unaudited cost report is audited to determine the final rate.

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 hospitals 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.

For a new in state hospital in which an audited cost report is not available, outpatient hospital services 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.

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.

4210 Calculate Average Inflated Cost per Visit. An average 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. 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, 63.5 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 facility's 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 beginning 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 index used is from the publication, "Health Care Cost Review" that is published quarterly by the IHS 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 is the Hospital and Related Services Individual Price Index.

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 31.72% for rate year 2013. The resulting *"rate per outpatient visit"* is a prospective payment rate and is considered final payment, except for laboratory services which are

subject to the retrospective settlement that will be done in subsequent years.

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 31.72% for rate year 2013 (beginning on July 1 and ending on June 30).

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, rehabilitation, and critical access 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. However, the access payment per visit paid to critical access hospitals are reimbursed at a different payment rate compared to the access payment rate per visit paid to acute care, children, and rehabilitation hospitals.

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 state fiscal year. The funding pool amount for rate year 2013 is $116,965,165 for acute care, children's, and rehabilitation hospitals. The funding pool amount for rate year 2013 is $2,692,382 for critical access hospitals. 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. This payment per visit will be in addition to the base payment per visit described in §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. 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 to acute care hospitals, children, rehabilitation, and psychiatric hospitals are based on the rate setting methodology outlined in Section 4210. The payment per visit is a prospective based rate and is not subject to annual cost settlement. However, each hospital is subject to a retroactive settlement only for laboratory services billed as outpatient hospital services as outlined in section 4400.

4400 Computation of Retroactive Settlement

4410 Retroactive Settlement Period. Payments to acute care hospitals, children, rehabilitation, and psychiatric hospitals are based on the rate setting methodology outlined in Section 4210. The payment per visit is a prospective based rate and is not subject to annual cost settlement. However, each hospital is subject to a retroactive settlement only for laboratory services billed as outpatient hospital services as outlined in section 4400.

4420 Limitations On Laboratory Reimbursement. The amount of allowable outpatient payment that is finally reimbursed in the retroactive settlement is limited by all of the following amounts.