Wisconsin Medicaid

Methods of Implementation for Nursing Home Payment Rates

for July 1, 2023 through June 30, 2024

Division of Medicaid Services
8/10/2023

1.00 Table of Contents

1.00 Table of Contents ii

1.00 Introduction & Rate-Setting Procedures 1

1.01 Definitions 1

1.10 Cost Reporting 2

1.20 Cost Allowability 2

1.30 Penalties for Overdue Cost Reports, Supplemental Information and/or Licensed Bed Assessments 3

1.40 Records Retention 3

1.50 Related Parties 3

1.60 Restricted Use Beds 3

1.70 Interim rates 4

2.00 Direct Care 4

2.10 Direct Care Allowance Calculation 4

2.20 Direct Care Nursing Services 5

2.30 Direct Care – Other Supplies and Services 7

2.40 Case Mix Indices (CMI) 8

2.50 Cost Report Inflation and Deflation Factors 9

3.00 Support Services 10

3.10 Support Services Allowance Calculation 10

3.20 Support Services Allowance Description 10

3.30 Cost Report Inflation and Deflation Factors 11

4.00 Property 11

4.10 Property Payment Allowance Calculation 11

4.20 Equalized Value 12

4.40 Changes of Ownership 13

4.50 Allowable Property-Related Expenses 14

5.00 Property Tax 16

5.10 Property Tax Allowance Calculation 16

5.20 Tax-Exempt Facilities 16

5.30 Property Tax Changes 16

5.40 Property Tax Inflation Factor 17

6.00 Provider Incentives 17
6.10 Exceptional Medicaid Utilization Incentive (EMUI) 17
6.20 Private Room Incentive 17
6.30 Innovative Area Incentive 17
6.40 Bariatric Equipment Incentive 18
6.50 Behavioral/Cognitive Impairment (Beh/CI) Incentives 18
6.60 Medicaid Access Incentive (MAI) 20
6.70 Small Facility Incentive 20
7.00 Other Payment Calculations 20
7.01 Ventilator Dependent Residents 20
7.02 Traumatic Brain Injury Residents 20
7.03 Isolation Rate 20
7.04 Appraisal Payments 21
7.10 State and Tribal Owned or Operated Facilities 21
7.20 Supplemental Payments for Facilities Operated by Local Units of Government 21
7.30 Specialized Psychiatric Rehabilitative Services (SPRS) 22
7.40 Medical Transportation 22
7.50 Out-of-State Nursing Facilities 22
7.60 Purchased Relocation Services 22
7.70 Payment for Services Provided During Temporary Evacuation 23
7.80 Bedhold 23
8.00 Cost report audit and rate finalization process 24
8.01 Official cost report submission and audit correspondence system 24
8.02 Exceptions limited 24
8.03 Documentation requirements 24
8.04 Completeness review 24
8.10 Desk review 25
8.20 Initial rate letter notification 25
8.30 Contested adjustments 25
8.40 Administrative review 25
8.50 Material Adjustments 26
8.60 Rate finalization timelines 27
8.70 Circumstances Necessitating a Rate Recalculation 27
8.80 Recoupment of Overpayment 28

9.00 Attachment A – Desk Review Checklist Attestation 29

10.00 Attachment B – Desk Review Checklist..... 30

1.00 Introduction & Rate-Setting Procedures

These Methods establish Wisconsin Medicaid rate-setting procedures for nursing facilities (NFs) and intermediate care facilities for individuals with intellectual disabilities (ICFs-IID) for the period of July 1, 2023 – June 30, 2024 unless subsequently modified by separate state plan amendment, legislative action or court order. The Methods provides for payments which are divided into five major cost centers: Direct Care, Support Services, Property Tax, Property, and Provider Incentives.

1.01 Definitions

Active Treatment - an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

Auditor adjustment – any modification to reported costs by a DHS Medicaid auditor. An auditor adjustment does not include the re-classification of costs nor the re-reporting of costs from an initial cost report line to another.

CPI – The Consumer Price Index for all Urban Consumers (United States City average).

Facility – The term facility is used throughout this document to generally refer to either a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID). When information more specific to each facility type is presented, the abbreviations NF and ICF-IID are used.

Fifty Bed Facilities - Unless granted an exception in writing from the Department, to be considered a facility of 50 or fewer beds the total sum of beds from all SNF and ICF-IID licenses on the same or contiguous properties must be 50 or fewer.

IMD – An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or CMS. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

Medicaid Days - General references to Medicaid days in this plan refer only to Medicaid fee-for-service (FFS) residents. Only residents eligible for the Medicaid FFS benefit will receive payment under any provision of this plan.

Self-Insurance - Self-insurance is a means where a provider, directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs. The creation of a separate entity, trust or fund for insurance purposes does not eliminate the provider's ultimate insurance risk or liability. Payment of insurance premiums to an insurance company, in the business of offering insurance to the general public, where such premiums are the final liability of the provider regardless of the actual cost incurred by the insurance company does not constitute self-insurance.

1.10 Cost Reporting

All certified NFs and ICFs-IID must submit a Medicaid Nursing Home Cost Report (F-01812) prepared in accordance with the instructions. Revenue and expenses are to be reported on the accrual basis of accounting except government facilities may use the cash method of accounting. A distinct part ICF-IID must submit a combined cost report.

Cost Reports must be signed by an officer of the facility as well as the paid preparer, if one was used. Supplementary information about the facility and any related parties or prior owners of the facility must be made available on request. Cost reports and supporting documentation are due within four months of the close of a facility's cost reporting period. Supplemental information due dates will be set by regional facility auditors and will follow sections 8.10 and 8.20.

In general, a facility's cost reporting period shall be the provider's fiscal year ending in the calendar year prior to the effective date of the payment rates. For example, the provider's fiscal year ending in 2022 would be the base cost reporting period for rates effective 7/1/23, 10/1/23, etc. Payment rates may be based on alternative cost reporting periods at the discretion of the department. The SFY24 rate-setting period is based off 2022 cost reports.

Beginning July 1, 2023, providers may only submit their cost report, in whole or in part, up to 2 times for each cost reporting period. The cost report resubmissions under section 8.50 are included as one of the 2 submissions.

1.20 Cost Allowability

Allowable costs are limited to those necessary and proper for patient care, appropriate for developing and maintaining the operation of the facility, and obtained by a reasonably prudent buyer. Costs may be limited when the Department determines costs are excessive compared to prices paid by similar providers.

Not allowable costs include, but are not limited to:

- Forfeitures, civil money penalties, or other fines
- Bad debts, charity, or other courtesy allowances
- Estimated liabilities
- Legal fees, unless directly related to patient care
- Out-of-state travel expenses (including training, seminar, and convention fees), except to and from the facility's home office or within 100 miles of the Wisconsin border
- Taxes or assessments on licensed beds
- Losses on investments
- Costs attributable to the care of residents aged 21-64 at an IMD
- Accrued expenses not paid within 180 days of the end of the cost reporting period
    - These disallowed expenses are not allowable on any subsequent cost report without a department-granted exception
    - This provision does not apply to property tax payments
- Costs for separately billable services.

1.30 Penalties for Overdue Cost Reports, Supplemental Information and/or Licensed Bed Assessments

Payment rates will be reduced according to the following schedule if a provider does not submit cost reports, required supplementary information, pay the appraisal contractor, or pay the licensed bed assessment balances by the established due dates. Rates will be retroactively restored when the cost report, supplemental information is received, the appraiser is paid, or the licensed bed assessment balance is received.

Days Overdue	Payment Rate Reduction
1-30	25%
31-60	50%
61-90	75%
90+	100%

1.40 Records Retention

Providers must retain financial records including cost reports and supporting items in sufficient detail to substantiate costs claimed for a period of five years. These records must be made available to the Department at a location within Wisconsin within a reasonable time upon request.

1.50 Related Parties

A “related party” or “related organization” is an individual or organization related to a facility by either common ownership or control.

“Related to the facility” means that the facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies.

“Common ownership” exists when an individual or individuals possess significant ownership or equity in the facility and in the institution or organization serving the facility.

“Control” exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

The existence of an immediate family relationship creates a rebuttable presumption of relatedness.

For costs incurred through a related party transaction, allowable expenses shall be limited to the lesser of:

- The expense incurred by the related party which furnished the goods or services, or
- The price of comparable goods or services that could be purchased elsewhere.

1.60 Restricted Use Beds

In order to receive restricted use status, facilities must request and receive Department approval in writing before the effective date. Approvals will be made at the Department’s discretion, and only in one of the following circumstances:

- The facility demonstrates a remodeling contract is in place which will cause the bed area to be out of service.
- The facility has documented life safety code violations, with an approved plan of correction.
- The facility transfers beds from another facility, with plans to build space for those beds.

Approval of restricted use status is for 12 months, and may be extended for an additional six months if the facility requests such in writing and is able to demonstrate that the remodeling or construction is still in progress. No restricted use bed approvals will be extended beyond 18 months unless space for the restricted use beds is not available at the facility and construction of the additional space is in progress.

In limited and exceptional circumstances, the Department will consider applications for extended restricted use status of beds for a period of up to five years. The facility would be required to identify a specific need for extended approval which cannot otherwise be met by the normal approval process. All extended approvals will be subject to an annual written status update; a formal, one-year written notice before removing the beds from restricted use status; and a 10% annual return of restricted use beds (i.e., de-licensing each year of 10% of the number of beds that were originally placed in restricted use status). Extended restricted use bed approval is solely at the Department's discretion and is primarily intended to support long-range strategic planning and modernization, or facility remodeling efforts.

Approval of a restricted use request has no effect on prior or future licensed bed assessment balances. Providers are ineligible to request restricted use status if the relevant facility has any late licensed bed assessment due to the Department.

1.70 Interim rates

The Department shall set interim rates annually. The interim rates shall be based off submitted, unaudited cost reports submitted under 1.10. Providers do not have a review period for such rates. Providers cannot appeal or contest such rates.

2.00 Direct Care

2.10 Direct Care Allowance Calculation

The rate calculation will use the Patient Driven Payment Model (PDPM). The DD rate will be used for residents in ICFs-IID and for residents that require specialized services in nursing facilities. In addition to the acuity classification, all residents must meet the minimum definition for Limited Nursing Care in Wis. Admin. Code §DHS 132.13, or have a "nursing home level of care." For information on the process for establishing the need for nursing care with ForwardHealth, please see the Provider Handbook.

Direct care allowances (Direct Care Nursing and Direct Care Other) will be calculated separately for facilities certified as ICF-IID (or distinct part ICF-IID) and nursing facilities, as the targets and case mix weights for direct care services may differ. Separate direct care allowances will be calculated for each of the following rate classes: non-DD in-house residents, developmentally disabled (DD) residents, non-DD bedhold residents, and DD bedhold residents.

The facility's actual allowable direct care nursing service expenses for staff wages, fringe benefits, purchased services and supplies shall be inflated or deflated from the cost reporting period to the reimbursement period using the weights in Section 2.50. The sum of these inflated expenses is divided by total patient days to yield per day inflated expenses.

The Direct Care Nursing allowance calculation uses two case mix indices (CMI). The All-Resident PDPM Nursing CMI represents acuity of all residents during the cost reporting period. Facilities must submit claims with HIPPS codes reflecting the applicable PDPM Nursing Payment Group (NPG) classification of each Medicaid resident receiving care during the rate year.

The Inflation Adjusted Nursing Services Expense per patient day is divided by the All Resident CMI to produce the Case-Mix-Neutral Nursing Services Expense per patient day.

The Nursing Services Target is the product of Nursing Services Base (table below) and the Labor Region Factor. Beginning July 1, 2022, the Nursing Services Target for NFs will be set at 125% of the median inflation adjusted Case-Mix-Neutral Nursing Services Expense per patient day based on the cost reports used for setting rates for the given rate year.

The Case-Mix-Neutral Nursing Services Allowance is the lesser of the facility's Case-Mix-Neutral Nursing Services Expense per patient day or the Nursing Services Target. This calculation is done separately using the PDPM-Nursing CMIs and PDPM DCN base.

The Case-Mix-Neutral Other Supplies and Services Allowance is equal to the Other Direct Care Supplies and Services Base (table below).

Under PDPM, the Case-Mix-Neutral Nursing Services Allowance is multiplied by the NPG CMI represented by the 3rd digit of the HIPPS code on the resident-specific claim and summed with the Direct Care – Other Supplies and Services Base multiplied by the Non-Therapy Ancillary (NTA) CMI represented by the 4th digit of the HIPPS code on the resident-specific claim. The summation of the Direct Care – Nursing and Direct Care – Other Supplies and Services components is the total Direct Care allowance paid on the resident-specific claim line.

Effective July 1, 2023 – September 30, 2023

	NFs and ICFs-IID (PDPM)
Nursing Services Base	$137.45
Other Direct Care Supplies and Services Base	$16.95

Effective October 1, 2023 – June 30, 2024

	NFs and ICFs-IID (PDPM)
Nursing Services Base	$141.22
Other Direct Care Supplies and Services Base	$17.37

2.20 Direct Care Nursing Services

Direct Care Nursing Services shall include wages, fringe benefits, and purchased service expenses for registered nurses, nurse practitioners, licensed practical nurses, qualified intellectual disabilities personnel, certified nursing assistants, feeding assistants, nurse aide training and nurse aide training supplies. To be included as direct care, certified nursing assistants must be listed on the registry (unless they have enrolled but not yet completed the required instructional program) and feeding assistants must have completed the state training program. Nursing personnel who provide inservice training are

included. The expenses and hours for direct care nursing services not meeting the above requirements should be included in the cost center that most represents the task performed other than direct care.

2.21 Labor Factors

For each labor region, the labor factor is a three-year, rolling average of the preliminary factor from the most recent cost period and the final factors from the two immediately preceding rate periods.

Labor Region	Labor Factor	Counties
Rural Wisconsin	0.953	Adams, Ashland, Barron, Bayfield, Buffalo, Burnett, Clark, Crawford, Door, Florence, Forest, Grant, Green Lake, Iron, Jackson, Jefferson, Juneau, Lafayette, Langlade, Manitowoc, Marinette, Marquette, Menominee, Monroe, Oneida, Pepin, Polk, Portage, Price, Rusk, Sawyer, Shawano, Taylor, Trempealeau, Vilas, Vernon, Walworth, Washburn, Waupaca, Waushara, Wood
Minneapolis	1.177	Dunn, Pierce, Saint Croix
Duluth/Superior	1.058	Douglas
Eau Claire	0.952	Chippewa, Eau Claire
La Crosse	1.061	La Crosse
Wausau	1.048	Marathon, Lincoln
Madison	1.048	Columbia, Dane, Dodge, Green, Iowa, Richland, Rock, Sauk
Racine	0.996	Racine
Kenosha	1.074	Kenosha
Green Bay	0.979	Brown, Kewaunee, Oconto
Sheboygan	1.025	Sheboygan
Milwaukee	1.050	Milwaukee, Ozaukee, Washington, Waukesha
Appleton	1.000	Calumet, Outagamie
Oshkosh	0.950	Winnebago
Fond Du Lac	0.984	Fond du Lac

2.22 Fringe Benefits

Fringe benefits for staff are allocated to the same cost center as their wage category during the rate calculation. Unique fringe benefits (those provided to only a few employees) shall be reported as a salary or wage expense and not as a general fringe benefit. Bonuses that are associated with hours worked shall be reported in the same cost center as the employee's associated wages. The cost of employee meals as a fringe benefit will be $4.25 times the allowable employee meals, less the employee meal revenue. The net cost for employee meals shall not be less than zero.

Medical services (such as vaccinations and wellness screenings) provided to ongoing employees of the provider may be classified as fringe benefits. Medical services provided to applicants (such as pre-employment physicals or drug screenings) will be treated as a recruitment expense in the Support Services cost center.

2.23 Worker's Compensation

The allowed worker's compensation cost will be the lesser of the calculated amounts obtained from the Wisconsin Compensation Rating Bureau policy or allowable cost of a self-insurance plan. Expenses may need to be accrued on an estimated basis since subsequent audit may result in additional costs or

refunds for the cost reporting period. Allowed expense will be the amount accrued and paid within 75 days of the end of the cost report period. Any changes to previously estimated amounts that result in additional costs or refunds shall be reported as an addition or reduction of worker's compensation expense in the cost reporting period that they become known.

2.24 Self-Insurance Costs

The allowable expense for self-insurance plans is the actual claims paid during the cost reporting period. At the facility's option, accrual of pending claims may be made to the extent that such claims are paid within 75 days of the close of the cost reporting period. Such accrued claims may not be expensed in the following year's cost report. If a facility's self-insurance fund is managed by an independent (non-related) trustee, the fee paid to the trustee may be included in allowable self-insurance costs. If actuarial determinations are performed by an independent (non-related, non-employee) actuary, the fee paid to the actuary may be included in allowable self-insurance costs. Allowable self-insurance costs may also include the premium costs of re-insurance ("stop-loss") policies purchased from an unrelated company and any costs to administer the self-insurance plan. Allowable costs shall then be reduced for investment income. In order for investment income to remain in the self-insurance allowable cost determination, it must be separately identified and accounted for as related to the self- insurance plan. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

2.25 Inservice Training

The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to Nurse Aide Training and Competency Evaluation Programs (NAT/CEP) mandated by OBRA shall not be included as separate reimbursement is provided.

2.30 Direct Care – Other Supplies and Services

Direct Care – Other Supplies and Services shall include expenses for ward clerks, non-billable physician time, non-billable lab, radiology, pharmacy, PT/OT/Speech, Dental, psychiatric and respiratory services, active treatment, volunteer coordinators, social service personnel, recreation personnel, religious services and other special care personnel, as well as their supplies, including purchased laundry-diapers and underpads, catheter and irrigation supplies, and other medical supplies. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per Wis. Admin. Code Chapter DHS 107.

Direct Care – Other Supplies and Services shall also include expenses to provide certain over-the-counter drugs ordered by a physician. For information on what drugs are considered over-the-counter, please reference the Covered Over-the-Counter Drugs data table available on the Forward Health Portal. Costs for any such over-the-counter drugs are considered to be reimbursed in the facility's daily rate and not to be billed or paid for separately. The allowable expenses may include the average wholesale price of the drugs and any pharmacy dispensing costs. Pharmacy dispensing costs shall not exceed 50% of the pharmacy's average wholesale price of the drug.

2.31 Supplies and Equipment

Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS) reasonably associated with resident's personal living needs in normal and routine facility operations are to be provided to Medicaid members without charge to the patient, the patient's family, or other interested persons. Costs for any

such items are considered to be reimbursed in the facility's daily rate and not to be billed or paid for separately. See the Forward Health Provider Handbook for lists of covered items.

If a Medicaid member specifically requests a brand of a non-durable item which the facility does not routinely supply and for which there is no equivalent or close substitute brand routinely supplied, then the recipient will be expected to pay the actual cost of that item out of personal funds, after being informed in advance that there will be a charge for the item. However, if the non-durable item was ordered by a physician, the member cannot be charged (Wis. Admin. Code. § DHS 107.09(2)(b)).

Information regarding DME is contained in Wis. Admin. Code §DHS 107.24 and in the DME Provider Handbook.

2.40 Case Mix Indices (CMI)

The PDPM reimbursement system is resident specific. CMIs for the Nursing Payment Group (NPG) and Non Therapy Ancillary (NTA) payment group are established using the information available on MDS assessments active during the billing dates.

Eligible dates of service from the admission date, but preceding the assessment date, shall be assigned the PDPM values from the MDS established on the assessment date.

Non-DD bedhold residents are also included in the all-resident CMI. Medicaid residents receiving special payment under the traumatic brain injury rate will not be included in either the all resident or the Medicaid CMI.

Default CMIs, representative of HIPPS Code ZZZZZ and the lowest CMIs for each category, will be applied when applicable.

For cost allocation purposes, average all-resident Non-DD PDPM Nursing and NTA CMIs will be computed for quarters within the facility's cost reporting period and based upon the distribution of patient days by rate class provided in the cost report. These Non-DD CMIs will be blended with the statewide PDPM-Nursing and PDPM-NTA CMIs for other rate classes shown in Section 2.42, using the distribution of patient days reported on the cost report.

2.41 Review and Correction of Case Mix Indices

Facilities should correct HIPPS codes on claims by submitting revised claims. The Department will review HIPPS codes and MDS data to ensure that facilities are billing at the appropriate PDPM acuity levels. Cases of over-coding acuity scores may be subject to claims recoupment or referral to the Office of the Inspector General (OIG).

2.42 Case Mix Weights

Wisconsin Medicaid will apply the same CMIs as Medicare SNF PPS for the NPG and NTA components of PDPM. No durational factor will be applied. The NPG component CMI will be used for weighting the Direct Care – Nursing cost center. The NTA component CMI will be used for weighting the Direct Care – Other Supplies and Services cost center.

For the following special rate classifications, the below specific CMIs will be used in lieu of HIPPS-based pricing. The Department shall adjust the below weights and aforementioned Direct Care Nursing base, Direct Care Other base, and Support Services price, to reflect any impact pursuant to CMS down-ward revision of Medicare PPS. For SFY2024, the effective dates of the weights, bases, and prices are 7/1/23 and 10/1/23.

For dates of service 7/1/23 through 9/30/23:

Rate Classification	PDPM NPG Case Mix Weight	PDPM NTA Case Mix Weight
Non-DD Bedhold	0.31	0.22
DD	2.43	1.75
DD Bedhold	1.34	0.96
Ventilator	4.86	3.49
Hospice Room & Board (100%)	1.41	1.02

For dates of service 10/1/23 onward:

Rate Classification	PDPM NPG Case Mix Weight	PDPM NTA Case Mix Weight
Non-DD Bedhold	0.30	0.21
DD	2.36	1.71
DD Bedhold	1.30	0.94
Ventilator	4.73	3.40
Hospice Room & Board (100%)	1.37	0.99

Note: Hospices will be reimbursed at 95% of the rate calculated by the above CMI and may reimburse facilities for hospice room and board at a rate between 95% and 100%, per federal regulations.

2.43 Source of Case Mix Weights

All-resident case mix indices for the cost reporting period will be calculated based on data available as of June 30, 2023. PDPM dates of service will be priced using CMIs according to facility-submitted HIPPS codes and are subject to later adjustment if the Department's calculations materially differ.

2.50 Cost Report Inflation and Deflation Factors

The inflation factors used to adjust expenses from 2022 cost reports to the reimbursement period are listed below according to the ending month of the cost reporting period. The direct care wages factor for the final quarter is applied to the SPRS add-on and the TBI all-inclusive rate. The Department may establish alternate factors for periods not listed.

	January February March 2022	April May June 2022	July August September 2022	October November December 2022
Direct Care Wages	7.9%	7.3%	5%	3.4%
Direct Care Fringe Benefits	5.4%	4.8%	4.3%	3.5%
Direct Care Supplies/OTC Drugs	7.9%	4.8%	3.4%	2.7%
Direct Care Purchased Services	9.96%	7.4%	5.4%	4%

3.00 Support Services

3.10 Support Services Allowance Calculation

The support services allowance is a priced allowance set at 125% of the median inflation adjusted expense per patient day based on the cost reports used for setting rates for the given rate year.

The allowance for the current rate year is as follows and subject to the below per-facility reduction:

NF and ICF-IID	$157.73

If on a per-patient day basis, the sum of (CMI = 1) all rate components, excluding incentives, exceeds the sum of inflated expenses on a per-patient day basis (CMI = 1), then the difference will be subtracted from the support services per-diem component of the rate. Expenses for the purposes of this per-facility support services reduction are defined below.

1. Direct Care Nursing expenses shall be the Case-Mix-Neutral Nursing Services Expense per patient day as referenced in 2.10 of the methods, and as calculated and shown in the final rate calculation provided to the provider by the Department.

2. Direct Care Other expenses shall be the Inflated Expense PPD (per patient day) (Case Mix Neutral) as per 2.30 of the methods, and as shown in the final rate calculation provided to the provider by the Department.

3. Support services expenses shall be the sum of expenses for each of Dietary and Environmental; Administrative & General, and Fuel & Utilities, as per 3.20-3.23, and 3.30 of the methods, a per-patient day amount for the licensed bed assessment, and as shown in the final rate calculation provided to the provider by the Department.

4. Property Tax Expense shall be equivalent to the Property Tax Allowance Calculation per 5.10 of the methods and as shown in the final rate calculation provided to the provider by the Department.

5. Property Expense shall be equivalent to the Property Payment Allowance Calculation per 4.10 of the methods and as shown in the final rate calculation provided to the provider by the Department.

3.20 Support Services Allowance Description

The support services allowance covers allowable expenses for dietary, maintenance, housekeeping, laundry, security, transportation, administrative service, and fuel and utilities expenses. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses

which are directly related to providing the services and other allowable expenses which cannot be appropriately recognized in other cost centers.

Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative service expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses.

3.21 Home Office Cost Allocations

Administrative expenses allocated to the nursing facility from centralized administrative units shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

3.22 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted for unreasonable or unnecessary levels of service, compensation, or duplicative services.

3.23 Legal and Other Professional Fees

Legal and other professional fees incurred by a provider that are not directly related to patient care are not allowable.

Legal and other professional fees awarded to a provider as a result of an administrative appeal of any licensing/certification action by a state agency shall be allowed.

3.30 Cost Report Inflation and Deflation Factors

The inflation factors used to adjust expenses from cost reports to the reimbursement period are listed below according to the ending month of the cost reporting period. The Department may establish alternate factors for periods not listed.

	January February March 2022	April May June 2022	July August September 2022	October November December 2022
Support Services	8.4%	6.3%	3.8%	2.6%

4.00 Property

4.10 Property Payment Allowance Calculation

The property payment allowance will be a per patient day amount based on the equalized value of the nursing facility; target amounts established by the Department, and the nursing facility's allowable property-related expenses. If needed, the expenses and patient days reported shall be adjusted to a 365-day period. This allowance is intended to provide payment for ownership and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets.

Annualized allowable property expenses will be limited to 15% of the equalized value of the facility.

The property target is 7.5% of equalized value.

When the facility's allowable property-related expenses are greater than the target, the property payment allowance will be the target amount plus the cost share value (20%) times the amount by which allowable expenses exceed the target.

The intent of the property payment allowance is for Medicaid to pay no more than 9% of equalized value, before incentives. For this reason, the property payment allowance is used for the support services reduction described in 3.10.

4.11 Maximum Decrease

A facility's payable property allowance will not be reduced by more than $3.50 per patient day from the allowance in effect for the prior rate year. If the prior rate year's allowance was based on "start-up" occupancy provisions for newly-licensed or expanded facilities, the $3.50 maximum reduction is measured from the allowance which would have resulted from applying the Methods without those provisions on the last day of the prior rate year.

4.20 Equalized Value

The equalized value will be derived from the values determined by an independent appraisal contractor using the CoreLogic Building Valuation System (BVS). The values established by such contract will be indexed, if necessary, to the current rate year. The equalized value will be the Depreciated Replacement Cost (DRC) from the BVS valuation after adjustment for square footage allocations and the per bed maximum on equalized value.

The values derived from the BVS valuation will be adjusted to exclude the value of areas not related to skilled nursing facility patient care. To the extent possible, this adjustment will be based on the square footage used in the BVS valuation.

The Undepreciated Replacement Cost (URC) arrived at under the BVS valuation will be limited to not exceed $96,735 times the beds for rate setting. This amount was calculated by inflating $75,900 by the weighted average growth in equalized value for Wisconsin nursing homes and the growth in equalized value for residential property in Wisconsin as reported by the Department of Revenue. Where this maximum is exceeded, the equalized value will be adjusted proportionately. This amount shall be known as the URC per-bed limit.

Equalized value (EV) = (URC after adjustment for square footage and per bed limits / URC after adjustment for square footage but before per bed limits) * DRC after adjustment for square footage

For state fiscal year 2024 rates, the Department will apply an inflation factor of 14.95% to each facility's prior year URC and DRC in lieu of an updated BVS valuation. The Department may review exceptional circumstances on a case by case basis at its sole discretion.

4.40 Changes of Ownership

If a facility changes ownership, the new owner's costs will be reported in the following cost reporting period.

The asset value of nursing facilities acquired at a total cost of less than $101 shall be allowed at the lesser of fair market value or net book value of the owner last participating in the Medicaid program.

For facilities acquired at a price in excess of $101; the new owner's allowed costs will be the lesser of the purchase price or maximum allowed costs. The maximum allowed cost is the sellers annual asset acquisition costs by year(s) of acquisition times the lesser of one-half of the percentage increase, measured over the same period of time, in the Consumer Price Index (CPI) for All Urban Consumers (United States city average) or the Dodge Construction Index (DCI) applied from the year(s) of acquisition to the date of the sale. The year(s) of acquisition is/are the year(s) the assets were purchased or constructed by the seller.

If either the seller or the buyer cannot support the individual assets acquired, the historic asset acquisition cost(s) and/or the date(s) of asset acquisition, the following procedure will be followed to impute the maximum allowed costs:

1. The ending balance of the total capitalized historical cost of all depreciable assets, from the last available fiscal year cost report of the seller will be the base value.
2. The ending balance of accumulated depreciation of all depreciable assets, from the same cost reporting period, will be divided by the reported depreciation expense (annualized, if necessary) to impute average years of ownership.
3. The lesser percentage of CPI or DCI will be determined based on the imputed average years of ownership and applied to the base value of all assets acquired to calculate an initial maximum.
4. This initial maximum will be compared to 108% of the equalized value and the lesser value will be allowed as the maximum value related to all assets.

Where no cost report information is available, the maximum allowable value will be 108% of the equalized value.

If more than one nursing facility is purchased at the same time, the purchase price of all property related assets will be allocated proportionately to all purchased assets based upon an independent uniform appraisal method chosen by the purchasing provider.

The merger or the consolidation of a corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, constitutes change of ownership.

The costs of acquiring the rights to licensed beds from another provider are non-reimbursable.

If a facility's valuation is limited by a change of ownership to maximum allowed costs, the associated depreciation, amortization, and interest expenses will be limited by the ratio of allowed value to reported value.

4.41 Inadequate Documentation

If the provider, buyer, or seller is unable or unwilling to provide adequate documentation of acquisition cost, acquisition date or other data relevant to the property-related expenses, or does not comply with property documentation requests, secondary sources of information, such as income and property tax records will be used. The source chosen may result in the lowest value or the lowest property payment allowance.

4.50 Allowable Property-Related Expenses

Allowable property-related expenses include property and mortgage insurance, amortization of construction-related costs, amortization of bond discount and premium, interest on plant asset loans, depreciation, and lease and rental expenses. Costs associated with property that is not necessary for providing nursing home patient care is non-allowable. This includes property held for future use.

4.51 Property Insurance

Allowable property insurance expense will be the accrual-based expense from the base cost reporting period. This expense will be subject to allocations for revenue-producing areas and non-nursing facility areas. Allowable property insurance expense includes mortgage insurance required by the lender.

4.52 Amortization

Amortization of bond discounts and premiums are to be considered an element of interest expense. Letter of credit fees related to a letter of credit used only as collateral for obtaining long term financing shall be allowed.

4.53 Interest Expense

Interest expense on debt incurred for acquisition of land, land improvements, buildings, leasehold improvements, and fixed and movable equipment related to nursing facility patient care shall be allowed subject to the limitations that follow.

The order for cost finding adjustments for interest expense is;

1. Reclassification of expenses; only debt for asset purchases are reimbursed.
2. CPI limitation, applied if associated asset purchases are limited by a CPI factor for allowed value.
3. Allocations to non-nursing home areas.
4. 110% of Equalized Value limit for total loan balances.

4.53(a) Recognizable Debt Balances

Interest expense will not be allowed on the portion of debt balances which were disallowed or not allocated to the SNF due to a change in ownership.

Interest expense will only be recognized for allowable assets purchased in the same cost report period of loan acquisition and the following two cost report periods. Assets purchased in the second and third cost report periods may increase the maximum allowable financing.

Maximum allowable financing may not exceed 110% of Equalized Value.

4.53(b) Systematic Reduction of Debt

Allowable interest expense may not exceed the amount which would have been incurred under a systematic reduction of debt which has payments of interest and principal that are uniform over the total length of debt and a length not exceeding the remaining useful life of the longest lived asset acquired with debt proceeds.

If a facility does not make at least annual principal payments, the allowable interest expense will be limited by an amortization schedule calculation. The amortization schedule will be prepared for the period of the longest-lived asset acquired by the debt and use the interest rate as stated in the debt contract.

4.53(c) Refinancing Expenses

Refinancing fees and amounts borrowed for working capital will not be recognized as property costs.

The allowable interest expense for refinancing arrangements may not exceed the amount which would have been allowed on the recognizable debt balance, excluding financing fees, had the refinancing not occurred.

4.54 Depreciation

Depreciation expense must be calculated under a straight-line method over a useful life determined by the American Hospital Association guidelines, subject to the minimums below. Depreciation options available for income tax purposes, such as the Asset Depreciation Range System or the Additional First-Year Depreciation, may not be used. A composite useful life may be used for a class or group of assets.

For the initial construction of buildings, including fixed equipment and land improvements, the minimum useful life must be 35 years from the earlier of the date of initial licensure or the date of initial occupancy. A minimum useful life of 20 years will be applied to purchased facilities. A minimum useful life of 5 years will be applied to purchase of used moveable equipment. Remodeling of existing licensed facilities will be depreciated according to American Hospital Association guidelines for each of the individual components of the project.

Amortization of costs related to acquiring financing (i.e., bond issuance costs, bond placement fees, letter of credit fees, finder's fees, credit checks, origination fees, appraisal fees, feasibility studies, and loan application fees) are not considered property-related expenses but are allowable amortizable expenses under the support services cost center. Write off of the entire unamortized discount (premium) and unamortized fees associated with refinanced debt will be allowed as of the date of refinancing as recognized for cost reporting purposes.

4.55 Lease Expense

Leased facilities will be subject to a lease maximum. The property costs recognized will be the lower of actual payments made as required under the lease contract or the lease maximum. Lease expenses determined under the capitalized lease method will not be recognized.

Facilities leased for the first time will have their lease maximums determined by reference to the current owners' years of acquisition of the facility's fixed assets. If a facility is unable to provide adequate support of the dates of asset acquisition, average years of ownership may be imputed as they would be under a change of ownership Reference. The allowable property costs included in rates on the last day of the prior cost report period will be multiplied by the ratio below:

- If the current owner constructed the facility: Original costs adjusted by one-half CPI divided by original costs.
- If the current owner purchased the facility: Purchase price and capital additions adjusted by one-half CPI divided by the allowable purchase price plus capital additions in prior cost report period.

Facilities leased in previous cost report periods will have their lease maximums increased by one-half of the percentage change in the CPI.

New or replacement facilities will have a lease maximum of the lessor's allowable depreciation and interest for the new building, with the lessor's loan balance being limited to 110% of Equalized Value.

An unrelated party sale and lease back transaction will have a lease maximum determined by applying one-half the increase in the CPI from the year of the sale to the allowed reimbursable property expenses in the year before the sale for the assets that are now leased.

Lease maximums will not apply to depreciation, interest, lease and rental or other property costs on assets acquired after lease inception, such as the purchase or leasing of new equipment or leasehold improvements. The costs of acquiring existing leasehold rights are not allowable.

5.00 Property Tax

5.10 Property Tax Allowance Calculation

Allowable property tax expense is the tax due in the calendar year in which the rate year begins. For example, the 7/1/23 rate calculation will include the amount of the 2022 property tax bill increased by the inflation factor in Section 5.40.

Allowable property tax expense shall be net of any state property tax credit and any special assessments for capital improvements or additional fees or interest. Whenever exemptions to property tax are legally available, the provider is expected to pursue such exemptions or the expenses incurred shall not be allowed. Vacant land is non-allowable for reimbursement.

5.20 Tax-Exempt Facilities

The property tax allowance for tax-exempt providers includes municipal service fees or payments in lieu of property taxes made subject to an agreement with a taxing authority, as long as these fees are not intended for capital expenditures or utilities and otherwise mirror property taxes that would be charged a similarly situated for-profit provider.

5.30 Property Tax Changes

The property tax allowance shall not be adjusted to recognize a change in tax status upon a change of ownership until it is reported in the normal cost report period.

The provider may request the property tax allowance for a new facility or expanded facility to be adjusted if the expense in the previous tax allowance had been based on an assessment date prior to the month of licensure. The adjustment shall be effective January 1 of the year payment is due.

5.40 Property Tax Inflation Factor

Property tax inflation factor	0.7%

6.00 Provider Incentives

6.10 Exceptional Medicaid Utilization Incentive (EMUI)

Nursing facilities with exceptional Medicaid utilization not operated by a governmental entity may receive the Exceptional Medicaid Utilization Incentive (EMUI). The primary source of ownership information is the owner identified on the operating license issued by the Department as of the last day of the cost report period.

The incentive is calculated according to the Medicaid percentage, which is the facility's Medicaid FFS, Medicaid Hospice, and Managed Care Medicaid patient days divided by the facility's total patient days.

Min T19%	Max %	Incentive per patient day
50%	59%	$0.75
60%	69%	$1.49
70%	79%	$2.61
80%	89%	$4.10
90%	100%	$5.97

6.20 Private Room Incentive

Nursing facilities may receive a Private Room Incentive (PRI) by signing a cost report affidavit stating the facility will not charge Medicaid residents a surcharge for private rooms as allowed under DHS 107.09(4)(k) for the entire rate year. The affidavit must be received prior to the effective date of the incentive unless the Department approves otherwise.

The amount of the incentive is determined using the excess of the percentage of licensed beds in private rooms over the percentage of cost report patient days associated with non-Medicaid residents. This excess, if greater than zero, is divided by the percentage of cost report patient days associated with Medicaid residents and the result is multiplied by $1.50 per patient day.
For the purposes of calculating this incentive, Medicaid resident patient days include Medicaid Fee-For-Service, Medicaid Managed Care and Medicaid Hospice days.

6.30 Innovative Area Incentive

Nursing facilities may be eligible for the Innovative Area Incentive by requesting Department approval for improvement of the physical environment and the quality of resident life through renovation or replacement of the building. The facility must improve the physical plant and operations in which nursing care is provided in a manner that will not increase the overall cost to the Medicaid program. For details, please request an application packet from the Section Manager for Nursing Home Policy & Rate Setting.

Nursing facilities that have received approvals for the incentive will continue to receive the incentive according to the terms of their approval letter. The incentive does not transfer in the event of a change of ownership.

6.40 Bariatric Equipment Incentive

The bariatric equipment incentive covers specialized bariatric moveable equipment purchases during the cost report period. Rentals and lease purchase agreements will not be considered for this incentive. The incentive is calculated by the cost of the purchases in the cost reporting period divided by the total patient days to get the acquisition cost per day. The incentive is equal to 50% of the acquisition cost per day. The bariatric equipment must meet all normal cost reporting capitalization requirements. No options or attachments to the bariatric units will be allowed for the incentive. In situations of a short period cost report or where the same cost report is used for multiple payment periods, the calculation will only be allowed in one rate year as to not duplicate the incentive.

Allowable purchases for the incentive:

- Lifts identified for 400 lbs. or more
- Beds identified for 500 lbs. or more and 40" or greater in width
- Mattresses identified to fit the bariatric bed only
- Commodes identified for 600 lbs. or more and extra wide
- Wheelchairs identified for 450 lbs. or more

6.50 Behavioral/Cognitive Impairment (Beh/CI) Incentives

The Behavioral/Cognitive Impairment Incentives (Beh/CI) provides additional reimbursement for costs associated with the care of patients with specific behavioral or cognitive difficulties. The incentives are calculated by applying two scores for each resident, an Access Score and an Improvement score. The score values are defined by the MDS elements listed below and acuity categories ranging from 0 to 5 based on psychiatric and related diagnosis codes under the International Classification of Diseases, as organized via decision rules promulgated under the Chronic Illness and Disability Payment System (CDPS). The Beh/CI scores are based on index values aggregated at the facility level, calculated using data from Title 19 FFS Non-DD residents present on the last day of the second quarter of the fiscal year that also had a PDPMable MDS assessment on or prior to that date. The scores are only calculated for individuals when they have both a PDPMable MDS assessment and a CDPS score greater than zero. Non-PDPMable MDS assessments or MDS assessments that do not coincide with a CDPS score greater than zero are excluded and treated as a break in stay for the purposes of the incentive.

a) Beh/CI Access Incentive: The incentive is determined by multiplying the Beh/CI Access Score by the Beh/CI Access Base Rate of $7.27. The Access Score for each resident is calculated by subtracting 1.00 from the higher of the resident's first two available MDS Behavioral Scores and setting any negative results to zero. The first and second MDS behavioral scores are defined as the resident's first and second scores after whichever of the following Starter Events occurred most recently:
    - Admission to the facility;
    - A change in the POP ID;
    - A break in stay of more than 30 days;
    - October 1, 2010.

b) Beh/CI Improvement Incentive: The incentive is determined by multiplying the Improvement Score by the Beh/CI Improvement Base Rate of $0.69. The Improvement Score for each resident is calculated using the six most recent PDPMable MDS Behavioral Scores since the Starter Event determined for the Beh/CI Access Incentive. If fewer than six PDPMable MDS Behavior Scores exist, all available scores are used. First, an Improvement Baseline is set. If the Starter Event occurred far enough in the past that the resident has more than six available MDS Behavioral

Scores, the Improvement Baseline is set to the fifth most recent MDS Behavioral Score. If six or fewer MDS Behavioral Scores are available, the Improvement Baseline is set to the greater of the two earliest available MDS Behavioral Scores. Next, the Improvement Score is determined by a) calculating the change from the Improvement Baseline to the average of the MDS Behavioral Scores that remain after excluding the two earliest MDS Behavioral Scores; b) setting negative results to zero; and c) multiplying the calculated change by a CDPS factor ranging from zero to five. The CDPS factor is the CDPS score that the individual had on the date of the MDS Behavioral Score used for the BEHCI Access Incentive.

MDS Variable Item Number	Item Title	Coded Score	Behavioral Score Weight
E0900	Wandering Presence & Frequency	1 2 3	.4 .8 1.2
E01000A	Wandering Impact	1	1.5
E01000B	Wandering Impact	1	1.5
E0200A	Behavior: Physical Directed Toward Others	1 2 3	.6 1.2 1.8
E0200B	Behavior: Verbal Directed Toward Others	1 2 3	.6 1.2 1.8
E0200C	Behavior: Other Symptoms	1 2 3	.6 1.2 1.8
E0500A 1 1.5 .6	Behavior: Risk of Physical Injury	1	1.5
E0500B	Behavior: Interferes with Care	1	.75
E0500C	Behavior: Interferes with Activities	1	1.5
E0600A	Behavior: Others at Risk	1	1.5
E0600B	Behavior: Intrudes on Others	1	.75
E0600C	Behavior: Disrupts Care	1	.75
E0800	Behavior: Rejects Care	1 2 3	.6 1.2 1.8
D0300	Severity: Resident Mood Interview	15 or greater	1.5
D0600	Severity: Staff Assessment of Mood	15 or greater	1.5
G0110E	Locomotion: Resident Movement	0 1 2	1.0 .75 .75
For Dates of Service on or after July 1, 2024, the MDS Item G0110E will be replaced with the following, noting that the total maximum score for this section remains 1.0:			
GG0170I5	Mobility: Walk 10 Feet	06 05	1 .75

		04	.75
GG0170Q5 AND GG0170R5	Use of wheelchair and / or scooter Wheel 50 feet with two turns	1 AND 06 05 04	 1 .75 .75

6.60 Medicaid Access Incentive (MAI)

The Medicaid access incentive is provided to all facilities to facilitate access to nursing facility care for Medicaid recipients. Facilities certified as a nursing facility will receive an incentive of $9.65. Facilities certified as an Intermediate Care Facilities for Intellectual Disabilities (ICF-IID) will receive an incentive of $33.24. Distinct part ICF-IIDs will have separate rates reflecting the separate incentives.

6.70 Small Facility Incentive

The Small Facility incentive of $17.74 per patient day provides additional reimbursement to facilities where the same or contiguous property upon which the facility resides has a combined total of 50 or fewer licensed beds for rate setting. The rationale for the Small Facility Incentive is to encourage smaller and more community-like nursing facility settings as well as to recognize the lack of purchasing power and the spread of fixed overhead associated with a smaller facility size.

Unless previously granted an exception in writing from the Department, to be considered a facility of 50 or fewer beds the total sum of beds from all SNF and ICF-IID licenses on the same or contiguous properties must be 50 or fewer pursuant to the definition of fifty bed facility under 1.01.

7.00 Other Payment Calculations

7.01 Ventilator Dependent Residents

An all-encompassing rate of $926 per patient day shall be paid in lieu of the normal daily rate for any facility treating a resident who has received prior authorization for ventilator-dependent care. Bedhold days for these residents, if qualifying, will pay at the applicable bedhold rate. The costs of exceptional supplies related to care of ventilator-dependent residents are included in the above rate and cannot be billed separately. Facilities must receive approval of their ventilator program in order to treat residents and receive payment under this section.

7.02 Traumatic Brain Injury Residents

An all-encompassing rate of $982 per patient day shall be paid in lieu of the normal daily rate for any facility treating a resident who has suffered a traumatic brain injury and received prior authorization for related rehabilitative care. This rate shall be inclusive of all such rehabilitative care and supplies provided to the resident. Facilities must receive approval of their traumatic brain injury program in order to treat residents and receive payment under this section.

7.03 Isolation Rate

Subject to prior authorization and the requirements of DHS 132.51(2)(b), a facility providing an isolation room may receive an add-on of the difference between the facility's semi-private and private-room rates, limited to $35 per day.

7.04 Appraisal Payments

Facilities are responsible for paying the Department's selected appraisal contractor for approved appraisals used for rate-setting purposes. The rate charged by the contractor will be determined by the state procurement process. Facilities will be reimbursed these costs through supplemental payments when the Department has received verification that the contractor has received the facility's payment.

7.10 State and Tribal Owned or Operated Facilities

The rate for State and Tribal-owned nursing facilities will be the Medicare payment rate effective during the reimbursement period, based on the Medicaid case mix of the facility.

The payment rate for state and tribal-owned or operated ICFs-IID will be based on the actual allowable cost during the reimbursement period. Interim rates may be established. A cost reconciliation will be conducted at the end of each state and tribal-owned or operated ICF-IID's fiscal year. In no case shall the total Medicaid payment exceed the Medicare Upper Limit.

Maximums and limitations shall not be applied in determining payments to state-and tribal operated facilities. The amount of the final payment shall be based upon the actual and allowable costs in the cost reporting period plus the Medicaid Access Incentive. Actual and allowable capital expenses for the cost reporting period shall be used to calculate the final property allowance. The facilities shall be subject to all cost reporting requirements.

7.20 Supplemental Payments for Facilities Operated by Local Units of Government

Total supplemental payment funding of $39,100,000 will be made unless it is determined that aggregate payments would exceed the Medicare upper limit, or if additional supplemental funding is authorized by state statute.

Providers may not appeal a supplemental payment calculation under this section due to the Department distributing payments in an amount less than $39,100,000 when such a reduction in payment is necessitated due to the Medicare upper limit.

In order to participate in the supplemental payment program, each NF must have on file a cost report, a prospective supplemental award application form, and a signed affidavit certifying the amount of local government expenditures eligible for FFP under 42 CFR 433.51(b).

Supplemental payments will be awarded based on the Projected Overall Operating Deficit (OAOD) following calculated Medicaid deficits from the audited cost reports used for rate-setting.

If funding is sufficient, each facility will receive their OAOD. If funds are not sufficient to distribute each facility's OAOD, facilities will receive a uniform per day amount for each Medicaid patient day up to the amount of their OAOD. Medicaid patient day includes all eligible billed T-19 patient days, including fee-for-service, managed care, and hospice.

If a governmental facility is sold during the effective period of this plan, deficits and patient days will be prorated based on the number of calendar days the facility was licensed as a governmental facility during the cost reporting period. If the facility was sold prior to the effective period of this plan, there shall be no award under this provision. If an existing facility is purchased by a local unit of government during the effective period of this plan, there will be no award because the purchasing local unit of government had no days during the cost reporting period.

7.30 Specialized Psychiatric Rehabilitative Services (SPRS)

A $24.26 per patient day payment is available to skilled nursing facilities that provide SPRS to residents determined to have a mental illness by a Level II PASRR screen. A Level II PASRR screen that indicates that nursing facility placement is appropriate and that SPRS is needed is required every two years to maintain eligibility for the supplemental payment.

To qualify for the supplemental payment, the nursing facility must prepare a SPRS care plan that defines measurable goals and objectives for the client's specialized psychiatric rehabilitative services. The SPRS care plan must be reviewed and updated at least annually or as needed to appropriately reflect change in the client's need for mental health services. If the facility believes that specialized rehabilitative services are no longer required, they must request a resident review from the PASRR contractor.

This payment is inflated annually based on the inflation factor used to inflate direct care wages from the final quarter of the cost report year as shown in section 2.50.

7.40 Medical Transportation

Medical transportation is separately billable and reimbursed at $43 per trip plus $1.90 per mile. Medical Transportation is transportation provided by a nursing facility to permit a recipient to obtain healthcare if prescribed by a physician as medically necessary. Such transportation may be provided in the facility's own controlled equipment and by its staff, or by other carriers, such as bus or taxi.

7.50 Out-of-State Nursing Facilities

Wisconsin Medicaid recipients may receive care in a NF located outside the State of Wisconsin if the facility is certified in the Medicaid program of the other state.

Payment for temporary coverage will be at a standard payment rate for the month of admission and for a maximum of three full calendar months after the admission date. The Department will establish the rate based on the approximate average payment rate for a comparable level of care as paid to Wisconsin nursing facilities.

A payment rate more specific to the out-of-state facility may be established if either the facility or the Department determines the standard rate is inappropriate for the resident or if the resident stays longer than the temporary rate period. In determining a different rate, the Department may consider Medicaid rates being paid to the facility by their home state; payment for similar services in Wisconsin; available information on the cost of the facility's operation; and any specialized services or unique treatment regimens.

Ancillary items may be separately reimbursed to the out-of-state facility according to the usual procedures.

7.60 Purchased Relocation Services

A lump sum payment may be paid in addition to the daily payment rate if a relocation plan is ordered by the Department, the Department approves the contractor, and the allowed amount meets all Departmental contracting limits. Staff costs otherwise allowable are not to be included in the lump sum payment.

The Department will pay the Medicaid portion of the purchased relocation services, as determined by the percentage of residents receiving FFS Medicaid in the month prior to the relocation order. The Department may pay 100% of the purchased relocation services if it is in their best interest.

7.70 Payment for Services Provided During Temporary Evacuation

If a facility is evacuated due to a natural or man-made disaster, pursuant to a declaration by the Governor or approval by the Department Secretary of a state of emergency, the Department shall provide payment for extraordinary expenses that occurred on or after the first day of the base cost reporting period and associated with the temporary evacuation.

Extraordinary expenses include the Medicaid share of payments for direct expenses or purchased services for temporary accommodations and emergency repairs to the nursing home, including costs associated with the evacuated residents incurred by other service providers in providing care, treatment, housing and housing-related services for the evacuated residents. Payment for extraordinary expenses is not subject to the formula maximums but is net of insurance and third party payments.

The Department may establish an interim payment for extraordinary expenses, subject to reconciliation with a retrospective settlement.

Payment for extraordinary expenses is contingent upon the facility pursuing all possible sources of revenue, including third party insurance for resident services, property insurance, business interruption insurance and litigation for damages from responsible parties. Payment may be recouped in part or in full if the facility does not make a good faith effort to pursue all possible sources of revenue for extraordinary expenses or if the facility successfully recovers funds.

7.80 Bedhold

Hospital bed hold days and therapeutic bed hold leave days, including bed hold days for residents approved for ventilator-dependent payment, will be paid at the Non-DD Bedhold rate for qualifying nursing facilities and at the DD Bedhold rate for qualifying ICFs-IID. Bed hold cannot be billed for residents approved for traumatic brain injury stays, or for residents receiving Medicare Part A nursing facility services. A maximum of 15 consecutive days is covered for each hospitalization leave.

In order to qualify to bill for bed hold, the provider's occupancy level must be 94.0% or greater during the calendar month prior to the bed hold days. For purposes of this calculation, licensed bed-days shall not include any restricted use beds or beds out of service due to code violations or for isolation, seclusion, or restraint purposes. Chargeable bed hold days in the prior month shall be included as occupied patient days in the calculation.

Facilities pursuing a closure or licensed bed reduction may receive an exemption from the occupancy requirements if approved in advance by the Department. A provider operating two or more separately certified facilities on contiguous property with common ownership, including distinct part facilities, may elect to combine the occupancy tests or maintain separate occupancy tests on a month-by-month basis.

No resident or third party may be charged for covered but unreimbursed bed hold days provided to a Medicaid recipient, even if a provider does not meet the occupancy requirements to bill for them.

8.00 Cost report audit and rate finalization process

8.01 Official cost report submission and audit correspondence system

Auditors and providers must use the WINHRS (Wisconsin Nursing Home Rate Setting) web-based system to submit cost reports, substantiating documentation, communicate rate notifications, cost report adjustments, and document the rate approval process.

8.02 Exceptions limited

Only in exceptional circumstances with prior written approval of the section manager will documentation be accepted by any other means. In any event, the documentation must be conveyed to WINHRS. A provider not splitting a file they intend to upload into WINHRS due to file upload maximum size requirements is not considered an exceptional circumstance.

8.03 Documentation requirements

All documentation submitted by a provider to the Department must be germane to the cost report or request of the Department, legible, and contain all data elements as required by the Department. If upon review of the submitted documentation, the auditor considers the submitted documentation irrelevant, illegible, or not containing all necessary data elements, the auditor will disregard the documentation.

8.04 Completeness review

Upon review of a cost report submission into the system referenced in 8.01, the auditor will conduct a completeness review. A completeness review is intended to ensure all relevant documentation submission requirements are met prior to the auditor beginning a desk review. A submission will be considered incomplete if the submission is missing one or more of the following (note: this is not an exhaustive list):

- Signed desk review checklist attestation (see Attachment A – Desk Review Checklist Attestation)
- Completed checklist (see Attachment B – Desk Review Checklist)
- Depreciation schedule documentation which comports with the following:
    - Removed assets that DHS auditors disallowed in prior years from both the schedule and supporting documentation.
    - Adjustment to any useful lives to comply with the American Hospital Association (AHA) guidelines that the DHS auditors adjusted in prior years.
    - Ensuring all new assets are recorded following the AHA guidelines for useful lives.
    - The depreciation schedule is submitted as an excel file.
    - Make additional entries to the prior cost report year's audit adjustment workbook to reflect asset additions/deletions in the current cost reporting period and submit the workbook as supplemental documentation for the current cost reporting period.

If the auditor determines the submission is incomplete, they will notify the facility. The auditor will not revisit the facility's cost report submission until all other cost report audits are complete.

8.10 Desk review

Upon determining a cost report submission is complete, the auditor will begin the desk review. The desk review will result in a single request to the provider of all documentation requested by the auditor. The provider will have 30 days, including the date the request is sent to the provider, to provide all requested documentation to the auditor. The auditor will only proceed with the audit on the 31st day, or upon notification by the provider that all documentation responsive to the desk review has been submitted to WINHRS.

By notifying the auditor that all documentation has been uploaded, the provider agrees to waive any remaining time in the 30 day submission window to respond to the desk review. Any documentation submitted after such notification will not be considered by the auditor, and not considered part of the audit record.

8.20 Initial rate letter notification

Providers will receive a rate notification from their Medicaid Auditor including cost report adjustments and explanations upon audit completion. If a provider intends to contest auditor adjustments to their rate, they must follow 8.30 in this document.

This requires the provider to inform their auditor no more than 15 days after and including the date of the initial rate notification of their intent to contest adjustments and must submit their request and substantiating documentation no more than 30 days after and including the date of the initial rate notification. A provider may inform their auditor of approval of their rate any time before said 30 days.

8.30 Contested adjustments

If a provider wishes to contest auditor adjustments (as required under 42 CFR §447.253(e)), they must first respond to the initial rate notification provided under 8.20 in WINHRS no later than 15 days after and including the date of the notification. The provider must provide additional documentation and support for the amounts claimed no more than 30 days after and including the date of the initial rate notification. The provider must articulate to which audit adjustment each document submitted under this section applies, and why they disagree with the auditor's determination.

Upon receipt of intent to contest an adjustment, the auditor will review all documentation submitted within 30 days from and including the date of the notification. The auditor will consider any revisions to their adjustments, if warranted. Upon review completion, the auditor will provide the provider with revised adjustments, if applicable, and a revised rate calculation, if applicable. The auditor will immediately upload the provider's rate into ForwardHealth.

A provider is not allowed to use the process described under this section to re-classify costs as submitted on their cost report. A provider may only use this process to contest the disallowance of costs by the auditor. A provider is not allowed to use this process if they fail to notify the auditor pursuant to the timelines described in this section.

8.40 Administrative review

A provider may request a final administrative review only upon notification by an auditor of the auditor's determination under 8.30. This is the second and final step in Wisconsin for 42 CFR §447.253(e). The administrative review will be limited to the documentation submitted to WINHRS according to the requirements and deadlines described in sections 8.50 and 8.70. The provider may request an administrative review by writing to:

Nursing Home Rate Setting & Policy Section Manager
P.O. Box 7851
1 West Wilson Street
Madison, WI 53703
dhsdmsbrs@dhs.wisconsin.gov

A provider may not elect a review under this section unless the process under 8.30 has completed. A provider is not allowed to use the process described under this section to re-classify costs as submitted on their cost report. A provider may only use this process to contest the disallowance of costs by the auditor. A provider is not allowed to use this process if they fail to notify the auditor pursuant to the timelines described in 8.30. The result of an administrative review is final and not appealable.

8.50 Material Adjustments

After final rates are set, only adjustments and/or corrections of errors which have a combined net material impact on rates will be corrected. "Material" is defined as the combined net increase or decrease being equal to or greater than $0.50 per patient day for the non-DD in-house base rate. Department determined corrections and any required rate change made pursuant to this section are final immediately upon notice by the Department and are not subject to appeal.

A provider must deliver written notice of errors to the Department no more than 150 days from and including the date of the notification under 8.20 for any corrected rates to take effect on the original effective date of the rates in error.

If a provider fails to comply with this timeline, any resulting rate increase will occur on the first of the month following the month in which the error was communicated to the Department. In no event will a rate be changed 210 days after the notification under 8.20. If the provider has not already used their maximum 2 submissions under 1.10, the provider will be limited to only one such retroactive adjustment per rate effective period in order to correct errors in reported data. If using this section to re-submit cost report errors, a written notice must be provided to the Department.

This notice to the Department must contain the following:

1. A write up which clearly explains the difference between the cost report schedule used for the current rate and the differences stemming from the re-submission.

2. All supporting documentation needed. Such documentation must comply with 8.03.

3. A preliminary analysis to demonstrate a high likelihood that the effect of the re-submission is material.

8.60 Rate finalization timelines

The auditor will submit rates to ForwardHealth for payment when one of the following occurs:

1. 16 days after and including the date of the notification under 8.20 if the provider did not inform their auditor of the provider's intent to contest adjustments pursuant to 8.30.
2. 31 days after and including the date of the notification under 8.20 if the provider did inform their auditor of the provider's intent to request changes but did not provide the request and substantiating documentation by the 30th day.
3. Immediately upon notification by the provider that the provider accepts the rate. If a provider accepts the rate, the provider waives the ability to contest an auditor adjustment. If a provider accepts the rate, the provider waives the ability to request an administrative review.
4. Immediately upon notifying the provider of the results of the contested adjustment process, if applicable.
5. Immediately upon notifying the provider of the results of the administrative review, if applicable.

8.70 Circumstances Necessitating a Rate Recalculation

A change of ownership will not result in a rate recalculation for the current payment rate year. The new owner will be paid the rate the former owner would have been paid if no change of ownership had occurred. For the following rate year, the Department may permit rates to be based on the new owner's costs if a cost report can be submitted that covers a period of at least six months. This provision does not exclude the prior owner from submitting a cost report if the Department so requires. If the prior owner's cost report is needed, but not submitted, the new owner's rates for the payment rate year will default to the facility's June 30th rate of the prior payment rate year, less a reduction of up to 25% if the Department deems appropriate.

Providers may request or the Department may require a rate recalculation following a certification and/or licensure change (such as from SNF to ICF-IID or IMD and vice versa). Rate recalculations requested by providers will be granted at the discretion of the Department.

New facilities will receive an interim rate during the start-up period, which consists of the initial twelve months from the date of facility licensure. During the start-up period, a facility's minimum patient days for the property and property tax allowances will be 50% occupancy of licensed beds. Actual patient days will be used if greater than the minimum. If an existing licensed facility becomes certified for Medicaid after the start-up period, the facility must provide a cost report covering at least six months for rates to be established.

Replacement facilities, or facilities that have replaced at least 25% of their licensed bed capacity or reduced to 50 beds, may request a property payment allowance adjustment based on a cost report covering at least 6 months of new property costs following the licensure of the replacement area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

Facilities experiencing a significant increase or decrease in licensed bed counts may request, or the Department may require rates to be reestablished. Facilities decreasing licensed bed capacity over a

period of time longer than six months may have rates retrospectively established for the phasedown period based on a six month or longer cost report. Facilities undergoing a major phasedown, significant bed reduction, or closing may request negotiated rates.

The Department may modify the above start-up period and cost reporting requirements for special situations or to accommodate the fiscal year of a provider to permit more efficient or accurate cost reporting.

If the Department identifies a material difference between the interim rate and final rate or between the final rate and a re-calculated rate based on further review of a cost report submission and independent financial audit, the Department can recoup the amount of the difference from the provider under 8.80.

8.80 Recoupment of Overpayment

Upon a rate decrease for any purpose, including when a final rate is less than an issued interim rate, any excess payments for previously provided services shall be recovered. Large recoupments will be recovered as a set percentage of future remittances according to the ForwardHealth Provider Handbook. The Department may choose to recover amounts due from new owners of facilities or from facilities owned by the same individuals if the situation warrants. Providers may request repayment arrangements that differ from the fiscal agent's regular schedule for reasons of financial hardship. Such requests should be addressed to the Nursing Home Policy and Rate Setting Section Manager, who will grant such requests in limited and exceptional circumstances at the sole discretion of the Department.

9.00 Attachment A – Desk Review Checklist Attestation

The below is an example of the attestation required by the Department, and is subject to changes by the Department.

To Be Submitted on Facility Letterhead:

Desk Review Checklist Attestation

I, _____, attest that I am an officer of the facility or a paid preparer of the cost report and am authorized to sign this attestation on behalf of, _____(the facility). I have reviewed the cost report and the documentation supplied in response to the Desk Review Checklist (above) and confirm that the information therein is correct and follows the cost report instructions to the best of my knowledge and ability. If applicable, I have submitted with this checklist a revised cost report that reflects any corrections I have identified as part of completing this checklist. I acknowledge that the Department's sole responsibility in auditing the cost report and documentation is to identify and make adjustments where the facility has failed to follow Medicaid nursing home audit standards and that the Department will not make changes to the facility's cost report beyond those adjustments needed to enforce those audit standards. I acknowledge that it is my responsibility to make any corrections to this or other cost reports that may impact the facility's reimbursement from Medicaid as a result of the cost report not adhering to Medicaid nursing home audit standards.

_____

Signature and Date

Name (Typed)

Title

Facility

Address

Phone Number

Email Address

10.00 Attachment B – Desk Review Checklist

The below is an example of the Desk Review Checklist required by the Department, and is subject to changes by the Department.

Desk Review Checklist

Please submit the following documentation if your facility has an expense reported on the corresponding line item. All documentation should be in an Excel or readable PDF format and must be uploaded to the facility's 2022 stat log by XX/XX/XX. Please upload the documentation all at one time and have it labeled per the list below. Additional information may be requested at a later date in order to fully complete the facility's cost report audit. Submit the signed and dated attestation language on your facility's letterhead and include the completed checklist as an attachment.

- ☐ **Schedule 6 – Patient Days:**
  - ☐ Run an updated daily patient census report, totaled by month, from the census software system
  - ☐ Legend of payer codes
- ☐ **Schedule 13 - Payroll:**
  - ☐ Run an annual payroll labor distribution report, broken down by position, that includes hours
  - ☐ Run payroll labor distribution reports for any accrual periods
  - ☐ Job descriptions for all positions being expensed on Sch. 20, Line 1 (direct care nursing)
  - ☐ Legend of job codes to corresponding cost report schedule
- ☐ **Schedule 20, Line 3 – Purchased Service Nursing:**
  - ☐ General ledger detail
  - ☐ All invoices for allowable expense reported
- ☐ **Schedule 31, Line 1 – Property Insurance:**
  - ☐ Actual property insurance policy, or policies if there are multiple in the cost reporting year
  - ☐ Full Statement of Values for each corresponding policy
- ☐ **Schedule 33 – Plant Asset Loans:**
  - ☐ If any new loans are reported, submit the full, signed, final loan closing documentation
  - ☐ For any new loans, submit monthly statements showing the principal and interest payments
- ☐ **Schedule 34 – Depreciation Expense:**
  - ☐ All capital asset addition invoices
- ☐ **Schedule 35 – Moveable Equipment Leases:**
  - ☐ General ledger detail
  - ☐ All invoices for allowable expenses reported
  - ☐ For invoices that include both allowable and non-allowable costs, indicate on the invoice the costs that are allowable
- ☐ **Schedule 36 – Capitalized Leases:**
  - ☐ General ledger detail

☐ All invoices for actual payments made on allowable expenses