

**Wisconsin Medicaid Program**

*Outpatient Hospital State Plan, Attachment 4.19B  
Methods and Standards for Determining Payment Rates  
With Amendments Effective July 1, 2009*

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## 1000 OVERVIEW

This section is an overview of how the Wisconsin Medicaid program (WMP) establishes payment rates for hospital outpatient care provided persons eligible for fee-for-service coverage under the WMP. The payment is for outpatient medical services provided by a hospital in its 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 Medicaid provider. Payment rates are hospital-specific, cost-based and annually adjusted to recognize that hospitals vary significantly in the types of medical services they provide.

Hospitals located in the State of Wisconsin are reimbursed for outpatient services at an interim rate per visit with a subsequent retrospective final settlement as described in section 4000. The settlement takes into account the costs incurred by the hospital during its cost-reporting period, which generally is the hospital's fiscal year. Reimbursed costs under the retrospective settlement are limited to a prospectively established ceiling amount. The ceiling amount is a prospective, hospital-specific rate per outpatient visit that is based on a hospital's historical cost and adjusted to stay within the State's available funding for outpatient hospital services. Providers' allowable outpatient cost includes a limitation on capital costs to no more than 8% of the hospitals' total cost. Critical access hospitals are exempt from the ceiling rate but are subject to the capital cost limitation.

Ceiling rates are recalculated annually for the upcoming State fiscal year effective July 1 based on an audited cost report for each hospital. Administrative adjustment for the ceiling are available to recognize certain changes in costs incurred by the hospital that are not reflected in the historical cost report period (\$6000). Payments for outpatient hospital laboratory tests are limited to the WMP's fee schedule for laboratory tests.

For hospitals not located in the State, reimbursement is at a percentage of charges (\$5000). No final cost settlement is done for these hospitals. 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 general hospital. Payment for this service is separate from and not covered by the final cost settlements.

## 2000 STATUTORY BASIS

The outpatient reimbursement shall comply with all current and future applicable Federal and State laws and regulations and shall reflect all adjustments allowed under said laws and regulations. Federal regulations (42 CFR §447.321) require the Medicaid agency not pay more for outpatient hospital services than hospital providers would receive for comparable services under comparable circumstances under Medicare.

## 3000 GENERAL ITEMS

**Hospital Facility.** A *hospital facility* is the physical entity, surveyed and licensed by the Wisconsin Department of Health and Social Services under Chapter 150, Wis. Stats. For hospitals not located in Wisconsin, a hospital facility is 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.

**Hospital Licensure of Provider Premise.** Only medically necessary covered services provided within the physical licensed premises of a licensed *hospital facility* are eligible for reimbursement under outpatient hospital payment rates described in this document entitled "Methods and Standards for Determining Outpatient Hospital Payment Rates". This means a hospital cannot bill as outpatient hospital services those services provided off the physical premise of the licensed hospital facility or in an unlicensed portion of the hospital

facility.

**Outpatient Visit.** An admission to the outpatient hospital on a given calendar day, regardless of the number of procedures or examinations performed or departments visited. A maximum of one outpatient visit per patient per calendar day shall be recognized and paid.

**Cost Reporting.** To establish cost for outpatient rate setting, DHS will utilize the most recently available audited cost report (as of the January 1 date that occurs before the rate year) in the Health Cost Report Information System (HCRIS) maintained by the federal Center for Medicare and Medicaid Services (CMS).

**Clinical Diagnostic Laboratory Reimbursement.** The lower of laboratory fee schedule amounts of the Wisconsin Medicaid program or the hospital's laboratory charges for services provided.

**Upcoming State Fiscal Year.** The upcoming state fiscal year is the fiscal year of the State of Wisconsin that begins each July 1 for which prospective outpatient rates are calculated under section 4200.

**Critical Access Hospital.** A critical access hospital (CAH) is a hospital that meets the requirements under 42 CFR Part 485, Subpart F and is designated as a critical access hospital by CMS (HCFA), and the requirements of Wisconsin Administrative Code HFS 124.40 and is designated as a critical access hospital by the Department.

#### **4000 REIMBURSEMENT OF OUTPATIENT SERVICES OF IN-STATE HOSPITAL PROVIDERS FOR OUTPATIENT VISITS ON AND AFTER JULY 1, 2009**

**4100 Introduction.** This section 4000 describes the methodology for reimbursing hospitals located in the State of Wisconsin for outpatient hospital services provided persons eligible for fee-for-service medical coverage by the Wisconsin Medicaid program (WMP). The methodology described in §4200 through §4400 applies for outpatient visits occurring on and after July 1, 2009. Special provisions for the reimbursement of critical access hospitals are described in §4900 also effective July 1, 2009. An example of the calculation of a hospital's rate per outpatient visit is in the Appendix.

#### **4200 Establishing a Hospital-Specific Rate per Outpatient Visit**

**4205 Cost Report Used and Base Year.** A hospital's rate per outpatient visit is based on a hospital's historical cost of a recent fiscal period. Cost is identified from the most recently completed cost reporting period of at least six months for which the Department has an audited Medicare cost report on file as of January 1 prior to the beginning of the upcoming State fiscal year.

For newly established hospitals for whom an audited cost report is not available, the Department may designate a cost report to be used that may be a cost report that is received after the above January 1st date. It may be the audited cost report for the first retrospective settlement period of the new hospital that is six months or longer.

A new owner may take-over the operation of a hospital. Cost reports from the prior owner of the hospital are used to establish the prospective rate per outpatient visit until an audited cost report becomes available under the new ownership. Separate hospitals may combine into one operation, under one WMP provider certification, either through merger or consolidation or through 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. The audited cost reports of the separate hospitals are combined to establish the prospective rate per outpatient visit for the combined

hospital provider until an audited cost report is available for the combined operation.

It should be noted that the audited cost report is the basis for calculating the rate per outpatient visit of \$4220. The same audited cost report is used for the retrospective settlement period process described in §4410. For the administrative adjustment criteria of §6000 and §6800, the terms "*outpatient base year*" and "*base year*" refer to the cost report period described above even if the period is more or less than a year.

**4210 Calculate Average Inflated Cost per Visit.** An average inflated cost per visit is established from the audited cost report of each hospital. The cost report includes a methodology of cost finding that identifies the amount of costs applicable to outpatient services provided persons covered by the WMP. Capital costs applicable to outpatient services provided to WMP recipients is limited to no more than 8% of the total outpatient cost consistent with the limitations in section 5162 of the Inpatient State Plan. Capital costs are calculated from Worksheet B Part II and Part III of the Medicare cost report. Specifically, capital costs are taken from column 27, line 103 from Worksheet B Part II and Part III. However the Department removes non hospital and non allowable capital costs, specifically the following cost centers are removed to calculate total capital costs: cost centers 34 through 36, 63 through 81, 92, 93, and 96 through 100. Total cost is calculated in the same manner but the values are taken from Worksheet B Part I, column 27, line 103 from the Medicare cost report. If a facilities total capital costs are greater than 8 percent of total costs, a limitation is imposed. The total allowable outpatient cost is inflated to the upcoming State fiscal year by an inflation adjustment multiplier. The resulting inflated cost divided by the number of WMP outpatient visits incurred by the hospital during the cost report period results in the hospital's "*average inflated cost per visit*".

Inflation adjustment multipliers result from the following ratio calculation:

Price index for the ending quarter of the upcoming State fiscal year divided by the price index for the ending quarter of the audited cost report of each hospital. The indexes used are from the publication, "Health Care Cost Review", that is published quarterly by the DRI•WEFA, Inc., a Global Insight Company. (Prior to the second quarter of 2001, the "Health Care Cost Review" was published quarterly by the Standard & Poor's DRI division of The McGraw-Hill Companies.) Specifically used are the total market basket indexes as listed by calendar quarter in the tables for HCFA's hospital prospective reimbursement. In the publication's second quarter 2000 edition, this table is entitled "HCFA Hospital Reimbursement Market Based (PPS) – Historical Data" for historical quarters and, for forecasted future quarters, the table is entitled "HCFA Hospital Prospective Reimbursement Market Basket (PPS) – Quarterly Forecasts".

**4220 Calculate Rate per Outpatient Visit.** A prospective "*rate per outpatient visit*" is calculated for each hospital for the period of each upcoming State fiscal year beginning July 1. The average inflated allowable cost per visit is multiplied by a budget neutrality factor. The budget neutrality factor is a percentage applied to costs in order to maintain payments within the federal upper payment limits of 42 CFR §447.321 and the State's available funding for outpatient hospital services for the upcoming State fiscal year. The factor is 34.62% for rate year 2010. The resulting "*rate per outpatient visit*" is a limit or ceiling on the costs to be reimbursed in the retrospective settlement that will be done in subsequent years when the hospital's audited cost report for its present in-process fiscal period becomes available to the Department.

**4250 Budget Neutrality Factor.** A budget neutrality factor is calculated for each upcoming State fiscal year. Before calculating the budget neutrality factor, the Department identifies the amount of funds that are available in the upcoming State fiscal year to reimburse hospitals for outpatient services. The Department

also estimates the gross projected costs to be incurred by each and all hospitals for these outpatient services. The budget neutrality factor is the quotient of the total funding available for reimbursing non-CAH hospitals for outpatient services divided by the projected costs of outpatient services of all non-CAH hospitals. The budget neutrality factor is 34.62% for rate year 2010.

According to §4220, the budget neutrality factor times the average inflated costs per visit for each hospital results in each hospital's rate per outpatient visit.

*4260 Outpatient Access Payments.* To promote WMP member access to acute care, children's and rehabilitation hospitals throughout Wisconsin, WMP will provide a hospital access payment amount per outpatient visit. Access payments are intended to reimburse hospital providers based on WMP volume. Therefore, the payment amounts per visit are not differentiated by hospital based on acuity or individual hospital cost.

The amount of the hospital access payment per visit is based on an available funding pool appropriated in the state budget. This amount is divided by the estimated number of paid outpatient visits for the fiscal year. The funding pool amount for rate year 2010 is \$82,007,587. The access payment per visit amount is identified on the hospital reimbursement rate web page of the Wisconsin Forward Health website at [www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov). This payment per visit will be in addition to the base payment per visit described in Section 4220.

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

Access payments per visit are only provided until the fee-for-service hospital access payment funding pool has been expended for the rate year.

#### **4300 Interim Payments.**

Payments, based on an interim rate, are provided during a hospital's fiscal year. Interim payments are reconciled to reimbursable costs at the time of retroactive settlement. For most hospitals, this interim rate is the hospital's rate per outpatient visit. For new hospital providers for which an audited cost report is not available, the Department makes interim payments at the average percentage of allowed outpatient hospital charges paid to in-state hospitals. Clinical diagnostic laboratory tests performed with outpatient visits are paid at WMP fee schedule for such tests. The Department may adjust interim payment rates in order to approximate the amount that is expected to be due the provider upon final settlement. This may include, but is not limited to, administrative adjustments under \$6000 and \$6800.

#### **4400 Computation of Retroactive Settlement**

*4410 Retroactive Settlement Period.* A hospital's interim payments are reconciled to the hospital's reimbursable cost for the period of its audited cost report. Most cost reports cover the hospital's fiscal year but could cover a period other than twelve months. The period need not coincide with the State fiscal year.

*4420 Allowable Outpatient Costs.* A hospital's "allowable outpatient costs" are identified in its audited cost report and are determined according to applicable Medicaid and Medicare standards and principles of reimbursement (42 CFR Part 405 and HIM-15). The cost report provides a methodology of cost finding that identifies the amount of costs applicable to outpatient services provided persons eligible for fee-for-service coverage of the Wisconsin Medicaid program.

*4430 Limitations On Reimbursed Costs.* The amount of allowable outpatient cost that is finally reimbursed in the

retroactive settlement is limited by all of the following amounts. Allowable outpatient costs that exceed any of these limitations are not reimbursed.

1. The “*calculated gross rate amount*” is the rate per outpatient visit including amounts for administrative adjustments under §6800, multiplied by the number of outpatient visits incurred by the hospital for WMP recipients in the settlement period. For a cost report period that overlaps two State fiscal years, rates and visits for each of the overlapping periods are combined. For example, given a cost report of a December end fiscal year, the January to June visits multiplied by the rate for January to June equals a gross amount. The July to December visits multiplied by the rate for those months equals a gross amount. Summing the two gross amounts gives the “*calculated gross rate amount*” for the cost report period.
2. The “*total allowed charges*” for the outpatient visits of WMP recipients during the cost report period are tabulated and summed from the UB-92 billing claims submitted by the hospital to the WMP. Allowed charges means charges for medically necessary services covered by the WMP.
3. A “*gross laboratory-fee-limited ceiling*” is the sum of the amounts calculated under items (a) and (b) below.
  - (a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests based on the WMP fee schedule for such tests.
  - (b) For other services provided in the outpatient visits (that is, services other than the above laboratory tests), the lower of the following is determined, either (1) the total allowed charges for such other services, or (2) the total allowable costs, including capital costs limited to no more than 8% of total cost, for such other services.

**4450 Determine Reimbursement Settlement.** The “*reimbursable costs*” for a hospital is the lower of (1) its “*calculated gross rate amount*”, (2) its “*total allowed charges*”, or (3) its “*gross laboratory-fee-limited ceiling*”, or (4) its “*allowed outpatient costs*” including capital costs limited to no more than 8% of total cost.

If interim payments for the cost report period exceed “*reimbursable costs*”, then the Department recovers the excess payments. If interim payments are less than the “*reimbursable costs*”, then the Department is liable to the hospital for the difference.

#### **4900 Critical Access Hospitals**

**4920 Interim Payments.** Interim payments are made at the critical access hospital’s (CAH) average inflated cost per visit of \$4210 above including limitation of capital costs to no more than 8% of total cost.

**4930 Retroactive Settlement.** Critical Access Hospital’s outpatient payments are subject to a retroactive settlement based on the final Medicaid cost report for the hospital’s fiscal year. The final settlement will compare the lower of the hospital’s allowable costs including capital costs limited to no more than 8% of total cost, allowable charges, or “*gross laboratory-fee-limited ceiling*”, with the interim Medicaid payments for those services.

A “*gross laboratory-fee-limited ceiling*” is the sum of the amounts calculated under items (a) and (b) below.

- (a) For diagnostic laboratory tests provided in outpatient visits, the total amount that the WMP would reimburse for the laboratory tests based on the WMP fee schedule for such tests.
- (b) or other services provided in the outpatient visits (that is, services other than the above laboratory tests), the lower of the following is determined, either (1) the total allowed charges for such other services, or (2) the total costs for such other services including capital costs limited to no more than 8% of total cost.

If the interim payments exceed the final settlement comparison for the lower of the allowable costs, allowable charges or "gross laboratory-fee-limited ceiling", the department will recover the excess payments.

If the final settlement comparison for the lower of the hospital's allowable cost, allowable charges or "gross laboratory-fee-limited ceiling" exceed the interim payments, the department will reimburse the hospital by the amount of the lower of the hospital's allowable cost, allowable charges or "gross laboratory-fee-limited ceiling, minus interim payments.

## **5000 REIMBURSEMENT FOR OUTPATIENT SERVICES PROVIDED OUT-OF-STATE**

Outpatient hospital services provided at all out-of-state hospitals, including border status hospitals, shall be paid at the average percentage of allowed outpatient hospital charges paid to in-state non-CAH hospitals. Reimbursement for diagnostic laboratory services will be the lower of laboratory fee schedule amounts of the Wisconsin Medical Assistance Program or the hospital's laboratory charges for services rendered. Payment for outpatient services provided by out-of-state hospitals which are not certified as border status will be limited to emergency authorized services or services prior by the Wisconsin Medical Assistance Program

## **5700 HOSPITAL OUTPATIENT EXTENDED NURSING SERVICES**

Hospital outpatient extended nursing services 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 general hospital approved under Wis. Admin. Code ch. HS 124 or in a building physically connected to an acute care general 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.* Hospital outpatient extended nursing services must be prior authorized by the WMAP 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 WMAP may qualify for outpatient extended nursing services. The WMAP will use 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 outpatient extended nursing services shall cover all nursing services and shall recognize the additional costs associated with individuals who must remain for observation for extended periods of time. The services will be reimbursed at an hourly rate. The hourly outpatient extended nursing services rate may be billed only for the time during which an outpatient extended nursing services 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 outpatient extended nursing services 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 or the maximum hourly fee established by the Wisconsin Medicaid program for private duty nursing services provided by a registered nurse (RN) certified for respiratory care. The methods and standards for establishing the maximum fee is described in Item F, Methods and Standards for Establishing Payment Rates for Non-Institutional Care, of Attachment 4.19B of this state plan as amended by Wisconsin State Plan Amendment 96-013, effective April 1, 1996.



*No Final Settlement.* The reimbursement for outpatient extended nursing services will not be included in the outpatient final settlement described in section 4000.

*Cost Reporting.* A hospital must separately identify and report in its cost report those direct and indirect costs attributable to the outpatient extended nursing services in order to qualify.

## **6000 ADMINISTRATIVE ADJUSTMENT ACTIONS**

For Hospitals In Wisconsin Only

### **6100 Introduction.**

The Department provides an administrative adjustment procedure through which an in-state hospital may receive prompt administrative review of its outpatient reimbursement under the circumstances described in section 6800. Department staff review a request for an adjustment and determine if it should be denied or approved and, if approved, the amount of adjustment. If the hospital disputes the staff determination, the administrative adjustment can be forwarded for review to the Administrative Adjustment Committee (AAC). The AAC provides a recommendation to the Department regarding the disputed adjustment. A detailed description of the policies and procedures for processing administrative adjustments is in the Appendix. Administrative adjustment actions are not available to out-of-state hospitals (reference §5000).

### **6200 Hospital's Submission of Request for Adjustment.**

A hospital must deliver a written request to the Department for an administrative adjustment within the time constraints of the 60 day rule below. An adjustment may be requested for interim payment rates and for reimbursement final settlements.

In order to be considered sufficient, the hospital must specify the following items in its written request: (1) that the request applies to its outpatient reimbursement, (2) either the effective date of the interim payment rate or the final settlement year for which an adjustment is being requested and (3) the specific matter listed in §6800 below for which the hospital is making its request for an adjustment. The Department may, at its discretion, pursue clarification of and subsequently accept an incomplete request.

Requests should be addressed to the:

Department of Health Services, Hospital Unit,  
1 West Wilson Street, Room 250,  
P. O. Box 309, Madison, Wisconsin 53701-0309.

The FAX telephone number is (608) 266-1096 but may change without notice.

If a hospital had requested an adjustment to an interim payment rate, the Department will generally include the adjustment in subsequent interim rate calculations or final settlement calculations without the hospital specifically requesting the adjustment. (Adjustment §6810 below allows a hospital to withdraw such an adjustment the Department made at its discretion.) *However, it is the hospital's responsibility to assure that any administrative adjustment it wants are included in its interim rates and in its final settlement calculations.* If not included, the hospital must submit a request for the adjustment within the appropriate time limit.

### **6300 The 60 Day Due Date Rule.**

The effective date of an administratively adjusted payment rate shall depend on when the hospital requests the adjustment or the Department initiates the adjustment. The effective date shall be established according to the following criteria.

**6301 Definition, "Delivery date".**

The U.S. Postal Service postmark date will be considered delivery date of a mailed administrative adjustment request. If delivered by FAX machine, the inscribed date from the Department's FAX machine shall be considered the delivery date. Delivery date under any method, other than U.S. mail or FAX, shall be the day the Department receives delivery.

The Department is not responsible for written requests which are lost in transit to the Department. If lost, the hospital must demonstrate to the satisfaction of the Department that a "delivery date" had been established according to the above criteria. The Department recommends that hospitals use registered return-receipt U.S. mail in order that they have documentation of the postmark date and that the Department received the request.

**6302 Interim Rates, Due Date for Request for Administrative Adjustment.**

A hospital may request an adjustment to its interim payment rate. Within the 60 day period after the date of a notice of interim rate approval, a hospital must deliver a written request to the Department for an administrative adjustment in order for the requested adjustment to take effect on the original effective date of the interim rate. If a hospital delivers a written request more than 60 days after the date of a notice of interim rate approval, then any adjusted rate shall take effect on the first of the month following the delivery date. The Department's notice of the adjusted interim rate does not start a new 60 day period.

*A notice of interim rate approval* is a written notice to a hospital from the Department which lists the hospital's interim rate and its effective date and also states that the hospital has 60 days to request an administrative adjustment.

**6303 Final Settlement, Due Date for Request for Administrative Adjustment.**

A hospital must deliver a written request to the Department for an administrative adjustment within the 60 day period after the date of the notice of final settlement. A request will be denied if it is delivered more than 60 days after the date of the notice of final settlement. It should be noted that the rates per outpatient visit which apply to a final settlement may be administratively adjusted at the time of the final settlement.

*A notice of final settlement* is a written notice to a hospital from the Department which identifies the results of the final settlement calculation for a specified fiscal year of the hospital. It will also state that the hospital has 60 days to request an administrative adjustment.

**6400 Administrative Adjustments Initiated by the Department.**

The Department may initiate an administrative adjustment not requested by the hospital and incorporate the adjustment into its calculation of an interim rate or into its final settlement calculations. However, the Department may initiate an adjustment after it has sent a notice of interim rate approval or a notice of final settlement to the hospital. The date the Department initiates the adjustment is the date of any written notice the Department may provide to the hospital which notifies the hospital that the Department has initiated an administrative adjustment. If the date of that notice is within 60 days after the date of a notice of an interim rate approval or a notice of final settlement, the adjustment shall take effect on the original effective date of the interim rate or the final settlement. If more than 60 days, the adjustment shall take effect on the first of the month following the date of the Department's notice that it is initiating an adjustment. If the Department's adjustment causes a reduction of reimbursement, the hospital may request an administrative adjustment within the above 60 day rule period.

**6500 Correction of Inappropriate Calculations, Coincident With An Adjustment.**

The Department may find an inappropriate calculation of a hospital's interim rate or final settlement coincident with its processing an administrative adjustment. An inappropriate calculation is defined in §6820 below. The Department's correction of the inappropriate calculation will be effective the date the administrative adjustment

is effective. If a requested adjustment is denied, the correction of the inappropriate calculation found by the Department will be effective the date the requested adjustment would have been effective had it been approved. A new 60 day rule period shall be allowed the hospital commencing with the date of notification to the hospital of the corrected interim rate or final settlement if the correction causes a reduction of reimbursement.

For example, the adjustment requested by a hospital provided a \$10 rate increase. An inappropriate calculation found by the Department caused a \$2 decrease. Even though the net effect is an \$8 rate increase, the isolated effect of the Department's correction caused a \$2 decrease. As a result, the hospital will have a new 60 day period for requesting an administrative adjustment.

#### **6600 Reduced Payment Possible.**

If an administrative adjustment results in a lesser payment than would have been provided had no administrative adjustment been applied, the lesser amount will be paid. If an administrative adjustment results in an increased payment, the increase shall be paid.

#### **6700 Withdrawal.**

Once Department staff has calculated the adjustment requested by a hospital and notified the hospital of the results the hospital cannot withdraw its request for the administrative adjustment. However, adjustment §6810 below allows a hospital to withdraw an adjustment under certain circumstances at the time of final settlement. The Department cannot withdraw an administrative adjustment after it has notified the hospital that it has initiated an administrative adjustment.

#### **6820 Criteria for Administrative Adjustment: Correction of a Rate Calculation Error**

The Department provides a mechanism through which a hospital may receive review of its outpatient reimbursement in case of a calculation error. This mechanism is described below:

*Qualifying Determination:* The interim payment rate or a final settlement must have been inappropriately calculated under the rate setting plan.

- (a) The application of the rate setting methodology or standards to incomplete or incorrect data contained in the hospital's cost report or to other incomplete or incorrect data used to determine the hospital's payment rate, or
- (b) A clerical error in calculating the hospital's payment rate, or
- (c) Incorrect or incomplete application by the Department of provisions of the reimbursement methodology or standards in determining one or more components of the hospital's payment rate schedule or in determining any administrative adjustment of a hospital's payment.

### **SECTION 7000 FUNDING OF OUTPATIENT MEDICAID DEFICIT IN GOVERNMENTAL HOSPITALS**

#### **7001 GENERAL INTRODUCTION**

An acute care general hospital operated by the State or a local government in Wisconsin will receive reimbursement from the Wisconsin Medicaid program for costs it incurred for providing outpatient hospital services to Wisconsin Medicaid recipients if provisions of this section are met. This is referred to as deficit reduction funding and is an adjustment to prior year costs as defined in 45 CFR §95.4. This reimbursement is available for hospital fiscal years beginning on and after July 1, 2006 and is determined

based on a hospital's Medicare cost report for its completed fiscal year.

### **7010 QUALIFYING CRITERIA**

A hospital will qualify for deficit reduction funding if:

- (a) The hospital is an acute care general hospital operated by the State or a local government in Wisconsin.
- (b) It incurred a deficit from providing Medicaid outpatient services (described in §7020 below).
- (c) The governmental unit that operates the hospital certifies it has expended public funds to fund the deficit.

### **7020 DEFICIT FROM PROVIDING MEDICAID OUTPATIENT SERVICES**

The deficit from providing outpatient services to Wisconsin Medicaid recipients (that is, the Medicaid deficit) is the amount by which the cost, reduced for excess laboratory cost, exceeds the payment for the Medicaid outpatient hospital services.

Payment above refers to the total of the reimbursement provided under the provisions of section 4000 of this Attachment 4.19B of the State Plan for the respective fiscal year.

Excess laboratory cost is the amount by which the costs of laboratory procedures exceed the clinical diagnostic laboratory reimbursement for those procedures. Clinical diagnostic laboratory reimbursement is the lower of laboratory fee schedule amounts of the Medicaid program or the hospital's charges for the procedures (as defined in §3000).

This section describes the cost of providing outpatient hospital services. For the payment year, the cost to charge ratios for the routine and ancillary cost centers are determined using the hospital's most recently filed Medicare cost report (CMS 2552) as filed with the Medicare fiscal intermediary. Routine outpatient costs refer to hospital based clinic services. The cost to charge ratios are calculated as follows:

#### **Step 1**

Total hospital costs will be identified from Worksheet C, Column 1, lines 37-62. These costs represent the total hospital costs for purposes of determining the outpatient cost to charge ratios.

#### **Step 2**

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

#### **Step 3**

For each outpatient routine and ancillary cost center the cost to charge ratio is obtained from Worksheet C, column 9, lines 37-62.

The cost to charge ratios determined through the above process (steps 1-3) for the filed cost report year are used to determine the hospital's outpatient costs for the payment year. The hospital costs for Medicaid FFS for the payment year are determined as follows:

#### **Step 4**

To determine the outpatient cost center costs for the payment year, the hospital's projected Medicaid FFS outpatient charges by cost center are used. To project Medicaid FFS charges as accurately as possible for the payment year, the hospital will base its projection on its actual experience of Medicaid FFS outpatient charges for the most recent six month period. The projected charges are multiplied by the cost to charge ratios from Step 3 for each respective routine and ancillary cost center to determine the Medicaid FFS outpatient costs for each cost center.

Step 5

The Medicaid FFS costs eligible as certified public expenditures are determined by adding the Medicaid FFS outpatient costs from step 4 and subtracting estimated Medicaid FFS outpatient payments. The hospital will base its payment estimate on its Medicaid FFS payment experience for the most recent six month period.

Final Reconciliation

Once the CMS 2552 cost report for the payment year has been finalized by the Medicare fiscal intermediary, a reconciliation of the finalized amounts will be carried out. This settlement will be completed within one year after the Medicare cost report has been audited by the Medicare fiscal intermediary. The same method as described for the interim reconciliation will be used except that the finalized amounts will be substituted as appropriate.

**7030 LIMITATION ON THE AMOUNT OF DEFICIT REDUCTION FUNDING**

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

The aggregate deficit reduction funding provided hospitals under this section will not exceed the amount for which FFP that is available under federal upper-payment limits at 42 CFR §447.321.

**SECTION 8000 SUPPLEMENTAL FUNDING FOR ADULT LEVEL ONE TRAUMA CENTERS**

For services provided on or after July 1st, 2009, the WMP will provide annual statewide funding of \$8,000,000 per rate year to hospitals with an Adult Level One Trauma Center, as designated by the American College of Surgeons.

The trauma outpatient supplement is paid as a monthly amount established according to the following method. A total of \$8,000,000 is distributed each rate year among hospitals qualifying for this supplement. This is distributed proportionately among qualifying hospitals based on their number of eligible hospitals as described below.

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

$$\text{Hospital's annual trauma supplement} = \frac{\text{Qualifying Trauma Hospital}}{\text{Sum of all Hospitals qualifying as Trauma Hospital}} \times \$8,000,000 \text{ Statewide annual funding}$$

END OF OUTPATIENT HOSPITAL STATE PLAN

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**APPENDIX EXAMPLE CALCULATION OF RATE PER OUTPATIENT VISIT**

Period of Hospital's Base Year Cost Report..... 7/1/05 to 6/30/06

1	Outpatient costs for WMP fee-for-service covered recipients.....	\$237,433
2	Times: Inflation adjustment multiplier .....	1.13
3	= Inflated cost report cost .....	\$ 268,299
4	Divide by: Outpatient visits .....	2,012
5	= Average inflated cost per visit.....	\$ 133.35
6	Times: Budget neutrality factor.....	.70
7	= Rate per outpatient visit.....	\$ 93.34

End of Outpatient Hospital State Plan As Amended to July 1, 2009