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State/Territory Name: WI

State Plan Amendment (SPA) #: 17-0010

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

June 21, 2018

Heather K. Smith, Medicaid Director
Division of Medicaid Services
Wisconsin Department of Health Services
1 West Wilson Street, Room 350
Madison, WI 53702

ATTN: Al Matano, SPA Coordinator

RE: Technical Correction to Wisconsin State Plan Amendment 17-0010

Dear Ms. Smith:

This is a technical correction to Wisconsin State Plan Amendment (SPA) 17-0010 which was approved on May 2, 2018. Effective July 1, 2017, this SPA changes the reimbursement methodology for non-tribal federally qualified health centers from a cost-based reimbursement methodology to prospective payment system. It was discovered after this SPA was approved that the approved SPA pages were not the latest version approved by the Centers for Medicare & Medicaid Services (CMS). As a result, we are issuing this technical correction with the correct SPA pages and an updated CMS-179. The original date of approval will remain as is.

If you have any questions, please have a member of your staff contact Mai Le-Yuen at (312) 353-2853 or by email at mai.le-yuen@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-0010

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2017

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
1905(a)(2)(C) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 ..... $0K
b. FFY 2018 ..... $0K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Pages 10 and 10.a. through 10.d. .....
Attachment 4.19-B Pages 10.e. through ~~10.g.~~ 10.h. .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same. .....
New. .....

10. SUBJECT OF AMENDMENT:
Medicaid reimbursement for Federally Qualified Health Centers (FQHCs)

11. 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: [redacted]

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME:
Michael G. Heifetz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 29, 2017

16. RETURN TO:
Michael G. Heifetz
State Medicaid Director
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 29, 2017

18. DATE APPROVED:
May 2, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Alan Freund

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

HPSA incentive payments encourage primary care physicians and mid-level health professionals to provide primary care services to Medical Assistance recipients who live in medically underserved areas of Wisconsin. The HPSA incentive program is an adaptation of the Medicare HPSA program, with a special emphasis on primary care services. The enhanced payment assists HPSA areas in recruitment and retention of physicians and mid-level health professionals.

The reasons for targeting primary care services are discussed in the Primary Care Provider Incentive Payment (number 22 below).

Effective for payments made on or after October 16, 1993 for dates of service on and after July 1, 1993.

16. Non-Tribal Federally Qualified Health Centers (FQHCs)

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Wisconsin Department of Health Services (DHS) for non-tribal Federally Qualified Health Centers (FQHCs) operating in the State of Wisconsin.

FQHC reasonable cost payments are made on a per encounter basis. An encounter is a face to face visit between a client and a qualified Wisconsin Medicaid FQHC provider who is providing a Medicaid-covered medical, dental, and/or behavioral ambulatory service on a single day, at an approved FQHC location, for a diagnosis, treatment or preventative service. Only one medical, one dental, and one behavioral encounter will be paid per patient per day, except in the event of a subsequent illness or injury.

A. Prospective Payment System for Federally Qualified Health Centers

Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) repeals the reasonable cost-based reimbursement provisions of the Social Security Act and replaces them with a prospective payment system (PPS) for non-tribal Federally Qualified Health Centers (FQHCs).

B. Methodology for Calculating a Baseline PPS Rate

In compliance with BIPA, the Department of Health Services (DHS) has calculated baseline PPS rates using the following methodology:

1) Annual cost reports for a FQHC's fiscal years 1999 and 2000 were submitted to the DHS by the centers.

2) DHS audited the submitted cost reports and established an annual encounter rate for each center for center fiscal years 1999 and 2000.

3) The PPS baseline rate was calculated by weighting the audited encounter rates for FY 1999 and FY 2000 based on the share of audited Medicaid FQHC encounters during the respective fiscal years:

i) The numbers of audited Medicaid FQHC encounters for FY 1999 and FY 2000 were determined and then added together to obtain the total number Medicaid encounters at the center in both fiscal years. The share of total encounters that occurred in each fiscal year was then calculated.

ii) The share of total encounters that occurred in each fiscal year was then multiplied by that fiscal year's encounter rate to obtain an apportioned encounter rate for each fiscal year.

iii) The apportioned encounter rates for FY 1999 and FY 2000 were totaled to yield the PPS baseline rate.

4) FQHCs receiving their initial designation after FY 2000, will be paid an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis. Within two years of receiving its initial designation, the FQHC must demonstrate its actual costs using standard cost reporting methods maintained by the Department, to establish its baseline PPS rate. The Department will review the new center's CMS-approved cost report to ensure the costs are reasonable and necessary.

C. Subsequent Year MEI Adjustments

Effective each year on January 1, the Department will adjust the PPS rate by the Medicare Economic Index (MEI) in effect for that upcoming calendar year.

D. Scope Change Definition

The PPS rate will also be adjusted to reflect changes in the scope of services provided by the FQHC. Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate and, subsequent to rate approval, will be made retroactively effective beginning the first day of the month in which the qualifying event occurred. The adjustment may result in either an increase or decrease in the PPS Rate paid to the FQHC.

Following the end of an FQHC fiscal year, each FQHC has the option to submit documentation identifying whether or not a change in the scope of services has occurred. A scope change adjustment will be granted only if the FQHC demonstrates a change in the type, intensity, duration, and/or amount of services has occurred and the change in scope of services resulted in at least a three (3) percent increase or decrease in the center's MEI-adjusted PPS rate for the FQHC fiscal year in which the change in scope of service took place. To determine if the 3% threshold is met, the portion of the FQHCs cost-per-visit specifically attributable to the scope change will be divided by the PPS rate in effect during the fiscal year in which the qualifying event occurred.

It is the responsibility of the FQHC to submit documentation to the Department of Health Services identifying whether or not a scope change has occurred within one hundred twenty (120) days of the FQHC’s fiscal year end.

E. Scope Change Adjustment Process

In the event that documentation submitted by the FQHC demonstrates that a scope change has occurred, PPS rates will be updated through the completion and submission of a CMS-approved FQHC cost report in accordance with the FQHC cost reporting guidance maintained by the Department. The Department will review each submitted report to ensure that the PPS rates are based upon reasonable costs of providing FQHC services. Cost and visit data from the report will be used to set the FQHC's PPS reimbursement rate. Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate and, subsequent to rate approval, will be made retroactively effective beginning the first day of the month in which the qualifying event occurred. If the qualifying event begins during a fiscal year that does not meet the 3% threshold, but meets the 3% threshold in a subsequent fiscal year, then the rate will be made effective the first day of the fiscal year in which it qualifies.

If during the Department's review, the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, this may delay implementation of any approved scope-of-service rate adjustment.

The department will provide an appeals process for providers requesting further review of denied scope change requests.

F. Drug Cost Carve-Out

The cost of drugs associated with FQHC pharmacy claiming will be excluded from PPS rates and reimbursed pursuant to the fee schedule for drugs set forth by the Wisconsin Department of Health Services.

G. Supplemental Payments under Managed Care

In the case of any FQHC that contracts with a managed care organization, supplemental wrap around payments will be made pursuant to a payment schedule agreed to by the State and the FQHC, but in no case less frequently than every 4 months, for the difference between the payment amounts paid by the managed care organization, not including financial or quality incentive payments, and the amount to which the center is entitled under the Prospective Payment System rate or the applicable Alternative Payment Method rate.

16.B Tribal Federally Qualified Health Centers (Tribal FQHCs)

The purpose of this State Plan is to set forth policies and guidelines to be administered by the Wisconsin Department of Health Services (DHS) for tribal Federally Qualified Health Centers (FQHCs) operating in the State of Wisconsin.

Tribal FQHC reasonable cost payments are made on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at the Tribal FQHC. An encounter is defined as a face-to-face contact for the provision of medical services between a single Wisconsin Medical Assistance Program (WMAP) certified provider (e.g., physician. dentist, or physical therapist) on a single day, at a single location, for a single diagnosis or treatment. When a recipient receives care from multiple WMAP-certified providers in a day, multiple encounters are recorded.

Prospective Payment System for Tribal Federally Qualified Health Centers

Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) repeals the reasonable cost-based reimbursement provisions of the Social Security Act and replaces them with a prospective payment system (PPS) for Tribal Federally Qualified Health Centers (FQHCs). States have the option to pay clinics under an alternative methodology, if the alternative methodology does not pay less than what would be paid under the PPS.

1) Annual Cost Report
    i. Wisconsin uses a cost-settlement system to reimburse clinics at 100% of reasonable costs. The Tribal FQHC must submit a CMS-approved cost report to receive 100% of reasonable costs for FQHC services due within five years of the last day of the corresponding fiscal year. The identification of direct and indirect and overhead costs must comply with 45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. The Department will maintain this system under BIPA as an alternative methodology for payment. Furthermore, the Department will continue to reimburse Tribal FQHCs and Rural Health Clinics their reasonable costs using the cost-settlement system while the Department implements BIPA's provisions. The Department will, if necessary, make retroactive adjustments to settlement amounts paid to clinics or centers back to January 1, 2001. Wisconsin's Tribal FQHCs have agreed to this alternative payment methodology.

2) Cost Reconciliation and Settlement
    i. After receiving the Annual Cost report, the Department verifies the allowable costs and validates the encounters performed during the fiscal year by using a combination of data pulled from the MMIS system and on-site medical records. The Department will determine if Tribal FQHCs were underpaid or overpaid based on the number of encounters multiplied by the PPS (or APM) rate less revenues in the reporting period. Examples of revenues received include, but are not limited to: payments from fee-for-service activity, supplemental interim (wraparound) payments, and payments from third party insurers. If it is found the Tribal FQHC was underpaid, the Department will issue an additional settlement to 100% of reasonable costs. If it is found the Tribal FQHC was overpaid, the Department will issue a recoupment in the amount needed to reconcile to 100% of reasonable costs and return the Federal share to CMS.

3) Supplemental Interim Payments
    i. Fee-For-Service (FFS): Tribal FQHCs bill FFS Medicaid for Medicaid services rendered to Medicaid patients. The Tribal FQHCs then submit cost reports to the department which indicate the number of Medicaid encounters and the amount already reimbursed by FFS Medicaid through the State's MMIS system. The Department reimburses Tribal FQHCs the difference between what has been received from FFS Medicaid and their reasonable costs.
        - Centers receive settlement payments at least every four months. Annual audits of centers may show that these centers received excess payments throughout the year, which must be refunded to the Department.
    ii. Managed Care: Tribal FQHCs receive payments from a Medicaid-contracted managed care organization (MCO) for Medicaid services rendered to Medicaid patients. The Tribal FQHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by Medicaid-contracted MCOs. The Department reimburses Tribal FQHC the difference between has been received from Medicaid MCOs and their reasonable costs.
        - Centers receive settlement payments at least every four months. Annual audits of centers may show that these centers received excess payments throughout the year, which must be refunded to the Department.

Cost-Settlement Process -Fee for Service

Tribal FQHCs bill fee-for-service (FFS) Medicaid for Medicaid services rendered to Medicaid patients. The Tribal FQHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by FFS Medicaid. The Department reimburses Tribal FQHCs the difference between what has been received from FFS Medicaid and their reasonable costs.

Centers receive settlement payments at least every four months. Annual audits of centers may show that these centers received excess payments throughout the year, which must be refunded to the Department.

Cost-Settlement Process -Managed Care

Tribal FQHCs receive payments from a Medicaid-contracted managed care organization (MCO) for Medicaid services rendered to Medicaid patients. The Tribal FQHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by Medicaid-contracted MCOs. The Department reimburses Tribal FQHC the difference between what has been received from Medicaid MCOs and their reasonable costs.

Centers receive settlement payments at least every four months. Annual audits of centers may show that these centers received excess payments throughout the year which must be refunded to the Department. This is in compliance with Section 1932(h) of the Social Security Act and Section 5006(d) if the American Recovery and Investment Act of 2009.

Methodology for Calculating a Baseline PPS Rate

The Division of Medicaid Services (DMS) will calculate a baseline PPS rate using the following methodology:

1) Annual cost reports for a Tribal FQHC fiscal years 1999 and 2000 are submitted to the DMS by the centers.

2) The DMS audits the submitted cost reports thereby establishing an annual encounter rate for each center for center fiscal years 1999 and 2000.

3) The PPS baseline rate is calculated by weighting the audited encounter rates for FY 1999 and FY 2000 based on the share of audited Medicaid Tribal FQHC encounters during the respective fiscal years:

A) The numbers of audited Medicaid Tribal FQHC encounters for FY 1999 and FY 2000 are determined and then added together to obtain the total number Medicaid encounters at the center in both fiscal years. The share of total encounters that occurred in each fiscal year is then calculated.

B) The share of total encounters that occurred in each fiscal year is then multiplied by that fiscal year's encounter rate to obtain an apportioned encounter rate for each fiscal year.

C) The apportioned encounter rates for FY 1999 and FY 2000 are totaled to yield the PPS baseline rate.

The Department will compare the PPS rate calculated for each center to the encounter rate paid under the cost settlement methodology and will pay the center the higher of the two. For centers for which the PPS rate is the higher of the two, the Department will use the PPS rate as the encounter rate when determining a center's interim and annual settlement payments using the cost settlement methodology described above.

For centers that have not submitted FY 1999 and FY 2000 cost report data, the Department will request in writing that the center provide this data to the Department so that it can calculate a baseline PPS rate. In the interim, the Department will continue to pay centers using the cost-settlement process. If a center has not submitted FY 1999 and FY 2000 cost report data to the Department one year after the Department has requested in writing from the center such data, the Department will use the PPS rate from a center in the same or adjacent area with a similar caseload as the baseline PPS rate for the center that has not submitted FY 1999 and FY 2000 cost report data requested by the Department.

Subsequent Years (FY 2002 and beyond)

At the end of each center fiscal year, the Department will adjust the PPS rate by the Medicare Economic Index (MEI) in effect at the end of the center fiscal year and by expected changes in the scope of services provided to Medicaid patients at the center to determine the PPS rate for that center upcoming fiscal year.

Centers will be required to report to the Department expected staffing and service provision changes for the upcoming center fiscal year no later than one month prior to the end of the current center fiscal year. Staffing changes are to be estimated as changes in the number of full time equivalents (FTEs) employed by or contracting with the center to provide Tribal FQHC services and their estimated costs. Centers must also submit written documentation to the Department of the estimated costs of relevant capital changes that would affect the provision of Tribal FQHC services at the center. Changes to the PPS rate based on expected staffing or service provision changes as reported by the center that do not occur in the upcoming center fiscal year are subject to reconciliation at the end of the center's fiscal year.

The adjusted PPS rate will be compared to the settlement rate for that center fiscal year, and the Department will pay the center the greater of the two. For centers for which the PPS rate is the higher of the two, the Department will use the PPS rate as the encounter rate when determining a center's interim and annual settlement payments using the cost settlement methodology described above.

New Clinics

For clinics that qualify for Tribal FQHC status after FY 2000, the Department will use the PPS rate from a center in the same or adjacent area with a similar caseload. This rate will be compared to the rate paid by the settlement process, and the Department will pay the higher of the two. In subsequent years, the Department will inflate the PPS rate by the MEI and by changes in the scope of services provided and will compare this rate to that from the settlement process. The Department will pay the center the greater of the two. In the absence of a center in the same or adjacent area with a similar caseload, the cost settlement rate will be paid to the center.

Supplemental Payments under Managed Care

Tribal FQHCs that provide services with a Medicaid managed care organization (MCO) will receive state supplemental payments for the cost of furnishing such services at least every 4 months in compliance with Section 1932(h) of the Social Security Act and Section 5006(d) if the American Recovery and Investment act of 2009. These supplemental payments are an estimate of the difference between the payments the Tribal FQHC receives from MCO(s) and the payments the Tribal FQHC would have received under the alternate methodology. At the end of each Tribal FQHC fiscal year, the total amount of supplemental and MCO payments received by the Tribal FQHC will be reviewed against the amount that the actual number of visits provided under the Tribal FQHC contract with MCO(s) would have yielded under the alternative methodology. The Tribal FQHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits and the total amount of supplemental and MCO payments received by the Tribal FQHC, if the alternative amount exceeds the total amount of supplemental and MCO payments. The Tribal FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCO payments received by the Tribal FQHC, if the alternative amount is less than the total amount of supplemental and MCO payments.