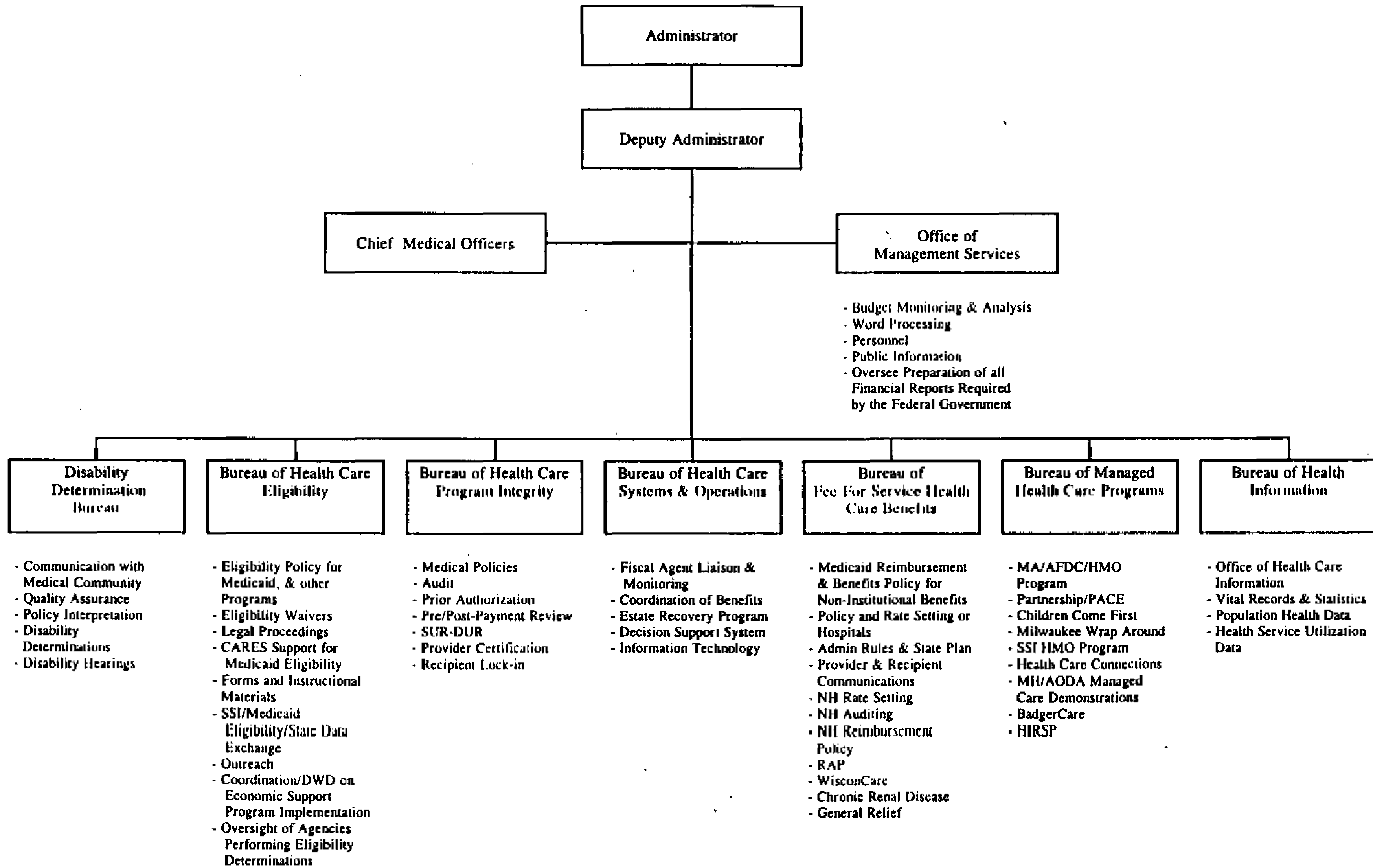
DHS Note: See MMDL forms A1-3 for current information.

DEPARTMENT OF HEALTH AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING



DIVISION OF HEALTH CARE FINANCING

ORGANIZATION SUMMARY

1. **Introduction**

The primary objective of the Division of Health Care Financing (DHCF) is to improve the health of Wisconsin's citizens who receive health care through State-administered health care programs. The DHCF purchases health care for value and results, using approaches employed and tested in the Wisconsin Medicaid program. The DHCF administers the Medicaid, BadgerCare, Health Insurance Risk Sharing Plan (HIRSP), Chronic Renal Disease, General Relief-Medical and Wisconcare programs. The DHCF will need to achieve the following for all health care programs in the DHCF:

- Purchase for defined cost and quality;
- Align fiscal and programmatic incentives to achieve desired results;
- Define quality, measure quality and work to improve quality; and
- Exert market leadership in health care purchasing.

The Division Administrator's Office includes the Chief Medical Officers and the Office of Management Services. These entities are responsible for the clinical and administrative management of the State's largest health insurance program

- **Chief Medical Officers**

  The Chief Medical Officers provide leadership and participate in the management decisions or medical and scientific health care information and program policies, including liaison with the medical profession and other providers.

- **Office of Management Services**

  The Office of Management Services provides Division-wide organization, coordination, and oversight of information technology, human resources, fiscal and accounting functions for administrative and contract costs, open records, space and telecommunications, forms, printing, and publications and secretarial support.

2. **Key Features of the Organization**

The DHCF is organized to support all health care programs for optimal operation. The organizational structure coordinates key functions needed to support programs. This organization includes the following Bureaus:

- Disability Determination Bureau
- Bureau of Health Care Eligibility
- Bureau of Health Care Program Integrity

- Bureau of Health Care Systems and Operations
- Bureau of Fee-for-Service Health Care Benefits
- Bureau of Managed Health Care Programs
- Bureau of Health Information

DISABILITY DETERMINATION BUREAU

The Disability Determination Bureau is a federally funded, state administered program that makes determinations for disability benefits for the Social Security Administration and for the state Medical Assistance program. The primary mission of the Bureau is to make accurate and timely disability decisions regarding eligibility for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) and Medical Assistance (Medicaid) for residents of Wisconsin. Applications for SSDI and SSI are filed at the twenty-seven (27) federal Social Security Administration District Offices in Wisconsin and represent 95% of the Bureau's workload. Applications for Medicaid disability coverage are filed with the counties. The Bureau is funded by the federal Social Security Administration and operates under the program policies outlined in the Code of Federal Regulations. The Medicaid program reimburses Social Security Administration for Medicaid determinations made by the Bureau.

BUREAU OF HEALTH CARE ELIGIBILITY

The Bureau of Health Care Eligibility develops and implements eligibility policy, program implementation and outreach. Eligibility policy is complex and based on multiple and interrelated provisions of the Social Security Act, federal regulations, state laws and administrative rules, legal interpretations through hearings and court orders, and on waivers of these requirements. The Bureau is responsible for eligibility policy for the Division's health care programs, including Medicaid and BadgerCare. Policy is implemented through three computer systems: the CARES system, operated by the Department of Workforce Development (DWD); the Medicaid Management Information System (MMIS); and the State Data Exchange with the Social Security Administration, which provides information for making Medicaid eligibility determinations for SSI recipients and their families.

The eligibility policies administered by the Bureau directly affect about 500,000 Wisconsin citizens, representing 10% of the State's population.

The State contracts with county and tribal agencies for the administration of eligibility determination functions under the oversight of Bureau staff. The overall budget for Medicaid eligibility determination functions exceeds $60 million annually for state, county and other contractual services.

This Bureau is also responsible for managing comprehensive outreach initiatives to assure that Wisconsin's citizens are aware of programs that offer health care coverage for low-income families.

The Bureau is composed of two sections: Policy and Systems Development and Program Implementation.

1. **Policy and Systems Development Section**

This Section analyzes state and federal law, and legal proceedings and policy instructions from the federal Health Care Financing Administration to formulate policy alternatives to recommend to the Administrator. The Section drafts proposed legislation, administrative rules, policy manuals and handbooks. It develops other supporting material such as training materials, fact sheets, letters and memoranda. The Section translates eligibility policy into operation in automated systems, by developing specifications, and working with programming staff to assure understanding and proper implementation of policy; by coordinating systems changes with other economic support program systems changes; by conducting user acceptance testing; and by preparing communications describing the systems changes. The Section manages eligibility policy for both family-based coverage and for the elderly and disabled.

This Section also manages an outreach program to assure that eligible Wisconsin residents are enrolled in health care programs that will improve their health. Section staff oversee all statewide public information and media initiatives and manage support for regional and local outreach initiatives.

2. **Program Implementation Section**

This Section supports and monitors all eligibility determination programs. This includes automated systems such as CARES, the administration of economic support policies and procedures as performed by county and tribal agencies, and implementation functions such as technical manuals, forms and instructional materials, quality control functions, and data analysis. This Section coordinates with the Department of Workforce Development, which manages the CARES system and the other economic support programs, with the fiscal agent for the Medicaid program, and with other DHFS staff who utilize the Medicaid eligibility determinations made in the CARES system to support child welfare and long term care programs. The Section convenes and staffs work groups, advisory groups and committees representing county and tribal agencies and other governmental and community-based agencies to obtain advice and comment on proposed policies and procedures, and to assure proper training of users. This Section also develops and monitors MOUs with these other agencies to define respective responsibilities in regard to program implementation and performance monitoring.

BUREAU OF HEALTH CARE PROGRAM INTEGRITY

This Bureau includes the Dental Consultant, Quality Improvement Nurse Consultants, administrative support services staff and data support staff. The Bureau also coordinates the activities of the Program Integrity Committee, Quality Improvement team and has oversight of the Independent Peer Review Contract.

1. **Quality Assurance and Appropriateness Review Section**

This Section houses the clinical and support staff related to the Prior Authorization and clinical review functions, develops prior authorization guidelines and oversees the prior authorization adjudication process. Staff also assist in developing quality assurance standards for managed care programs and for conducting quality assurance audits and reviews of both managed care and fee-for-service programs.

2. **Program Audit and Review Section**

This Section houses program compliance audit staff. These staff assist the Medical Audit and Review Staff in planning and conducting on-site audits of Wisconsin Medicaid providers, to ensure compliance with Medicaid policies and procedures. This function is accomplished through on-site audits, desk reviews, validation surveys, and provider self audits. The goals of this effort are to identify areas of non-compliance and recover overpayments and to provide education, consultation and assistance to providers.

3. **Medical Audit and Review Section**

This Section houses the clinical staff directly related to the audit function. This Section assists the Program Audit and Review Section staff in developing and conducting on-site audits and reviews of providers. This Section also educates providers about Medicaid requirements through participation in training programs and through consultations with providers and provider groups. This Section also responds to complaints regarding services provided to Wisconsin Medicaid recipients.

BUREAU OF HEALTH CARE SYSTEMS AND OPERATIONS

This Bureau is responsible for implementing, operating and monitoring systems, procedures, reports and contracts necessary to support the administrative requirements and activities of Division of Health Care Financing (DHCF) programs. This Bureau also operates several programs to identify and recover payments through coordination of benefits, estate recovery and drug rebate.

1. **Systems and Reporting Section**

This Section directs the procurement, implementation, enhancement and monitoring of the Medicaid Management Information System (MMIS), Medicaid Evaluation and Decision Support System (MEDS) and other systems, procedures and reports provided by the Fiscal Agent contractor and other contractors. It analyzes DHCF business processes and functions and develops requirements and specifications for enhancements and changes to Medicaid systems, procedures and reports. This includes liaison and coordination of DHFS system interfaces with other state and federal systems and data exchanges including the state's eligibility system CARES. This Section also monitors the fiscal agent contract,

performs claims processing quality assurance audits, coordinates the performance of external audits of the fiscal agent and the MMIS by federal and state agencies, manages the Medicaid Drug Rebate Program and has responsibility for processing and reporting of managed care data and quality assurance measures.

2. **Coordination of Benefits Section**

This Section directs implementation and monitoring of systems, policies, procedures and reports to coordinate payment of DHCF programs with Medicare, health insurance and other all available third parties to assure DHCF is the payer of last resort. It analyzes DHCF business processes and functions and develops requirements and specifications for enhancements and changes to MMIS, procedures and reports. This Section also manages a data exchange with all major health insurance companies in the state to identify insurance coverage information for Medicaid recipients. It operates programs to buy-in DHCF recipients into health insurance plans and Medicare when allowed and cost-effective. This Section also pursues recovery of DHCF payments through subrogation with lawsuits for recipients involved in accidents, injuries, malpractice and recoveries from providers for renal services covered by Medicare.

3. **Estate Recovery Program Section**

This Section's major function is to recover DHCF program payments from the estates of recipients who received certain publicly-funded services. Recoveries are made from estates of those recipients for three different programs: the Medicaid program (Title 19), the Community Options Program (COP), and the Wisconsin Chronic Disease Program. The Section identifies and recovers payments via three processes: filing claims in estates; the issuance of affidavits to recoup funds in very small estates (less than $10,000); and the placement (filing) of a lien on real estate (homes) of recipients of nursing home services. The Section is directly involved in both administrative hearings and court probate proceedings as a result of contested claims or decisions.

BUREAU OF FEE-FOR-SERVICE HEALTH CARE BENEFITS

The Bureau is composed of two sections: Nursing Home Services and Community Services. It is responsible for developing Medicaid policies for all services for which the State directly reimburses Medicaid providers. The Medicaid program provides direct provider reimbursement for approximately 35 service areas such as nursing home, physician, hospital, dental, and pharmacy services. The Bureau completes policy analysis and development, and determines the scope of benefits, benefit limitations, and rates of payment. The Bureau also maintains the Medical Assistance State Plan and Administrative Rule and staffs the Medical Assistance Advisory Committee. The Bureau administers a variety of health care programs for vulnerable populations that do not qualify for Medicaid, including the Wisconcare Program, General Relief-Medical and the Chronic Renal Disease Program.

1. **Nursing Home Services Section**

This Section reviews and audits nursing homes cost reports, calculates specific nursing home rates, develops policy recommendations for nursing home reimbursement, and operates the resource allocation program. The Section's staff includes the Nursing Home Appeal Auditor, the Review Auditor, the Bed Tax Administrator and two Program support. The Section also conducts comprehensive desk audits and selective scope field audits of facilities. Nursing home reimbursement is the single largest item in the State Medicaid budget, accounting for over 60% of Medicaid expenditures annually. The Section also coordinates the Bureau's activities in the areas of automated rate setting and data base development.

The Section provides consultation and advice regarding reimbursement policies and procedures to Bureau policy personnel, and independently develops major reimbursement policy and procedures and sets rates for reimbursement to nursing homes participating in the Medicaid program. The Nursing Home Section also operates a monthly tax assessment on occupied beds in all nursing homes and intermediary care facilities in the State.

The Section carries out studies of various Medicaid reimbursement issues mandated by the Legislature and independent requests of the Governor, individual legislators or Department management.

Finally, the Section administers the Resource Allocation Program (RAP) and bed banking program for over four-hundred nursing facilities in the State.

2. **Community Services Section**

This Section is responsible for developing and administering reimbursement methodologies for direct medical services and programs.

The Section develops the payment methodology to establish rates of reimbursement for individual hospitals participating in the Medicaid program. The hospital portion of the Medicaid program accounts for 12% of all Medicaid expenditures. The Section reviews and analyzes cost reports, claims data, budgets, and other financial documents in computing the rates. Limited scope desk audits are performed for outpatient year-end settlements to verify compliance with Title XVIII upper limits and other Federal/State regulations. In addition, the unit provides staffing to various standing and ad hoc committees involved in the hospital rate-setting function. The Section also directs the development and implementation of hospital reimbursement analysis including evaluation of alternative payment systems, such as Diagnosis Related Groups (DRGs) and payment policy involving special patient populations. The Section administers the hospital audit and DRG modeling contracts. The Section analyses, develops and implements policy related to physicians, clinics, rural health clinics, and federally qualified health centers (FQHCs) and performs desk and field audits and annual cost settlements for rural health clinics.

The Community Services Section manages the entire Medicaid program's budget process. Its staff direct and coordinate the development of budget proposals and policies for the biennial budget including analysis of fiscal and programmatic impact. Responsibilities include: developing budget proposals, presenting a variety of alternatives; recommending program policy and reimbursement methodologies; managing the development of fiscal estimates and implementation timetables for accepted program policy proposals; and preparing summary management reports on service trend analysis, expenditures, and reimbursement/pricing analysis. The Section analyzes policies related to reimbursement methodologies for payment for direct Medicaid services. The Section responds to requests for information about reimbursement rates, and analyzes changes in reimbursement codes. Services areas analyzed by the Section include: maternal and child health issues, HealthCheck (EPSDT), Healthy Start, transportation, family planning, case management, prenatal care coordination, chiropractors, dental, podiatry, hospice, and pharmacy.

The Section coordinates and monitors the development and maintenance of a communication system ensuring prompt, concise, and pertinent information with providers, and other interested parties. It prepares and revises Medicaid provider handbooks and Medicaid updates, assures timely provider notification of all policy changes, identifies provider training needs, and develops and implements an annual provider training schedule. The Section acts as a liaison between the Bureau and the fiscal agent in preparing and conducting provider workshops. The Section analyzes reimbursement methodologies for payment for direct Medicaid services. The Section responds to requests for information about reimbursement rates, and analyzes changes in reimbursement codes. Services areas analyzed by the unit include: home health, personal care, respiratory care, school based services, durable medical equipment and durable medical supplies, mental health, therapies, audiology, and hearing aids.

BUREAU OF MANAGED HEALTH CARE PROGRAMS

The Bureau of Managed Care programs (BMCP) is responsible for the development, implementation, and administration of all Medicaid Managed Care Programs. These include fully-capitated risk Health Maintenance Organization (HMO) programs as well as limited risk programs called Prepaid Health Plans (PHPs). Managed care programs are operated for the full range of Medicaid recipients—AFDC-related and BadgerCare low-income families with children, disabled children and adults, and low-income elderly. The quality assurance nurse consultant will be attached to the Bureau Director. The nurse will work daily with the Division's Chief Medical Officer, and be supervised by the Bureau Director.

1. Contract Monitoring Section

This Section develops, amends, implements and monitors all Medicaid managed care contracts. The Section secures federal approval of all

contracts and of implementing corrective action plans for HMOs or PHPs not in compliance with the contract. The Section also certifies new managed care organizations and recertifies already participating managed care organizations. The Section is responsible for the Health Insurance Risk Sharing Plan (HIRSP).

2. **Program Development and Rate Analysis Section**

This Section develops, implements, and modifies all rates for all Medicaid managed care programs, including the development and preparation of all Medicaid waiver and state plan requests. This Section also prepares the Bureau's biennial and operating budget requests for managed care and conducts financial, statistical and policy analyses needed in developing new Medicaid managed care initiatives.

BUREAU OF HEALTH INFORMATION

This Bureau responds to specific types of information requests with a special focus on specific users and uses for the data provided by each section. All four sections have close links to the rest of the Division.

1. **Health Care Provider Data Section**

This Section responds to external requests for health care information on hospitals and ambulatory surgical centers, and other health care providers. This Section prepares, collects and analyzes health (OHCI) survey information on various health care provider groups, such as physicians, dentists, physician assistants and nurses. The Section completes and publishes mandated reports and carries out legislatively mandated data collection functions. This Section prepares and disseminates information to assist consumers in decisions regarding choice of health care providers and health plans.

2. **Vital Records and State Registrar/Customer Service Section**

This Section responds to requests for data files of vital records. This Section creates and maintains state vital records registries (birth, death, marriage, divorce) and provides vital record files to authorized state agencies, including the Department of Workforce Development for paternity cases and the Division of Public Health for defined epidemiological studies. This Section develops analysis files for use by other sections and provides legal documents to citizens as required by statute.

3. **Population Health and Health Services Utilization Section**

The Section responds to requests to analyze population health data and develops, analyzes and disseminates population health data. The Section prepares, analyzes and distributes population survey and registry information, such as the family health and behavioral risk factor surveys, the induced abortion reporting system, and the cancer reporting system. Section staff use data to analyze and distribute

information on population health trends and outcomes from vital records data and other population-based information sources to support program and policy development at the community level. The Section develops population estimates to strengthen analysis of community health outcomes and service utilization. The Section provides editorial support to bureau information dissemination. The Section also responds to internal and external requests to develop databases to analyze the utilization of health care services. The Section surveys providers of long-term health care services to construct provider-specific databases. The Section also develops resident and client-based data to support analyses of health service utilization patterns. The Section prepares and disseminates information to consumers about their long-term-care options and providers. Finally, the Section prepares reports on utilization of health care services, with a special focus on long-term-care services, to inform department initiatives.