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State/Territory Name: WI

State Plan Amendment (SPA) #: 24-0008

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
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

August 23, 2024

Krista Willing
Assistant Administrator
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

RE: TN 24-0008

Dear Krista Willing,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wisconsin State Plan Amendment (SPA) to Attachment 4.19-B TN: #24-0008, which was submitted to CMS on March 29, 2024. This plan amendment proposes that Tribal Federally Qualified Health Centers (FQHCs) may choose reimbursement for Medicaid covered services under one of two options, 1. Prospective Payment System (PPS) Rate, or 2. OMB All Inclusive Rate (AIR). In addition, Tribal FQHC Pharmacy dispensed drugs will be reimbursed according to the 1905(a)(12) prescribed drug benefit under either option.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 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 January 1, 2024. 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 Matthew Klein at 214-767-4625 or via email at matthew.klein@cms.hhs.gov

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

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DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 4 — 0 0 0 8

2. STATE: W I

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: 1/1/24

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 405.2462

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 54,201,137
b. FFY 2025 $ 54,201,137

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
- Attachment 4.19-B Page 10.d., 10.e., 10.f., 10.g. (Tribal FQHCs)
- Attachment 4.19-B, Page 5, 5a, 5a1 (Pharmacy)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B page 10.d., 10.e., 10.f., 10.g. (Tribal FQHCs)
Attachment 4.19-B page 5, 5a, 5a1 (Pharmacy)

9. SUBJECT OF AMENDMENT
Tribal All Inclusive Rate

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
Krista Willing

13. TITLE
Assistant Administrator

14. DATE SUBMITTED
March 29, 2024

15. RETURN TO
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
March 29, 2024

17. DATE APPROVED
August 23, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Tribal Federally Qualified Health Centers Reimbursement Methodology

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. Wisconsin Tribal Federally Qualified Health Centers (FQHCs) may choose to participate in the Medicaid Program and receive reimbursement for Medicaid covered services under one of two options.

1. Prospective Payment System (PPS) Rate

A. Payment Methodology:
Wisconsin Tribal FQHC reasonable cost payments are made on a per encounter basis. An encounter is a qualifying visit between a client and a qualified Wisconsin Medicaid Tribal FQHC provider who is providing a Medicaid covered medical, dental, and/or behavioral ambulatory service on a single day, at an approved Tribal 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. All ancillary Medicaid services are bundled in the per encounter rate and cannot be billed as a separate encounter.

B. Methodology for Calculating a Baseline PPS Rate:
The Division of Medicaid Services (DMS) calculates a baseline PPS rate for Tribal FQHCs rate using the following methodology:

1. Annual cost reports for a Tribal FQHC's fiscal years 1999 and 2000 were 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:
   i. 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.
   ii. 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.
   iii. The apportioned encounter rates for FY 1999 and FY 2000 are totaled to yield the PPS baseline rate.

Tribal Federally Qualified Health Centers Reimbursement Methodology Continued

Tribal FQHCs receiving their initial designation after FY 2000, will be paid an average encounter rate of other Tribal FQHCs located in the same or adjacent area with similar caseloads, on an interim basis. Within two years of receiving its initial designation, the Tribal 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 adding the current CMS Market Basket Data inflation rate specific to Federally Qualified Center PPS.

D. Scope Change Definition:
The PPS rate will also be adjusted to reflect changes in the scope of services provided by the Tribal FQHC. Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate and, after 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 Tribal FQHC. Following the end of a Tribal FQHC fiscal year, each Tribal FQHC has the option to submit documentation identifying whether a change in the scope of services has occurred. A scope change adjustment will be granted only if the Tribal 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 Tribal 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 Tribal 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 Tribal FQHC to submit documentation to the Department of Health Services identifying whether a scope change has occurred within one hundred twenty (120) days of the Tribal FQHC's fiscal year end.

E. Scope Change Adjustment Process:
If documentation submitted by the Tribal FQHC demonstrates that a scope change has occurred, PPS rates will be updated through the completion and submission of a CMS-approved Tribal FQHC cost report in accordance with the Tribal 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 Tribal FQHC services. Cost and encounter data from the report will be used to set the Tribal 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, after 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

Tribal Federally Qualified Health Centers Reimbursement Methodology Continued

Department requests additional documentation to calculate the rate for the change(s) in scope of service, the Tribal FQHC must provide the additional documentation within thirty (30) days. If the Tribal 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 appeal process for providers requesting further review of denied scope change requests.

F. Drug Costs:

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 as described in Attachment 4.19-B, Page 5a - Pharmacy Fee Schedule – Option 1 at B.1.a.

G. Supplemental Payments under Managed Care:

In the case of any Tribal 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 Tribal 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 PPS rate.

2. <u>Alternative Payment Methodology (APM) - Indian Health Services (IHS) OMB All Inclusive Rate</u>

A. Payment Methodology:

Wisconsin Tribal FQHCs per encounter outpatient rate will be reimbursed in accordance with the rate published annually in the federal register. A Tribal FQHC in accordance with Federal Regulations, shall receive the Indian Health Services per encounter outpatient rate for a qualifying visit at the Tribal FQHC for Medicaid beneficiaries. An encounter is a qualifying visit between a client and a qualified Wisconsin Medicaid Tribal FQHC provider who is providing a Medicaid covered medical, dental, and/or behavioral ambulatory service on a single day, at an approved Tribal 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. All ancillary Medicaid services are bundled in the per encounter rate and cannot be billed as a separate encounter.

Tribal Federally Qualified Health Centers Reimbursement Methodology Continued

B. Subsequent Year APM Rate:
Effective each year on January 1, the Department will adjust the APM to the current rate on the Federal Register.

C. Drug Costs:
Prescriptions dispensed by a Tribal 638 FQHC Pharmacy constitutes as a separate encounter per prescription and are reimbursed as described in Attachment 4.19-B, Page 5a - Pharmacy Fee Schedule - Option 2 at B.1.b.

D. Supplemental Payments under Managed Care:
In the case of any Tribal 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 Tribal 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 APM.

Effective January 1, 2024, Tribal FQHCs will choose between option 1 (PPS) and 2 (APM) annually. The APM will never pay less than the PPS rate. Each Tribal FQHC has agreed to use either reimbursement option. PPS rates are adjusted for inflation each calendar year in accordance with the FQHC market basket data and the APM rate as published in the Federal Register. Effective January 1 each year, DHS will reconcile the two rates and give each Tribal FQHC the option of choosing their preferred rate. Rates are reconciled with an effective date of January 1 of the calendar year as both the APM rates and inflation rates applied to the PPS rate are published in the Federal Register each fall.

Wisconsin Medicaid
Pharmacy Fee Schedule

A Wisconsin will reimburse the following prescribed drugs with an Ingredient Cost methodology in accordance with Actual Acquisition Cost (AAC) as defined at 42 CFR 447.512 and Professional Dispensing Fee as defined at 42 CFR 447.502.

1. **Brand name and generic drugs** and other drugs/products meeting the definition of covered outpatient drug in 42 CFR 447.502 will receive an ingredient cost based on AAC plus professional dispensing fee.
    a. AAC is defined as the lesser of
        - National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee, or
        - The provider's usual and customary charge.

    b. **If NADAC is unavailable,** AAC is the lesser of:
        - Wholesale Acquisition Cost (WAC +0%) plus a professional dispensing fee,
        - State Maximum Allowable Cost (SMAC) rate, if available, plus a professional dispensing fee, or
        - The provider's usual and customary charge.

    c. **State MAC rates** use a two-step pricing factor calculation. SMAC rates are set based on the greater of 150% of the lowest-cost product in the most commonly used package size or 120% of the second lowest-cost product. All pricing is updated quarterly and ad hoc updates are made as needed to account for marketplace price increases, drug shortages or in response to provider inquiries.

    d. **Professional Dispensing Fee** will be based on the annual prescription volume of the enrolled pharmacy. The professional dispensing fee tiers are as follows:
        - Less than 34,999 prescriptions per year= $15.69
        - 35,000 or more prescriptions per year= $10.51

        An annual attestation by each Medicaid-enrolled pharmacy provider documents prescription volume and determines the tier under which the pharmacy will be paid for the subsequent year.

    e. **Compound Drug Allowance** is $7.79 and reimbursed in addition to a provider's assigned professional dispensing fee.

    f. **Repackaging Allowance** is $0.015 per unit billed and reimbursed in addition to a provider's assigned professional dispensing fee when repackaging occurs.

2. **340B covered entity** purchased drugs under 1927(a)(5)(B) of the Act will receive an AAC Ingredient cost that is no more than the 340B ceiling price plus a professional dispensing fee as defined above in (A)(1)(d).

    AAC is defined as:
    - The State calculated 340B ceiling price plus a professional dispensing fee, or
    - If the ceiling price is not available., WAC -50% plus a professional dispensing fee.

Wisconsin Medicaid
Pharmacy Fee Schedule, continued

3. **Drugs purchased outside of the 340B program by covered entities** will be reimbursed an ingredient cost based on the AAC plus professional dispensing fee as noted in (A)(1) above.
4. **Drugs acquired through the federal 340B drug price program and dispensed by 340B contract pharmacies are not covered.**
5. **Drugs acquired via the Federal Supply Schedule (FSS)** will be reimbursed ingredient cost based on AAC plus a professional dispensing fee as defined above in (A)(1)(d).
6. **Drugs acquired at Nominal Price (outside of 340B or FSS)** will be reimbursed ingredient cost based on AAC plus a professional dispensing fee as defined above in (A)(1)(d).

B. Wisconsin will reimburse the following drugs with the reimbursement methodology described as the drugs are not required to meet the AAC definition at 42 CFR 447.512.

1. **Drugs dispensed by IHS/Tribal facilities will be** reimbursed under one of two options, determined by how the tribal provider elects to pay for in-scope FQHC services under the Tribal **Federally Qualified Health Centers Reimbursement Methodology** described beginning on page 10.d of Attachment 4.19B:

   a. Option 1 - Tribal FQHCs will be reimbursed for AAC for drug costs, and professional dispensing fees will be included in the Tribal FQHC encounter rates except for SeniorCare members. For SeniorCare members, Tribal FQHCs will receive ingredient cost based on AAC plus the FQHC-specific professional dispensing fee of $24.92.

   b. Option 2 - Tribal FQHCs will be reimbursed at the Indian Health Services outpatient rate in accordance with the annual Federal Register Notice. All Tribal FQHC Facility Pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing.

   An IHS Tribal facility is defined as an FQHC that receives funds under the Indian Self-Determination Act.

2. **Non-tribal Federally Qualified Health Centers (FQHCs)** are those entities designated by the federal Department of Health and Human Services as FQHCs. Non-tribal FQHCs will be reimbursed AAC for drug costs. Professional dispensing fees will be included in the non-tribal FQHC encounter rates except for SeniorCare members. For SeniorCare members, non-tribal FQHCs will receive ingredient cost based on AAC plus the FQHC-specific professional dispensing fee of $24.92.

Wisconsin Medicaid
Pharmacy Fee Schedule, continued

3. **Specialty drugs not dispensed by a retail community pharmacy including drugs dispensed primarily through the mail (but not in institutions or long term care)** will receive an ingredient cost plus a professional dispensing fee as defined above in (A)(1)(d).

   Rates for specialty drugs will be based on a State Specialty Maximum Allowable Cost Specialty drug rates will be updated monthly based on a review of product availability and specialty pricing in the marketplace. The specialty drug list is comprised of drug therapy classes where the majority of drugs within the therapy class do not have an available NADAC rate.

   State Specialty Maximum Allowable Cost rates for generic specialty products are developed using the SMAC methodology described above in (A)(1)(c). For select single-source brand specialty products, Wisconsin or its contractor will use benchmark provider reimbursement discounts (e.g., commercial and/or Medicaid Managed Care) to develop State Specialty Maximum Allowable Cost reimbursement rates.

   Reimbursement is the lower of:
   - The State determined State Specialty Maximum Allowable Cost rate plus a professional dispensing fee as defined above in (A)(1)(d) or
   - The provider's usual and customary charge.