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State/Territory Name: Wisconsin

State Plan Amendment (SPA) WI: 25-0011

This file contains the following documents in the order

listed:1) Approval Letter

2) CMS 179 Form/Summary Form (with 179-like data)

3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

September 23, 2025

Bill Hanna
State Medicaid Director
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

RE: TN 25-0011

Dear Director Hanna:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wisconsin state plan amendment (SPA) to Attachment 4.19-A, which was submitted to CMS on June 27, 2025. This plan amendment updates reimbursement for outpatient or professional claims to be allowed if billed by a provider other than the admitting inpatient hospital.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of April 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at tom.caughey@cms.hhs.gov.

Sincerely,

A solid black rectangular box used to redact the signature of the sender.

Rory Howe
Director
Financial Management Group

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 5 — 0 0 1 1

2. STATE

WI

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL
SECURITY ACT



XIX



XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

4/1/2025

5. FEDERAL STATUTE/REGULATION CITATION

42 CFR 482.54

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 25 \$ 226,613

b. FFY 26 \$ 435,225

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

4.19-A (Inpatient Hospital State Plan) Pg. 18

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable)

4.19-A (Inpatient Hospital State Plan) Pg. 18

9. SUBJECT OF AMENDMENT

Allowing reimbursement of outpatient services rendered during an inpatient stay at another facility.

10. GOVERNOR'S REVIEW (Check One)



GOVERNOR'S OFFICE REPORTED NO COMMENT



COMMENTS OF GOVERNOR'S OFFICE ENCLOSED



NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL



OTHER, AS SPECIFIED:



11. SIGNATURE OF STATE AGENCY OFFICIAL



12. TYPED NAME

Bill Hanna

13. TITLE

Medicaid Director

14. DATE SUBMITTED

6/27/2025

15. RETURN TO

Allie Merfeld

State Plan Amendment Coordinator Department of Health
Services

1 W. Wilson St.

P.O. Box 309

Madison, WI 53701-0309

FOR CMS USE ONLY

16. DATE RECEIVED

June 27, 2025

17. DATE APPROVED

September 23, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

April 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL



20. TYPED NAME OF APPROVING OFFICIAL

Rory Howe

21. TITLE OF APPROVING OFFICIAL

FMG, Director

22. REMARKS

6540 Transfers

6541 Hospital to Hospital Transfers. Patient transfers can be reviewed by the EQRO or the Department for medical necessity. If the transfer is determined not to have been medically necessary, then no payment will be made for the stay that was not deemed medically necessary.

6542 IMD to Hospital Transfers. An inpatient at an IMD can transfer to an acute care hospital for a short term stay, then return to the IMD and eventually be discharged from the IMD. If the person's absence from the IMD is due to the person being an inpatient of one or more acute care hospitals for a period of three or less consecutive days, the IMD will not be paid a payment for the transfer to the acute care hospital. If the absence is for a period exceeding three consecutive days, the IMD will receive payment for the transfer to the acute care hospital. Three or less consecutive days means the patient is absent or on-leave from the IMD for three or less successive midnight census counts of the IMD. The IMD will be eligible for payment for each medically necessary day the patient was included in the census counts of the IMD. The acute care hospital, to which the patient was transferred, will be reimbursed for the medically necessary stay without regard to the patient's length of the stay in the acute care hospital. Any payment to the IMD for a person's inpatient stay is subject to the person being eligible for MA coverage for their stay in the IMD.

6550 Days Awaiting Placement

Days awaiting placement are those days of an inpatient hospital stay during which medically necessary services could have been provided to the patient in a nursing facility or some other alternative treatment setting. A DRG weighted discharge payment will not be adjusted for days a WMP recipient patient awaited placement to an alternative living arrangement. If placement to a NF or an ICF-IDD is delayed, not on the hospital's part, for completion of required pre-admission screening for mental illness and/or mental retardation (required under Subtitle C, Part 2 of PL 100-203, the Omnibus Budget Reconciliation Act of 1987), the hospital can request and receive a per diem payment for each allowed day identified as waiting placement due to the lack of the pre-admission screen. This payment shall be in addition to the DRG payment, not to exceed the estimated statewide average NF rate. Each allowed day awaiting placement must be adequately documented for review in the patient chart.

6560 Outpatient Services Related to Inpatient Stays

Outpatient hospital claims for services provided to a recipient during an inpatient stay are considered part of the inpatient stay and will be denied if submitted by the admitting inpatient hospital. Emergency room services shall be considered part of the inpatient stay, not outpatient services, if the patient was admitted and counted in the midnight census. Outpatient or professional claims will be allowed if billed by a provider other than the admitting inpatient hospital.

6570 Obstetrical and Newborn Same Day Admission/Discharge

A hospital stay shall be considered an inpatient stay when a WMP recipient is admitted to a hospital and delivers a baby, even if the mother and the baby are discharged on the date of admission and not included in the midnight census. This consideration applies to both the newborn infant and the mother and also applies in those instances when the recipient and/or newborn are transferred to another hospital.

6580 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 Medicare cost reports will be used until the new owner's Medicare cost reports come due for use in the annual rate update.