5353 Changes of Ownership

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

5362 Provisions Relating to Organ Transplants

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

a. The transplant must be performed at an institution approved by the WMAP for the type of transplant provided. A list of approved hospitals is available from the Department of Health Services, P.O. Box 309, Madison, WI 53701-0309.

b. The transplant must be prior authorized by the Department. Prior authorization requests must be submitted jointly by the hospital and the transplant surgeon, and must include written documentation attesting to the appropriateness of the proposed transplant. Payment will not be made without prior authorization approval.

c. In order to include the acquisition costs in the allowable charges, and not have the "acquisition costs" deducted from the transplant payment rate, the hospital will have to provide assurance to the Department that organs are procured from an organ procurement organization.

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

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

5400 Reimbursement for Critical Access Hospitals

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

Critical access hospitals shall be reimbursed no more than the lower of 90% of the hospital's allowable cost or 100% of charges for services provided to Medicaid recipients.

If payment exceeds 90% of costs, the Department will recover excess payments from the hospitals.

If 90% of costs exceed interim payments, the Department will reimburse the hospital the amount by which 90% of the hospitals costs exceed payments.

The Department will calculate an interim discharge rate based on 90% of a hospital's cost as reported on the most currently audited cost report. If no cost report is available, the best available data will be used to set an interim rate.

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

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

OS Notification

State/Title/Plan Number: Wisconsin 10-008

Type of Action: SPA Approval

Required Date for State Notification: December 16, 2010

Fiscal Impact: FY 2010 $(3,300,000)
FY 2011 $(4,170,000)

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after January 1, 2010, this amendment revises methodology for reimbursement to critical access hospitals (CAH). Specifically, the methodology is being revised so that CAHs shall be reimbursed no more than the lower of 90% of the CAH's allowable costs or 100% of charges for services provided to Medicaid recipients. Funding the non-Federal share of these payments comes from State appropriations and a permissible provider tax. UPL demonstration was acceptable.

The State feels that even with the reduction in payment rates to CAHs, these facilities still receive higher reimbursement than acute care hospitals operating in similar markets. The State met with providers as part of the public process and they did not comment on access being an issue with the implementation of this rate cut. They also performed surveys to gain comments on the cuts as well as researched similar cuts nation-wide and did not find any access issues.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the Recovery Act requirements noted above.

CMS Contact:

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