Wisconsin Medicaid Program

Outpatient Hospital State Plan, Attachment 4.19-B
Methods and Standards for Determining Payment Rates

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SECTION 1000 OVERVIEW

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

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

Under §5700, a prospective outpatient payment is provided for approved respiratory nursing care for part of a day on the site of an acute care hospital. Payment for this service is separate from and not covered by the final cost settlements for services provided prior to April 1, 2013.

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SECTION 2000 STATUTORY BASIS

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

SECTION 3000 DEFINITIONS

Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible outpatient claim. See §4250 for further details.

Acute Care Hospital. A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions, or injuries (usually for a short-term illness or condition).

Annual Rate Update. The process of annually adjusting hospital payment rates to be effective January 1 of each year based on more current Medicare cost reports.

Border Status Hospital. A hospital not located in Wisconsin, which has been certified by the WMP as a border status hospital to provide hospital services to WMP recipients. Border status hospitals can have major border status or minor border status. Exact criteria for eligibility for border status are provided in §4240 of the Inpatient Hospital State Plan.

Capital (component of the rate). Already-produced durable goods or any non-financial asset that is used in production of goods or services. Hospitals incur real and significant capital costs to provide services for Medicaid patients. In the outpatient weight recalibration setting, capital statistics are used in the calculation to standardize provider costs across the state.

Centers for Medicare and Medicaid Services (CMS). The federal agency which regulates the WMP.

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

Clinical Diagnostic Laboratory Reimbursement. The lower of the laboratory fee schedule amounts of the WMP and the hospital's laboratory charges for services provided. This payment shall not exceed the Medicare rate on a per-test basis.

Critical Access Hospital (CAH). A hospital that meets both the requirements under 42 CFR Part 485, Subpart F and the following requirements: no more than 25 beds for inpatient acute care and/or swing-bed services; no more than 4 beds for observation services; an annual average inpatient stay of no more than 96 hours; provision of emergency services and availability of registered nurses on a 24-hour-per-day basis; and establishment of a written referral agreement with one or more network hospitals.

Department. The Wisconsin Department of Health Services (or its agent); the state agency responsible for the administration of the WMP.

EAPG Base Rate. The dollar value that is multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable WMP operating payment for a visit.

Enhanced Ambulatory Patient Grouping (EAPG). A group of outpatient procedures, encounters, or ancillary services, which reflect similar patient characteristics and resource utilization, and which incorporate the use of ICD-9-CM (before October 1, 2015) and ICD-10-CM (after October 1, 2015) diagnosis and Healthcare Common Procedure Coding System (HCPCS) procedure codes.

Fee-for-Service (FFS). A WMP payment methodology in which providers are reimbursed service-by-service for serving WMP members. Most WMP members are either enrolled with Health Maintenance Organizations (HMOs) or have their services reimbursed on a FFS basis.

Final EAPG Weight. The allowed EAPG weight for a given visit as calculated by the EAPG software using the logic in the EAPG definitions manual, including all adjustments applicable to bundling, packaging, and discounting.

Graduate Medical Education (GME). The phase of training that occurs after the completion of medical school in which physicians serve as residents, typically at a teaching hospital, and receive several years of supervised, hands-on training in a particular area of expertise. Hospitals that train residents incur real and significant costs beyond those customarily associated with providing patient care; in recognition of this, the WMP provides various payment adjustments to help defray the direct costs of GME programs.

Healthcare Cost Report Information System (HCRIS). The centralized electronic clearinghouse for Medicare cost reports maintained by CMS.

Hospital Outpatient Extended Nursing Services (HOENSs). Nursing services and respiratory care provided by nurses, for part of a day, in a group setting, on the site of an acute care hospital or in a building physically connected to an acute care hospital. See §5700 for further details.

Hospital P4P Guide. The annual publication, available on the Wisconsin ForwardHealth Portal, that supplements this State Plan with additional details about, among other things, the HWP4P program.

Hospital Withhold Pay-for-Performance (HWP4P) Program. A performance-based reimbursement system in which the WMP withholds 1.5% of payment for outpatient hospital services and allows hospitals to earn back those dollars by meeting various quality benchmarks. See §4300 for further details.

HWP4P Pool Amount. The amount of money withheld from outpatient hospital reimbursement for use in the HWP4P program.

IHS Hospital Costs Index. The "Hospital and Related Healthcare Costs Index" published by IHS.

Inpatient Hospital Licensed Facility. For hospitals located in Wisconsin, that part of the physical entity, as surveyed and licensed by the Department, in which inpatient care is provided. Any emergency department, clinic, or other part of the licensed hospital that is not located on the same premises as the inpatient hospital licensed facility is not part of the inpatient hospital licensed facility, irrespective of whether that off-premises emergency department, clinic, or other part is considered to be part of the hospital under the hospital license or for purposes of Medicare reimbursement. For hospitals not located in Wisconsin, the physical entity that is covered by surveying, licensure, certification, accreditation, or such comparable regulatory activities of the state in which the hospital is located.

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.

Measurement Year (MY). The time period from April 1 through March 31 during which an iteration the HWP4P program is administered. The named year of the MY is the calendar year in which the MY ends; for example, MY 2014 runs from April 1, 2013 to March 31, 2014.

Medicaid Deficit. The amount by which the cost of providing outpatient services to WMP recipients exceeds the WMP payment for those services. See §7000 for further details.

Medicaid Management Information System (MMIS). The system used by the WMP to process and document provider claims for payment.

Medicare Cost Report. The CMS 2552 form. To establish cost for outpatient rate setting, the Department utilizes the most recent audited 12-month Medicare cost report (as of the March 31 that occurs before the RY) available in HCRIS maintained by CMS. If the most recent audited 12-month Medicare cost report available in HCRIS is greater than five years old, the Department may use an unaudited 12-month Medicare cost report. However, if an unaudited Medicare cost report is used, the Department will recalculate the outpatient rate once the unaudited Medicare cost report has been audited to determine the final rate.

Outpatient Visit. The provision of services by an outpatient department located within an inpatient hospital licensed facility on a given calendar day, regardless of the number of procedures or examinations performed or departments visited, which does not include or lead to an inpatient admission to the facility. Services provided at a facility operated by the University of Wisconsin Hospitals and Clinics Authority need not occur within an inpatient hospital licensed facility to qualify for outpatient status under this definition. Services provided at a facility operated by a free-standing pediatric teaching hospital need not occur within an inpatient hospital licensed facility to qualify for outpatient status under this definition if the facility was added to the hospital's certificate of approval on or after July 1, 2009.

Psychiatric Hospital. A general psychiatric hospital which is not a satellite of an acute care hospital and for which the department has issued a certificate of approval that applies only to the psychiatric hospital. A subcategory of psychiatric hospital is Institution for Mental Disease (IMD), which is defined in 42 CFR 435.1009, though IMDs are only eligible for Medicaid reimbursement under specific circumstances.

Rate Notification Letter. The notification mailed to hospitals at the conclusion of the annual rate update informing each hospital of its updated reimbursement rates and how to appeal them if necessary.

Rate Year (RY). The time period from January 1 through December 31 for which prospective outpatient rates are calculated under §4200.

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. The hospital provides intensive rehabilitative services for conditions such as stroke, brain injury, spinal cord injury, amputation, hip fractures, and multiple traumas to at least 75% of its patient population. IMD hospitals cannot be considered rehabilitation hospitals under the provisions of this plan.

State Fiscal Year (SFY). July 1 – June 30. For example, SFY 2014 is defined as July 1, 2013 – June 30, 2014.

Upper Payment Limit (UPL). The maximum amount the WMP may reimburse a hospital for services provided to WMP members. This is formally specified in 42 CFR 447.321.

Wage (component of the rate). Net reimbursement to staff and employees. Statewide wage data and wage data by individual providers are used to create the wage index, which in turn is intended to account for regional differences in the cost of wages across providers.

Wisconsin CheckPoint. A centralized electronic clearinghouse for quality data for Wisconsin hospitals, maintained by the Wisconsin Hospital Association, available at www.wicheckpoint.org.

Wisconsin ForwardHealth Portal. A website administered by the WMP listed at www.forwardhealth.wi.gov.

Wisconsin Medicaid Program (WMP). The State of Wisconsin's implementation of Medical Assistance as per Title XIX of the federal Social Security Act.

SECTION 4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS

4100 Introduction

This section describes the methodology for reimbursing all acute care, psychiatric, rehabilitation, and critical access hospitals located in the State of Wisconsin for outpatient hospital services provided in outpatient departments of inpatient hospital licensed facilities to persons eligible for FFS medical coverage by the WMP. The EAPG system, described in §4200 through §4240, is used to classify and calculate reimbursement for outpatient visits. EAPGs categorize the amount and type of resources used in various outpatient visits. The WMP base rates and EAPG weights have been updated as of January 1, 2015, effective for services provided on or after that date.

4200 EAPG Reimbursement Methodology

4210 Establishing Wisconsin-Specific EAPG Weights. The EAPG relative weight calculations are performed using line level charges from the three most recent complete SFYs of WMP outpatient hospital adjudicated claims, paid through MMIS, and converted to cost using a ratio of cost to charges methodology. The State calculates hospital-specific, cost center-specific cost-to-charge ratios using the most recent audited 12-month Medicare cost reports. The cost-to-charge ratios are cross-walked to the three most recent complete SFYs of WMP outpatient claims data using line level revenue codes and are then multiplied by the line level charges.

The line level costs are normalized across providers and time periods to determine the average cost of each EAPG by adjusting the cost-to-charge ratios as follows:

- Wage: Adjust the wage portion of costs using the published wage index from CMS;
- Capital: Adjust costs to account for only 95% of capital costs;
- Medical Education: Adjust costs to remove medical education costs; and
- IHS Hospital Costs Index: Inflate costs from the time period associated with the most recent audited 12-month Medicare cost report for each hospital to the current RY.

The EAPG weight is calculated by dividing the cost of an individual EAPG by the average cost of all EAPGs. For EAPGs that lack sufficient volume (less than 30 occurrences), the EAPG weight defaults to the national weight for the EAPG (as calculated by the proprietor of the EAPG software, 3M). The current EAPG weights can found on the Wisconsin ForwardHealth Portal.

4211 Cost Reports for Recent Hospital Combinings. A “hospital combining” is the result of two or more hospitals combining into one operation, under one WMP provider certification, either through merger or consolidation, or a hospital absorbing a major portion of the operation of another hospital through purchase, lease, or donation of a substantial portion of another hospital’s operation or a substantial amount of another hospital’s physical plant. For combining hospitals for which there is not an audited 12-month Medicare cost report available for the combined operation, the Department will perform calculations based upon the most recent audited 12-month Medicare cost reports of the combining hospitals prior to the combining.

4212 Changes of Ownership. Payment rates will not change solely as a result of a change of ownership. At the time of ownership change, the new owner will be assigned the hospital-specific EAPG base rate of the prior owner. Subsequent changes to the hospital-specific EAPG base rate for the new owner will be determined as if no change in ownership had occurred; that is, the prior owner's Medicare cost reports will be used until the new owner's Medicare cost reports come due for use in the annual rate update.

4220 Calculating EAPG Base Rates. CAHs each have a provider-specific EAPG base rate calculated by taking the outpatient WMP costs from the most recent audited 12-month Medicare cost report and dividing by the total hospital final EAPG weights. All other hospitals use a statewide EAPG base rate that is calculated by taking the Department’s outpatient budget, less projected CAH payments, and dividing this amount by the total final EAPG weights for all other hospitals. The current EAPG base rates can be found on the Wisconsin ForwardHealth Portal.

4221 Direct Graduate Medical Education Add-On. For non-CAH providers that have a GME program, the Department adds an amount to a hospital's specific EAPG base rate for costs directly associated to the program. The Department determines the direct GME add-on to the EAPG base rate from a hospital's Medicare cost report. The Department performs the calculation as follows:

1. The Department determines the direct GME costs attributable to WMP outpatient services by multiplying the projected outpatient costs attributable to WMP recipients by the ratio of total allowed direct GME costs to total allowed hospital costs. The total allowed direct GME costs are taken from Worksheet B Part I, Columns 21 and 22, Line 20200 (less exclusions listed below) for the CMS 2552-10 (Worksheet B Part I, Columns 22 and 23, HCRIS Code 10300 (less exclusions listed below) for the CMS 2552-96). The total allowed hospital costs are taken from Worksheet B Part I, Column 26 Line 20200 (less exclusions listed below) for the CMS 2552-10 (Worksheet B Part I, Column 27, HCRIS Code 10300 (less exclusions listed below) from the CMS 2552-96).
2. The Department divides the resulting amount by the total hospital-specific final EAPG weights for the current RY to form the direct GME add-on for that hospital.

4222 Approved Nursing and Allied Health Activities Add-On. For non-CAH providers that engage in approved nursing and allied health (ANAH) activities, the Department adds an amount to a hospital's specific EAPG base rate for costs directly associated to the activities. The Department determines the ANAH add-on to the EAPG base rate from a hospital's Medicare cost report. The Department performs the calculation as follows:

1. The Department determines the ANAH activities costs attributable to WMP outpatient services by multiplying the projected outpatient costs attributable to WMP recipients by the ratio of total allowed ANAH activities costs to total allowed hospital costs. The total allowed ANAH activities costs are taken from Worksheet B Part I, Columns 20 and 23, Line 20200 (less exclusions listed below) for the CMS 2552-10 (Worksheet B Part I, Columns 21 and 24, HCRIS Code 10300 (less exclusions listed below) for the CMS 2552-96). The total allowed hospital costs are taken from Worksheet B Part I, Column 26, Line 20200 (less exclusions listed below) from the CMS 2552-10 (Worksheet B Part I, Column 27, HCRIS Code 10300 (less exclusions listed below) for the CMS 2552-96).
2. The Department divides the resulting amount by the total hospital-specific final EAPG weights for the current RY to form the ANAH activities add-on for that hospital.

There are non-reimbursable cost centers which are excluded from the total allowed direct GME costs, total allowed ANAH activities costs, and total allowed hospital costs. These exclusions are provided below.

Cost Center and HCRIS Line Number Exclusions:

CMS 2552-10 Line Numbers	Cost Center
04400	44
04500	45
04600	46
08800-08900	88-89
09400-09700	94-97
09900-10100	99-101
11600	116
19000-19400	190-194

CMS 2552-96 HCRIS Codes	Cost Center
03400	34
03500	35
03600	36
06310-06319	63.5-63.59
06400	64
06500	65
07950-07999	100
09300-09304	93
09600-09619	96
09700-09719	97
09800-09819	98

09900-09919 99

4230 Calculating Final EAPG Payment. Each line of an outpatient hospital claim is assigned to an EAPG and therefore has a distinct weight. These weights are multiplied by the hospital's specific EAPG base rate. The total reimbursement for an outpatient hospital claim is the sum of these multiplications, with the following exceptions:

- Clinical Diagnostic Laboratory Services are paid on a fee schedule basis.

4240 Exclusions from the EAPG Reimbursement System. The following services are not included within the EAPG reimbursement system:

- Therapy Services
- Clinical Diagnostic Laboratory Services
- Durable Medical Equipment (DME)
- Provider-Based End Stage Renal Disease (ESRD) Services

4250 Outpatient Access Payment. To promote WMP member access to acute care, children's, rehabilitation, and critical access hospitals throughout Wisconsin, the WMP provides a hospital access payment amount per eligible outpatient FFS claim. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per claim are not differentiated by hospital based on acuity or individual hospital cost. However, critical access hospitals receive a different access payment per claim than do acute care, children's, and rehabilitation hospitals.

The amount of the hospital access payment per claim is based on an available funding pool appropriated in the state budget and aggregate hospital UPLs. This amount of funding is divided by the estimated number of paid outpatient FFS claims for the SFY to develop the per claim access payment rate.

For SFY 2015, the FFS access payment funding pool amount for outpatient acute care, children's, and rehabilitation hospitals is $98,820,391, resulting in a projected access payment amount of $329 per claim; the FFS access payment funding pool amount for outpatient critical access hospitals is $2,199,772, resulting in a projected access payment amount of $36 per claim. These access payment per claim amounts are identified on the hospital reimbursement rate web page of the Wisconsin ForwardHealth Portal. This payment per claim is in addition to the EAPG base payment described in §4230. Access payments per claim are only provided until the FFS access payment funding pool amount has been expended for the SFY.

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

4300 Performance-Based Payments

The Department has a Hospital Withhold Pay-for-Performance (HWP4P) program that provides for payments for acute care, children's, critical access, and psychiatric hospital services. Long-term care, rehabilitation, and out-of-state hospitals are exempt from the HWP4P program.

The Department administers the HWP4P program on a measurement year (MY) basis. The chart below shows the start and end dates for the first two MYs of the HWP4P program, which did not occupy a full 12 months.

MY 2013	**Start:** July 1, 2012	**End:** March 31, 2013
MY 2014	**Start:** May 15, 2013	**End:** March 31, 2014

Subsequent MYs are on a 12-month cycle, from April 1 through March 31 of the next calendar year.

For each MY, the Department pays FFS claims for services at the rate of 98.5% of the reimbursement in effect during the MY. The HWP4P pool amount is the remaining 1.5% of the reimbursement in effect during the MY for those same FFS claims.

Hospital supplemental payments made to eligible providers, including access payments, are excluded from the HWP4P pool amount.

The Department makes HWP4P payments for each MY annually by the December 31 following the conclusion of the MY.

The remainder of this section describes the program's design and requirements for MY 2015. In order to be eligible for HWP4P program payments, hospitals are required to report performance measure data and meet performance-based targets as specified in the Hospital Pay-for-Performance (P4P) Guide (effective October 15, 2014 for MY 2015) published on the Wisconsin ForwardHealth Portal.

Hospitals that meet both reporting requirements and performance-based targets, for the measures described later in this section, are eligible to receive payments from the HWP4P pool as follows:

a. The Department calculates individual HWP4P pool amounts for each eligible hospital. At the end of the MY, the Department divides each individual HWP4P pool amount by the number of measures applicable to the respective hospital to determine the value of each measure. (E.g., if a hospital's individual pool equals $100,000 and it qualifies to participate in four measures, then each measure is worth $25,000.) As a result, the value of a given measure will vary from hospital to hospital, impacted by both the size of the individual hospital's HWP4P pool amount and the number of measures for which the hospital qualified.

b. If a hospital meets all of its performance targets for all applicable measures, it receives a payment equal to its individual HWP4P pool amount.

c. If a hospital does not meet all of its performance targets, it earns dollars for those measures where the targets were met, in a graduated manner as specified in the Hospital P4P Guide.

d. If all participating hospitals meet all of their individually applicable targets, no additional HWP4P pool funds are available and thus no bonus payments beyond those described above can be made to any hospital.

e. If at least one participating hospital does not receive its full HWP4P pool amount, the Department aggregates all remaining HWP4P pool funds and distributes them as additional bonus payments to hospitals that met their performance targets.

The Department ensures that all HWP4P pool dollars are paid back to hospitals by providing bonus payments. If a hospital meets all reporting requirements and performs in the highest tier on at least one applicable pay-for-performance (as opposed to pay-for-reporting) measure, it qualifies to receive a bonus payment. Bonus dollars are shared proportionally among hospitals weighted by two factors: the relative magnitudes of the individual HWP4P pool amounts for all hospitals that qualified for the additional bonus and the percentage of applicable measures for which the hospitals performed in the highest performance tier. Therefore, hospitals with a larger HWP4P pool amount receive a larger portion of the additional bonus dollars available, while high-performing hospitals are also rewarded. The University of Wisconsin Medical Center and CAHs are only eligible for WMP payment, including the HWP4P payments, up to cost.

The Department notifies each eligible hospital, prior to the MY, of the minimum performance requirements to receive the HWP4P pool payment. Complete details, including technical information regarding specific quality and reporting metrics, performance requirements, and HWP4P adjustments, are available in the Hospital P4P Guide. The performance measures that are in effect in this State Plan on the first day of each MY are the measures that are used for that MY. Except in cases of emergency rule, providers are given at least 30 days' written notice of any and all changes to the Hospital P4P Guide.

The measures for MY 2015 are:

1) Thirty-day hospital readmission – Hospitals are scored on the percentage of patients that had a qualifying readmission within 30 days of a qualifying discharge. This measure is applicable to a hospital that has at least 30 observations during the MY. To qualify for its earn-back on this measure, a hospital must exceed either the state average or its past performance (MY 2013).

2) Mental health follow-up visit within 30 days of discharge for mental health inpatient care – Hospitals are scored on the percentage of patients that had a mental health follow-up appointment within 30 days of a qualifying mental health discharge. This measure is applicable to a hospital that has at least 30 observations during the MY. To qualify for its earn-back on this measure, a hospital must improve upon its past performance (MY 2013) (since the Department is not using a risk adjustment methodology for this measure, a hospital's score is not compared to the state average).

3) Asthma care for children – Hospitals are scored on the percentage of children admitted to a hospital with a qualifying asthma diagnosis that were discharged with a Home Management Plan of Care (HMPC). This measure is applicable to children's hospitals that have at least 30 observations during the MY. To qualify for its earn-back on this measure, a hospital must submit its data to the Joint Commission by the September 30 following the MY and must exceed either the national average or its past performance (MY 2013) on this measure.

4) Initial antibiotic for community-acquired pneumonia (PN-6) – Hospitals are scored on the percentage of immunoincompetent patients with community-acquired pneumonia that receive an initial antibiotic within 24 hours of admission into the hospital. This measure is applicable to a hospital that has at least 25 observations during the MY. To qualify for its earn-back on this measure, a hospital must submit its data to Wisconsin CheckPoint prior to the September 15 following the MY and must exceed either the state average or its past performance (MY 2013) on this measure.

5) Healthcare personnel influenza vaccination – Hospitals are evaluated on their performance on the Health Care Personnel Influenza Vaccination measure submitted via the Centers for Disease Control and Prevention's (CDC's) National Healthcare Safety Network (NHSN) module. To qualify for its earn-back on this measure, a hospital must exceed either the national average (as published by NHSN) for the previous flu season or its past performance (MY 2013). Hospitals must report their healthcare personnel influenza vaccination results to the NHSN module prior to the deadline set by NHSN.

6) Early elective induced deliveries - PC-01 (pay-for-reporting) – Hospitals are evaluated on their submission of the early elective induced delivery data to Wisconsin CheckPoint. To qualify for its earn-back on this measure, a hospital must submit its data to CheckPoint prior to the September 15 following the MY.

7) Catheter Associated Urinary Tract Infections (CAUTI) (pay-for-reporting) – Hospitals are evaluated on their submission of CAUTI data to Wisconsin CheckPoint. To qualify for its earn-back on this measure, a hospital must submit its data to CheckPoint prior to the September 15 following the MY.

HWP4P payments, including the additional bonus payments, are limited by the federal UPL regulations at 42 CFR §447.321. All HWP4P payments, including the additional bonus payments, are included in the UPL calculation for the MY regardless of when payments are actually made.

SECTION 5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, are paid using EAPGs. The EAPG weights applied to out-of-state outpatient hospital claims are the same weights calculated for in-state hospitals. The EAPG base rate for out-of-state hospitals is the statewide EAPG base rate for non-CAH hospitals, as outlined in §4200. Payment for outpatient services provided by out-of-state hospitals without border status is limited to emergency services and services prior authorized by the WMP.

SECTION 5700 HOSPITAL OUTPATIENT EXTENDED NURSING SERVICES

Hospital outpatient extended nursing services (HOENSs) are nursing services and respiratory care provided by nurses, for part of a day, in a group setting, on the site of an acute care hospital approved under Wis. Admin. Code Ch. HS 124 or in a building physically connected to an acute care hospital approved under Wis. Adm. Code Ch. HS 124. The nursing services must be administered by or under the direct on-site supervision of a registered nurse. All medical care services must be prescribed by a physician.

Prior Authorization. HOENSs must be prior authorized by the WMP and, if not prior authorized, will not be reimbursed. Only persons who require eight or more hours per day of nursing services as determined by the WMP may qualify for HOENSs. The WMP uses its criteria for private duty nursing services to determine a person's need for nursing services. The request for prior authorization must describe the expected means by which the participant will regularly be transported between the participant's residence and the hospital.

Reimbursement. Reimbursement for HOENSs covers all nursing services and recognizes the additional costs associated with individuals who must remain for observation for extended periods of time. The WMP reimburses the services at an hourly rate. The hourly HOENSs rate may be billed only for the time during which a HOENSs patient is physically present at the hospital and attended by a nurse or a hospital staff person under the direct supervision of a nurse. Any portion of a quarter of an hour of presence at the hospital for HOENSs can be charged as a full quarter of an hour.

The payment rate is the lesser of the provider's usual and customary charge per hour and the maximum hourly fee established by the WMP for private duty nursing services provided by a registered nurse (RN) certified for respiratory care. The methods and standards for establishing the maximum fee are described in Item F, Methods and Standards for Establishing Payment Rates for Non-Institutional Care, of Attachment 4.19B of this State Plan.

No Final Settlement. The reimbursement for HOENSs is not included in any outpatient final settlement.

Cost Reporting. In its cost report, a hospital must separately identify and report those direct and indirect costs attributable to HOENSs in order to qualify for this reimbursement.

SECTION 6000 ADMINISTRATIVE ADJUSTMENT ACTIONS FOR IN-STATE HOSPITALS

6100 Introduction

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement. Department staff will review a request for an adjustment and determine if it should be denied or approved; if a request is approved, Department staff will determine the amount of adjustment.

An in-state hospital may appeal its outpatient reimbursement for one of the reasons listed in §6200 within 60 days of the date of its 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 RY.

If, at any time during the RY, the Department identifies a rate calculation error (that is, qualifications (a) through (c) below), it may, at its own discretion, recalculate a hospital rate and apply the new rate to all claims with dates of service in the RY. The Department does not initiate rate adjustments due to qualification (d); adjustments under that qualification only occur after a successful appeal initiated by a provider.

6200 Criteria for Administrative Adjustment

Allowable reasons for an outpatient payment rate appeal include:

(a) the application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's Medicare cost report or to other incomplete or incorrect data used to determine the hospital's outpatient payment rate; or
(b) a clerical error in calculating the hospital's outpatient 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 outpatient payment rate or in determining any administrative adjustment of a hospital's outpatient payment rate; or
(d) the most recent audited 12-month Medicare cost report used for the calculation was more than five years old.

To resolve appeals arising from qualification (d) above, the 12-month Medicare cost report that will be used for RY 2015 is the provider's FY 2012 12-month Medicare cost report, obtained from HCRIS as of September 30, 2014. If the FY 2012 12-month Medicare cost report is an unaudited Medicare cost report, the Department will recalculate the hospital's outpatient payment rate once the Medicare cost report becomes audited. If no FY 2012 12-month Medicare cost report is available from HCRIS for the provider, the Department will use the next most recent available 12-month Medicare cost report (for example, the Department would first try to use the FY 2011 12-month Medicare cost report, then the FY 2010 12-month Medicare cost report, and so on).

SECTION 7000 FUNDING OF OUTPATIENT MEDICAID DEFICIT

7100 General Introduction

A hospital in Wisconsin can receive additional reimbursement from the WMP for costs it incurred for providing outpatient hospital services to WMP recipients if provisions of this section are met. This is referred to as Medicaid deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. The reimbursement as described below is available beginning September 1, 2013 and is determined based on a hospital's Medicare cost report for its completed fiscal year.

7110 Qualifying Criteria.
A hospital can qualify for Medicaid deficit reduction funding if:
(a) it is an acute care hospital operated by the State or a local government in Wisconsin or is a non-state public psychiatric hospital located in Wisconsin; and
(b) it incurred a deficit from providing WMP outpatient services (described in §7120 below); and
(c) the operator of the hospital certifies that it has expended public funds to cover the deficit.

7120 Deficit from Providing WMP Outpatient Services.
The deficit from providing outpatient services to WMP recipients (that is, the Medicaid deficit) is the amount by which the cost, reduced for excess laboratory cost, of providing the services exceeds the WMP payment for those services. The cost of providing the WMP outpatient services is identified from the hospital's audited Medicare cost report for the hospital's fiscal year under consideration for the Medicaid deficit reduction.

Payment refers to the total of the reimbursement provided for outpatient services under the provisions of §4000 and §8000 of this Attachment 4.19B of the State Plan for the respective hospital fiscal year. Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures.

7125 Interim Payment, Interim Reconciliation, and the Final Reconciliation

The Department identifies the total amount of uncompensated WMP FFS outpatient hospital costs as described in §7120 to determine interim payments under this section until finalized hospital Medicare cost reports are available. For the hospital fiscal year, the Department determines cost-to-charge ratios for routine (hospital-based clinic services) and ancillary cost centers using the hospital's most recently filed Medicare cost report as available on HCRIS. The process for the interim payment calculation is as follows:

Step 1
The Department identifies total hospital costs from Worksheet C, Column 1, Lines 50-76 and Lines 90-92 for the CMS 2552-10 (Worksheet C, Column 1, Lines 37 through 62 for the CMS 2552-96). The Department uses these costs to determine the outpatient cost-to-charge ratios.

Step 2
The Department identifies the hospital's total charges by cost center from Worksheet C Part I, Columns 6 and 7 for both the CMS 2552-10 and CMS 2552-96.

Step 3
For each outpatient routine and ancillary cost center, the Department calculates the cost-to-charge ratio by dividing the total hospital costs identified in Step 1 by the total hospital charges identified in Step 2.

The Department uses the cost-to-charge ratios determined through the above process (steps 1-3) to determine the hospital's outpatient costs for the hospital fiscal year. These costs for WMP FFS are determined as follows:

Step 4
To determine outpatient WMP costs for the hospital fiscal year, the Department aggregates the hospital's WMP FFS outpatient charges by cost center. These charges are obtained from MMIS. To project WMP cost, the Department inflates the WMP charges from MMIS by the "Hospital and Related Healthcare Costs Index" published by IHS. The Department then multiplies the projected charges by the cost-to-charge ratios from Step 3 for each respective routine and ancillary cost center to determine the WMP FFS outpatient costs for each cost center.

Step 5
The WMP FFS cost eligible to be reimbursed via certified public expenditure (the Medicaid deficit) is the difference between the WMP FFS outpatient payments as recorded in MMIS and the WMP FFS outpatient costs from Step 4.

Final Reconciliation
Once the Medicare cost report for the hospital fiscal year has been finalized and audited, the Department conducts a reconciliation of the finalized amounts. This settlement is completed no more than one year after the Medicare cost report has been audited. The Department uses the same method as described above for the interim reconciliation for the final reconciliation, except that the finalized amounts are substituted as appropriate.

7130 Limitations on the Amount of Deficit Reduction Funding.
The combined total of (a) the Medicaid deficit reduction funding and (b) all other payments to the hospital for outpatient WMP services shall not exceed the hospital's total charges for the services for the hospital fiscal year. If necessary, the Medicaid deficit reduction funding shall be adjusted so the combined total payments do not exceed charges.

The aggregate Medicaid deficit reduction funding provided to hospitals under this section shall not exceed the amount for which federal matching dollars are available under federal UPLs at 42 CFR §447.321.

SECTION 8000 SUPPLEMENTAL FUNDING FOR ADULT LEVEL ONE TRAUMA CENTERS

For services provided on or after July 1, 2012, the WMP provides annual statewide funding of $4,000,000 per SFY to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons. The WMP makes this payment to hospitals with an Adult Level One Trauma Center to assist with the high costs associated with operating a center with this designation.

The WMP pays the trauma outpatient supplement monthly. The WMP distributes the funds proportionately among qualifying hospitals based on the number of eligible hospitals as described below.

A qualifying hospital's outpatient supplement is determined as follows:

$$\text{Hospital's annual trauma supplement} = \frac{\text{Qualifying Trauma Hospital}}{\text{Total Number of Hospitals Qualifying as Trauma Hospital}} \times \text{\$4,000,000 Statewide Annual Funding}$$

SECTION 9000 PAYMENT ADJUSTMENT FOR PROVIDER PREVENTABLE CONDITIONS

Payment Adjustment for Provider Preventable Conditions

The Department meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The Department identifies the following Health Care-Acquired Conditions for non-payment under Attachment 4.19-A:

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The Department identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____ Additional Other Provider-Preventable Conditions identified below.

In compliance with 42 CFR 447.26 (c), the Department provides:

1) That no reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of the treatment for that patient by that provider.
2) That reductions in provider payment may be limited to the extent that the following apply:
    a. The identified PPC would otherwise result in an increase in payment.
    b. The Department can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the PPC.
3) Assurance that non-payment for PPCs does not prevent access to services for WMP beneficiaries.