third party payment for the services provided by the hospital. The cost will be established by multiplying charges for inpatient and outpatient services by a ratio of costs to charges for patient care services. The ratio will be determined from the most current audited Medicaid cost report on file with the Department.

Recovery of Excess Disproportionate Share Payments. If total disproportionate share payments to the hospital for services provided during its fiscal year exceed the sum of the payment shortfall for MA recipient services and the unrecovered cost of uninsured patients, then the excess disproportionate share payments will be recovered from the hospital.

Effective Date. This limitation applies only to hospitals owned or operated by a State or by a unit of local government beginning July 1, 1994. With respect to hospitals that are not owned or operated by a State or unit of local government, this limitation applies beginning July 1, 1995 unless the federal Department of Health and Human Services exempts such hospitals or modifies the limitation for them.

For hospitals with fiscal years in progress (not beginning) on July 1, 1994 (or July 1, 1995 if applicable), the MA shortfall and the unrecovered cost of uninsured for the fiscal year will be prorated between the period before July 1 and the period on and after July 1 based on the proportion of disproportionate share payments applicable to each period.

SECTION 10000
PAYMENT FOR SERVICES PROVIDED IN HOSPITALS OUT-OF-STATE

HOSPITALS NOT HAVING BORDER-STATUS AND MINOR BORDER STATUS HOSPITALS

10100 INTRODUCTION

Minor border status hospitals and out-of-state hospitals which do not have border status will be paid according to the DRG based payment system described in this section 10000. This payment system provides a single base DRG base rate for all minor border status and non-border status hospitals. This rate is applied to the DRG weights which have been developed for use under section 5000 for in-state hospitals and major border status hospitals. The rates do not consider hospital-specific costs or characteristics as is done for in-state and major border status hospitals.

For any out-of-state hospital, border status or not, certain services will not be reimbursed according to the DRG methodology if the hospital takes the necessary action to receive reimbursement under an available alternative payment. These services and their alternative payment method are described in section 7000 and include AIDS care, ventilator patient care, special unusual cases and brain injury care.

For questions and additional information, out-of-state hospitals may contact the Department at: Department of Health Services, P.O. Box 309, Madison, Wisconsin 53701-0309; telephone (608) 261-7838.

Any pre-established standard payment amounts which are described below and the DRG weighting factors for the current state fiscal year, July 1 through June 30 may be requested from the above address.

10200 DRG BASED PAYMENT SYSTEM
(For Minor Border Status and Non-Border Status Hospitals)

10210 Base DRG Rate

The base DRG rate for all minor border status and non-border status hospitals shall be the standard DRG group rate which is determined under section 5151 for the hospital grouping entitled "acute care hospitals." There is no further adjustment for wage area, capital, medical education, DSH or rural hospital.

10230 Cost Outliers

Minor border status hospitals and non-border status hospital claims may qualify for cost outlier claims as described in Section 5200.

10300 PAYMENT NOT TO EXCEED CHARGES

For out-of-state hospitals not having border-status, payment on each discharge may not exceed the hospital's charges for allowable services. This limit applies to discharges paid under the DRG based payment system and to payment for services exempt from the DRG payment system.

For minor border-status hospitals, payments are limited to charges according to the method described in section 9000. This method limits aggregate annual payments to charges, not by individual claims.

10400 CORRECTION OF A RATE CALCULATION ERROR

The Department provides a mechanism through which a hospital may receive review of its inpatient reimbursement in case of a calculation error. This mechanism is described below:.
Qualifying Determination: The payment rate or final settlement must have been inappropriately calculated under the rate setting plan.

(a) The application of the rate setting methodology or standards was applied to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or

(b) A clerical error in calculating the hospital's payment rate, or

(c) Incorrect or incomplete application by the Department of provisions of the reimbursement methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment.

Hospitals may appeal the accuracy of their rate calculation under this section within 60 days of the date of their rate notification letter. If the appeal results in a new rate determination, the rate will apply to all claims with dates of service in the rate year. The Department at its own discretion may recalculate a hospital rate at any time during the rate year if the Department identifies a rate calculation error.

APPENDIX SECTION 21000

EXAMPLE CALCULATION – State of Wisconsin Acute Care Hospital (over 100 beds)
COST OUTLIER PAYMENT

BASE DATA

APPROVED BEDS		250
T-19 INPATIENT COSTS	(Cost Report Source: Worksheet E-3 part III line 1)..	$2,669,763
T-19 INPATIENT CHARGES	(Cost Report Source: Worksheet E-3 part III line 21) Divide by	$4,348,653
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS		= 0.6139
	(Ratio of T-19 inpatient costs to T-19 inpatient charges)	

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges	$ 123,550
2.	Cost-to-charge ratio (see above)	X .6139
3.	Claim charges adjusted to cost	$ 75,847.35
4.	DRG Payment	($ 18,419.91)
5.	Claim cost exceeding DRG payment	$ 57,427.44
6.	Applicable trimpoint for hospital bed size (Trimpoints applicable to current rate year are listed in section 5320.1.)	($ 31,410.00)

7. Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?
   _x_ Yes - Continue at Line 8
   ___ No - No outlier payment in addition to DRG payment

8.	Claim cost exceeding DRG payment and trimpoint =	$ 26,017.44
9.	Disproportionate share adjustment percentage (Note A) . X 1.043	
10.	Adjusted variable cost factor	X 1.043
11.	OUTLIER PAYMENT	= $ 27,136.19
12.	DRG PAYMENT	+ $ 18,419.91
13.	TOTAL PAYMENT FOR CLAIM including outlier payment	**$ 45,556.10**

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used.

For Line 4 above, example calculation of base DRG payment.

	Total
Hospital-Specific Base Rate	$ 6,540
Times: DRG Weight for stay	2.8165
Basic DRG Payment	$ 18,419.91

APPENDIX SECTION 21000

EXAMPLE CALCULATION – MAJOR BORDER STATUS HOSPITAL (over 100 beds)
COST OUTLIER PAYMENT
Pursuant to Section 5220

BASE DATA

APPROVED BEDS	142
T-19 INPATIENT COSTS (Cost Report Source: Worksheet E-3 part III line 1)..	$ 663,287
T-19 INPATIENT CHARGES (Cost Report Source: Worksheet E-3 part III line 21) Divide by	$1,036,753
COST-TO-CHARGE RATIO FOR OUTLIER CALCULATIONS	= 0.6397
(Ratio of T-19 inpatient costs to T-19 inpatient charges)	

EXAMPLE CALCULATION OF COST OUTLIER PAYMENT

1.	Allowable claim charges		$ 113,982
2.	Cost-to-charge ratio (see above)		X .6397
3.	Claim charges adjusted to cost		$ 72,914.29
4.	DRG Payment		($ 5,160.95)
5.	Claim cost exceeding DRG payment		$ 67,753.34
6.	Applicable trimpoint for hospital bed size		($ 31,410.00)
	(Trimpoints applicable to current rate year are listed in section 5320.1.)		

7. Decision: Does Line 5 -exceed- Hospitals Trimpoint at Line 6?
_x_ Yes - Continue at Line 8
___ No - No outlier payment in addition to DRG payment

8.	Claim cost exceeding DRG payment and trimpoint	=	$ 36,343.34
9.	Variable cost factor	.77	
10.	Disproportionate share adjustment percentage (Note A) .	X 1	
11.	Adjusted variable cost factor		X .77
12.	OUTLIER PAYMENT	=	$ 27,984.37
13.	DRG PAYMENT	+	$ 5,160.95
14.	TOTAL PAYMENT FOR CLAIM including outlier payment		**$ 33,145.32**

Note A -- If no disproportionate share adjustment applies to hospital, then a 1.00 multiplier is used

For Line 4 above, example calculation of base DRG payment.

	Total
Hospital-Specific Base Rate	$ 4,430
Times: DRG Weight for stay	1.1650
Basic DRG Payment	$ 5,160.95

APPENDIX SECTION 22000
DISPROPORTIONATE SHARE ADJUSTMENT AMOUNTS

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A hospital's disproportionate share adjustment factor under section 5180 is calculated according to the following formula where:

S % = Medicaid inpatient utilization rate at one standard deviation above the statewide mean Medicaid utilization rate.

M = The hospital's Medicaid inpatient utilization rate for hospitals with a utilization rate greater than S%.

.26 = Linear slope factor allowing proportional increase in disproportionate share adjustment as utilization rate (M) increases.

Formula:

[(M -S%) X .26] + 3% = Hospital's Specific Disproportionate Share Adjustment Percentage for section 5180

FOR SECTION 8200, THE ESSENTIAL ACCESS CITY HOSPITAL (EACH) DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT

Annual Statewide Funding

The annual statewide funding for the essential access city hospital (EACH) disproportionate share hospital adjustment is $4,748,000.

APPENDIX SECTION 25000

RURAL HOSPITAL ADJUSTMENT PERCENTAGES PURSUANT TO SECTION 5170

The following table lists the the rural hospital adjustment percentages that are applied under section 5170. The rural hospital adjustment percentage is that percentage corresponding to the range of utilization percentages in which the individual hospital's Medicaid utilization rate falls. For example, a Medicaid utilization rate of 7.34% falls in the "5.0% through 9.99%" range that has a corresponding 11% rural hospital percentage. Similarly, a 11.23% utilization rate corresponds to a 17% rural hospital percentage.

EFFECTIVE ON and AFTER JULY 1, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%..................................	5.00%
5.0% through 9.99%...............................	11.00%
10.0% through 14.99%...........................	17.00%
15.0% and greater.................................	23.00%

EFFECTIVE JULY 1, 2000 THROUGH JUNE 30, 2001

Medicaid Utilization Rate	Rural Hospital Adjustment Percentage
Up through 4.99%..................................	8.00%
5.0% through 9.99%...............................	17.00%
10.0% through 14.99%...........................	26.00%
15.0% and greater.................................	35.00%