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State WISCONSIN

Methods and Standards for Establishing Non-Institutional Reimbursement Rates

General In accordance with Sec. 1902(a)(30) of the Social Security Act this attachment describes the policy and methods used in establishing reimbursement rates for non-institutional care and services provided by the state's Medical Assistance Program as iterated in Sec. 1905(a) of the Act. Reimbursement methodologies and standards for inpatient hospital care is found in Attachment 4.19A and, intermediate care and skilled nursing facilities, in Attachment 4.11D.

A. Reimbursement Limitations

1. In accordance with 42 CFR 447.200, payment for services is consistent with efficiency, economy and quality of care.

2. In general, the department will pay the lesser of a provider's usual and customary charge or a maximum fee established by the department. The maximum allowable fee is based primarily on the usual and customary charges submitted to the Medical Assistance Program, the Wisconsin State Legislature's budgetary constraints and other relevant economic limitations.

   The "usual and customary" charge is defined as the amount charged by a provider in the same service when rendered to non-Medicaid patients. If a provider uses a sliding fee scale for specific services, "usual and customary" means the median of the provider's charge for the services when rendered to non-Medicaid patients.

3. In no case will rate increases exceed those authorized by the Legislature and the Governor.

4. Provider rates are determined on an annual basis.

B. Audit - 42 CFR 447.202

The department ensures appropriate audit of records wherever reimbursement is based on cost of care or service, or based on fee plus cost of materials.

C. Documentation - 42 CFR 447.203

The department maintains required documentation of reimbursement rates and complies with the requirements regarding increases in reimbursement rates as described in 42 CFR 447.203. This information is available to HHS upon request.

D. Provider Participation - 42 CFR 447.204

TN: 88-0003
Supercedes
TN: 86-0029

Effective: 4/1/88 Approved: 9/12/88

1. TheReimbursement Methodologies are designed to enlist program participation by a sufficient number of providers so that MA recipients are assured that authorized medical care and services are available to the same extent those same services are available to the st, e" s general population.

2. Program participation is limited to providers who accept as reimbursement in full the amounts paid in accordance with the rate methodology, or to providers who enter into contracts with the department to provide services for free or at a reduced reimbursement level.

E. Public Notice

In accordance with 42 CFR 447.205, the department will post public notice in advance of the effective date of any significant proposed change in its methods and standards for setting reimbursement rates.

F'. Methods and Standards for Establishing Payment Rates for Non-Institutional Care

The Department will establish maximum allowable fees for the covered services listed below. Maximum fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding specified in federal law. Except as otherwise provided in the methods and standards for specific services set forth in this Attachment, for each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

1. Physician Services
2. Chiropractic
3. Early and Periodic Screening, Diagnosis and Testing (EPSDT)
4. Medical Day Treatment, Mental Health and AODA Counseling (except physician servi ces)
5. Optometrist/Optician
** 6. Private Duty Nursing
7. Transportation
*** a. Specialized Medical Vehicles
8. b. Amulance
9. Laboratory and X-ray
10. Blood Banks
11. Dental
12. Audiology
13. Occupational Therapy
14. Speech Therapy
15. Physical Therapy
16. Family Planning Clinics
17. Nurse Midwife and Licensed Midwife Services
18. Ambulatory Surgical Centers

18. Portable x-ray
19. Rehabilitation agencies
20. Personal Care Services
21. AODA Outpatient Services effective 1-1-89
22. AODA Day Treatment Services effective 3-1-89
23. Podiatry Services effective 7-1-90
24. Pediatric and Family Nurse Practitioner Services effective 7-1-90
25. Other Nurse Practitioner and Clinical Nurse Specialist Services effective 7-1-90
26. Psychosocial Rehabilitation Services effective 1-1-2015
27. Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs for TB-infected individuals, effective 7-1-95
28. Drugs (pharmacy)
29. Substance use disorder treatment in a residential setting

* For reimbursement of obstetric and pediatric services, see page 8 of this Attachment. For reimbursement for physician primary care services in a HPSA. see item #15, page 6.

** For reimbursement of high-tech care for children - private duty nursing services see item #19 in this attachment, page 6c.

*** For reimbursement for trips where more than one recipient is transported at the same time, see item #23, page 16.

1. Physician services

a. Supplemental payments to certain physicians

(1) Supplemental payments are available under this paragraph to physicians who are recognized as essential to the Wisconsin Medicaid program. To be identified as an essential physician and qualify for a supplemental payment, the physician must be:

(i) A physician licensed by the State of Wisconsin;

(ii) A certified Wisconsin Medicaid provider; and

(iii) Employed by an eligible physician group practice that is state-owned or operated.

The eligible physician group practice, the University of Wisconsin Medical Foundation is affiliated with the state academic teaching facility, the University of Wisconsin Hospital and Clinics.

(2) For services rendered by physicians affiliated with the practice at paragraph (1), a supplemental payment will be made that is equal to the difference between the Medicaid payments otherwise made and payments at the Medicare Equivalent (specifically the Medicare non-facility rate equivalent) of the Average Commercial Rate Payment. This supplemental payment will, for the same dates of service, be reduced by any other supplemental payment found elsewhere in the state plan.

(i) Payment will be made quarterly and will not be made prior to the delivery of services.

(3) The Base Period Medicare Equivalent of the Average Commercial Rate to be paid to practitioners affiliated with physician group practice eligible under paragraph (1) (iii) will be determined as follows:

The following calculation will be performed separately for the practice that employes and/or contract and bill for eligible practitioners. Supplemental payment to the practice will be based on this calculation.

I. Compute Average Commercial Fee Schedule: For the base period, compute the average commercial allowed amount per CPT Code, including patient share amounts, for the top five payers for procedure codes with payment rates. The top five commercial third party payers will be determined by total billed charges reported by a practice plan as defined in paragraph (1) (iii).

II. Calculate the Base Period Average Commercial Payment Ceiling: Multiply the Average Commercial Fee Schedule as determined in paragraph (3) I. by the number of times each procedure code was rendered in the base period and paid to eligible plans on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall determine the Base Period Average Commercial Payment Ceiling.

III. Determine the Base Period Medicare Payment Ceiling: For each of the procedure codes used to determine the Average Commercial Payment Ceiling in paragraph (3) II., multiply the base period non-facility, Medicare allowed rate from the April release of the Resource Based Relative Value Scale (RBRVS) by the number of times each procedure code was rendered in the base period and paid to the eligible plan on behalf of Medicaid beneficiaries as reported from the MMIS. The sum of the product for all procedure codes shall represent the Base Period Medicare-equivalent Payment Ceiling.

IV. Determine the Base Period Medicare Equivalent of the Average Commercial Rate: Divide the Base Period Average Commercial Payment Ceiling computed in paragraph (3) II. by the Base Period Medicare Payment Ceiling determined in paragraph (3) III.

V. Periodic Updates to the Base Period Medicare Equivalent of the Average Commercial Rate: The State shall update this ratio at least every three years.

(4) Determination of Supplemental Payment

(i) The supplemental payment ceiling for a physician practice eligible under paragraph (1) (iii) will be determined as follows: The Medicare Equivalent of the Average Commercial Rate is multiplied by Medicare payment at the non facility rate per CPT Code then multiplied by Medicaid volume by CPT Code for the same period as reported through the MMIS.

(Medicare Equivalent of the Average Commercial Rate) X (Medicare Payment per CPT Code) X (Medicaid Volume per CPT Code) = Payment Ceiling.

Medicare payment at the non facility rate and Medicaid volume for those services are derived from the same period of time.

(ii) Determine the Medicaid Supplemental Payment Ceiling: The Medicaid Supplemental Payment for the plan, as described in paragraph (1) (iii), shall equal the current period payment ceiling at the Medicare Equivalent of the Average Commercial Rate less all Medicaid payments, including enhanced payments, for procedure codes rendered in the current period and paid to the eligible physician group practice on behalf of Medicaid beneficiaries as reported from the MMIS. Medicaid volume and payments shall include all available payments and adjustments.

Reimbursement Template -Physician Services, continued

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on 12/31/2014 but not prior to December 31, 2014. All rates are published at:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

Vaccine Administration
This reimbursement methodology applies to services delivered on and after December 30, 2022. All rates are published at:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

Monkeypox Vaccine Administration Rate:

Effective October 1, 2022 the State will reimburse Monkeypox vaccine administration at $15. This will

expire with the conclusion of the Monkeypox public health emergency.

b. Physician Assistant Services

Reimbursement for physician assistant services is made at a percentage of a physician's payment for each specific procedure. Specifically, the physician assistant maximum allowable fee is based on 90 percent of a physician's maximum allowable fee for that procedure. Physician assistants are paid at a percentage of physician feesbecause they have less training, require physician supervision under state licensure, have a limited scope of practice and lower overhead costs.

Increased reimbursement is to encourage Medical Assistance Program participation by physician assistants who provide quality basic level care at a lower cost than physicians.

Effective 07/01/1993

2. Hearing Aids and Supplies

The Department will establish maximum reimbursement rates for all covered dispensing services, equipment and supplies. Providers will be reimbursed up to a maximum allowable dispensing fee and the next cash outlay cost to the provider of the materials and supplies purchased. "Net cash outlay cost" is defined as the actual cost to the provider to permit the provider to fully recover his out of pocket cost for the purchase of the heaing aid package furnished to Wisconsin Medical Assistance Program recipients.

Collaborative Care Model Services

Collaborative Care Model services are provided to members in order to reduce symptoms of their behavioral health issues by integrating behavioral health care management services and regular psychiatric consultation within the medical model of physician services. Any full-benefit Medicaid member is eligible to receive Collaborative Care Services if their treating practitioner's clinical judgement warrants integrating these behavioral health services into their medical care.

The state reimburses for Collaborative Care services provided by physicians meeting the requirement of 42 CFR 47.400(a). Only medical providers eligible to provider evaluation and management services are allowed to be a billing provider for this service.

The Department establishes maximum allowable fees for Collaborative Care Model (CoCM) services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of COCM services. The agency's fee schedule rates were set as of June 1, 2022 and are effective for services provided on or after that date.

All rates are published on the Wisconsin ForwardHealth website:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDynamicSearch.aspx

These rates were last updated on June 1, 2022.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

Section C Premiums and Cost Sharing:

The agency will not collect deductibles, copayments, coinsurance, and other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

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.

Wisconsin Medicaid
Pharmacy Fee Schedule, continued

4. **Hemophilia clotting factor and other blood products used to treat hemophilia and other blood disorders** will receive an ingredient cost plus a professional dispensing fee as defined above in (A)(1)(d).

   Rates for hemophilia clotting factor and other blood products will be based on a State Specialty Maximum Allowable Cost. State Specialty Maximum Allowable Cost rates will be updated monthly based on a review of product availability and specialty pricing in the marketplace. For hemophilia clotting factor and other blood products, Wisconsin or its contractor will use benchmark provider reimbursement discounts (e.g., commercial and/or Medicaid Managed Care) to develop hemophilia clotting factor and other blood products reimbursement rates.

   State Specialty Maximum Allowable Cost rates for hemophilia clotting factor and other blood products will not exceed WAC +0%.

   Reimbursement is the lower of:
   - The State determined State Specialty Maximum Allowable Cost plus a professional dispensing fee as defined above in (A)(1)(d) or
   - The provider's usual and .customary charge.
5. **Covered outpatient drugs not dispensed by a community retail pharmacy, but dispensed through institutions or long term care when not included as part of an inpatient stay** will receive an ingredient cost plus professional dispensing fee as defined above in (A)(1)(d).
   a. Ingredient cost is paid as the lesser of:
      - NADAC plus a professional dispensing fee or
      - The provider's usual and customary charge.
   b. If NADAC is unavailable, ingredient cost is the lesser of:
      - WAC +0% plus a professional dispensing fee,
      - SMAC rate, if available, plus a professional dispensing fee, or
      - The provider1 s usual and customary charge.
6. **Physician Administered Drugs** (PAD) –
   - Drug ingredient costs are reimbursed at the Medicare Fee Schedule.
   - If there is no ASP, then the drug ingredient costs are reimbursed at NADAC.
   - If there is no ASP or NADAC, then drug ingredient costs are WAC +0%.
   - No professional dispensing fee is reimbursed.
7. **Investigational Drugs** are not covered under the Medicaid State Plan, unless the drug has an FDA-approved emergency use authorization and is indicated for the treatment of COVID-19; these drugs are provided by the federal government free of charge.

C. Wisconsin will comply with the updated Upper Limits requirements.
1. Overall agency payment will not exceed the federal upper limit based on the ACA FUL for ingredient reimbursement ln the aggregate for multiple source drugs and other drugs, except prescription drugs which the prescriber certifies as being medically necessary for a beneficiary.
2. The State will ensure compliance, at the aggregate level, of MAC rates to not exceed the Federal Upper Limits on an annual basis.

State: Wisconsin

3.a. Other practitioners' services

Medication Therapy Management Services Performed by a Pharmacist

Medication therapy management services are paid at a maximum fee per unit of service as defined by CPT code.

The Department's rates are effective for services on or after April 1, 2017. All rates are published in our Online Handbook for Pharmacy Providers. See:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=48&s=2&c=642&nt=Comprehensive+Medication+Review+and+Assessments-Reimbursement

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

State: Wisconsin

Pharmacists Services

The Department establishes maximum allowable fees for pharmacist services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of pharmacist services. All rates are published on the Wisconsin ForwardHealth website: Max Fee Search (wi.gov). Rates were last updated on February 5, 2022. For each covered service, the Department shall pay the lesser of the provider's usual and customary charge or the maximum fee established by the Department.

For HCPCS codes subject to Section 1903(i)(27) of the Social Security Act, reimbursement is equivalent to the lowest corresponding Medicare max fee in Wisconsin as of January 1 each calendar year, and updated on an annual basis as needed.

For HCPCS codes not subject to Section 1903(i)(27) of the Social Security ACT or codes for which Medicare does not have an assigned rate, reimbursement is set at the following:

1. The Wisconsin Medicaid Fee Schedule amount available at:

   https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDynamicSearch.aspx

2. Competitive bid contracted rate;
3. 80% of the Manufacturer Suggested Retail Price (MSRP); or
4. Acquisition cost plus 20%

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's rates were set as of January 1, 2022 and are effective for services provided on or after that date.

6. Rural Health Clinics

Claims for Rural Health Clinic (RHC) services are reimbursed by Wisconsin Medicaid on a fee-for-service basis at the lower of:

- The provider's usual and customary fee; or
- Medicaid's maximum allowable fee.

In addition to fee-for-service reimbursement, all RHCs, other than such clinics in rural hospitals with less than 50 beds, that complete a cost report are eligible to receive interim payments with final settlements based on 100% of reasonable costs, up to a maximum limit as established or allowed in HCFA publication 27, RHC and FQHC Manual, Chapter 505.1.

RHCs in rural hospitals with less than 50 beds that complete a cost report are eligible to receive interim payments with final settlements based on 100% of reasonable costs as determined according to Medicare cost reimbursement principles. This provision is effective for final settlements completed on or after October 1, 1998, for services provided on or after January 1, 1998.

RHC reasonable cost payments are made on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at the RHC. An encounter is defined as a face-to-face encounter between a recipient and any Medicaid physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist or clinical social worker.

Effective 7-1-96

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

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 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). 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.

Wisconsin uses a cost-settlement system to reimburse clinics at 100% of reasonable costs. The Department will maintain this system under BIPA as an alternative methodology for payment. Furthermore, the Department will continue to reimburse RHCs 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 back to January 1, 2001. Wisconsin's RHCs have agreed to this alternative payment methodology.

6. Rural Health Clinics (cont.)

Cost-Settlement Process – Fee for Service

RHCs bill fee-for-service (FFS) Medicaid for Medicaid services rendered to Medicaid patients. The RHCs 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 RHCs the difference between what has been received from FFS Medicaid and their reasonable costs.

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

Cost-Settlement Process – Managed Care

RHCs receive payments from a Medicaid-contracted managed care organization (MCO) for Medicaid services rendered to Medicaid patients. The RHCs 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 RHCs the difference between what has been received from Medicaid MCOs and their reasonable costs.

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

6. Rural Health Clinics (cont.)

Methodology for Calculating a Baseline PPS Rate

The Division of Health Care Financing (DHCF) will calculate a baseline PPS rate using the following methodology:

1) Annual cost reports for an RHC's fiscal years 1999 and 2000 are submitted to the DHCF by the clinics.

2) The DHCF audits the submitted cost reports thereby establishing an annual encounter rate for each clinic for clinic 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 RHC encounters during the respective fiscal years:

A) The numbers of audited Medicaid RHC encounters for FY 1999 and FY 2000 are determined and then added together to obtain the total number Medicaid encounters at the clinic 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 clinic to the encounter rate paid under the cost settlement methodology and will pay the clinic the higher of the two. For clinics 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 clinic's interim and annual settlement payments using the cost settlement methodology described above.

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

6. Rural Health Clinics (cont.)

Subsequent Years (FY 2002 and beyond)

At the end of each clinic fiscal year, the Department will adjust the PPS rate by the Medicare Economic Index (MEI) in effect at the end of the clinic fiscal year and by expected changes in the scope of services provided to Medicaid patients at the clinic to determine the PPS rate for that clinic upcoming fiscal year. Clinics will be required to report to the Department expected staffing and service provision changes for the upcoming clinic fiscal year no later than one month prior to the end of the current clinic fiscal year. Staffing changes are to be estimated as changes in the number of full time equivalents (FTEs) employed by or contracting with the clinic to provide RHC services and their estimated costs. Clinics must also submit written documentation to the Department of the estimated costs of relevant capital changes that would affect the provision of RHC services at the clinic. Changes to the PPS rate based on expected staffing or service provision changes as reported by the clinic that do not occur in the upcoming clinic fiscal year are subject to reconciliation at the end of the clinic's fiscal year.

The adjusted PPS rate will be compared to the settlement rate for that clinic fiscal year, and the Department will pay the clinic the greater of the two. For clinics 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 clinic's interim and annual settlement payments using the cost settlement methodology described above.

New Clinics

For clinics that qualify for RHC status after FY 2000, the Department will use the PPS rate from a clinic 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 clinic the greater of the two. In the absence of a clinic in the same or adjacent area with a similar caseload, the cost settlement rate will be paid to the clinic.

6. Rural Health Clinics (cont.)

Supplemental Payments under Managed Care

RHCs that provide services under a contract with a Medicaid managed care organization (MCO) will receive state supplemental payments for the cost of furnishing such services. These supplemental payments are an estimate of the difference between the payments the RHC receives from MCO(s) and the payments the RHC would have received under the alternative methodology. At the end of each RHC fiscal year, the total amount of supplemental and MCO payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHC's contract with MCO(s) would have yielded under the alternative methodology. The RHC 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 RHC, if the alternative amount exceeds the total amount of supplemental and MCO payments. The RHC 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 RHC, if the alternative amount is less than the total amount of supplemental and MCO payments.

Effective 1-1-01

7. End Stage Renal Disease

The Department will pay free-standing End Stage Renal Disease (ESRD) providers the Medicare reimbursement rate for the services that they provide.

Effective 11/01/04

8. Case Management Services
EPSDT

Providers are reimbursed by a flat fee which is a percentage of the provider's average cost, established by the Department.

Effective 4-8-86

9. Case Management Services
Community Care Organizations

For case management services performed by Community Care Organizations, reimbursement will be made through the per diem rate as established by the department.

Certified providers will be reimbursed upon submission of an appropriate claim form, documenting recipient eligibility and services provided. This is true for all other MA-certified providers. Payments made from Title XIX funds for MA eligible clients will be appropriately matched with state and local funds, and will not duplicate other federal or state payments or match requirements.

Effective 10-1-86

9a. Case Management Services
Target Group N

This rate applies to clients in Target Group N where the child has been placed in substitute (out-of-home) care determined to be ineligible for Title IV-E administrative costs. The Department's proposal requires no change in the definition of the existing group and the benefits remain the same.

The rate methodology will employ the Random Moment Time Study (RMTS) as a tool in developing the monthly rate per client. The billing process will be established in such a manner as to prevent the processing of duplicate billings for the same client for the same service period. This will be accomplished by installing edits between procedure codes in the MMIS system. The methodology also contains a provision for adjusting the rate to an actual cost basis after completion of the Federal Fiscal Year.

Effective 10-1-01

9.b. For self-directed personal assistance services under 1915(j) (see Supplement to Attachment 3.1-A for a full description) the rate will be determined as follows:

Wisconsin's methodology for determining the participant's budget is based on the assessment of needs for the participant and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for personal care under the state plan referenced in Item 20 on page 3 of 4.19-B and are adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 83.9% of the expected waiver/state plan service reimbursement to calculate the participant's service budget for self-directed personal assistance services.

9.c. Case Management Services
Children with Medical Complexity (CMC) Target Group R

For children with medical complexity (CMC) the Department established maximum allowable fees for targeted case management services. Reimbursement will be made to certified children's hospitals as determined by the department. For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

Providers will be reimbursed at a uniform rate for the completion of a comprehensive patient assessment and the development of an individualized care plan; and ongoing care management and care coordination activities. The actuarially developed rate is based on a three-month time study of care management and care coordination activities completed by the Medicaid-enrolled children's hospitals for Medicaid members in the target group.

The Department will limit reimbursement to one claim per eligible individual per calendar month. A unit of service will be one (1) month. Providers must provide a minimum of one (1) contact that can include face-to-face, telephone, or written contact with, or on behalf of, the eligible individual.

The agency's fee schedule rates were set as of September 1, 2017 and are effective for services provided on or after that date. All current and adjusted rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

State: Wisconsin

10. Case Management Services
All Other Target Populations

Providers are reimbursed at a uniform statewide contracted hourly rate for each hour of allowable assessment, case planning, or ongoing monitoring services. The rate is based on the statewide average rate for a social worker with annual increases based on the Consumer Price Index.

Effective 7-1-93

11. Home Health Services

Payments will be made at the lesser of usual and customary agency charges, or maximum allowable fees. These rates include travel, recordkeeping, RN supervision and other administrative costs as well as direct care expenses. In comparing established rates-per-visit to inflated costs, it is anticipated that some agencies may receive reimbursement equal to or exceeding their individual anticipated costs per discipline. It should be noted that at no time will an agency be reimbursed more than its usual and customary fee or the WMAP maximum rate, whichever is less.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

State: Wisconsin

12. Hospice Care Services

Hospice services are reimbursed at the rates published by the federal Centers for Medicare and Medicaid Services at 42 CFR Part 418 Subpart G, as updated by annual Federal Register notices. Additionally, the rates are adjusted for regional differences in wages using the hospice wage index published by CMS.

This rate schedule provides rates for each of the four levels of hospice care, with the exception of payment for physician services.

Medicaid reimbursement for hospice services will be made at one of six (6) predetermined rates for each day in which a Medicaid members is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

1. Routine home care where most hospice care is provided-Days 1-60.
2. Routine home care where most hospice care is provided-Days over 60.
3. Continuous home care which is furnished during a period of crisis and primarily consists of nursing care to achieve palliation and management of acute medical symptoms.
4. Inpatient respite care which is short-term care and intended to relieve family members or others caring for the individual.
5. General inpatient hospice care which is short term and intended for pain control or acute or chronic symptom management which cannot be provided in other settings.
6. Service Intensity Add-on (SIA), effective for hospice services with dates of service on or after January 1, 2016, will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member's life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

Hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income (PETI) amount, for Medicaid clients who are receiving hospice services. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

For each hospice, the total number of inpatient days (both for general inpatient care and inpatient respite care) must not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid members enrolled in the hospice during the same period, beginning with services rendered November 1 or each year and ending October 31 or the next year.

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.

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. Alternative Payment Methodology (APM) - Indian Health Services (IHS) OMB All Inclusive Rate

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.

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.

17. Reimbursement for HealthCheck (EPSDT) Other Services

Mental Health

a. In-home psychotherapy: An hourly rate based on usual and customary charges will be applied by type of provider rendering service (psychiatrist, psychologist, psychiatric social worker, etc.).
b. Mental health day treatment: A comprehensive hourly rate based on usual and customary charges will be applied.
c. Specialized psychological evaluation: An hourly rate based on usual and customary charges will be applied by type of provider rendering service (psychiatrist, psychologist, psychiatric social worker, etc.).

Dental Services

a. Oral examinations: Usual and customary charges subject to a maximum fee.
b. Pit and Fissure Sealants: Usual and customary charges subject to a maximum fee.
c. Single unit crowns: Usual and customary charges subject to a maximum fee.

Over-the-Counter Drugs

Manual pricing based on estimated acquisition cost plus 50% mark-up.

Assurances

All services have been reviewed to ensure that service limitations will not adversely affect HealthCheck recipients. Organ transplant services will continue to be available to children as well as adults. All payments for these services are consistent with efficiency, economy, and quality of care.

Effective 7-1-91

State: Wisconsin

17. Reimbursement for HealthCheck (EPSDT) Other Services, continued

HealthCheck (EPSDT) Other Services – Comprehensive Treatment

"Health Check (EPSDT) Other Services – Comprehensive Treatment" refers to HealthCheck Other Services services defined in section 4. of Attachment 3.1-A Supplement 1 and Attachment 3.1-B Supplement 1.

The Department establishes maximum allowable fees for all other practitioners for behavioral treatment services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral treatment services.

The agency's fee schedule rates were set as of January 1, 2016 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website: https://www.forwardhealth.wi.gov/

For each covered service, the Department shall pay the lesser of the provider's usual and customary charge or the maximum fee established by the Department.

Provider travel time is not separately reimbursed.

18. Prenatal Care Coordination Services, Health Education and Nutrition Counseling Extended Services to Pregnant Women

The Department will establish maximum allowable reimbursement rates for all covered prenatal care coordination, health education and nutrition counseling services. The risk assessment and case plan services will be paid at a flat fee, while all other services will be paid at an hourly rate. The maximum rates for prenatal care coordination, health education, and nutrition counseling services and the maximum amount allowed per recipient for all services are based on cost and payment information from eleven pilot projects and from other states with similar services. The hourly rates were derived from service specific cost and payment information. The flat rates were established by multiplying the average hourly rate for the specified service by the average length of time needed to complete the department-required procedures. All reimbursement rates were reviewed by a statewide advisory committee. The advisory committee included provider agency and consumer representatives who advised the Department on the service components, the reimbursement methodology and the risk assessment. Payments will be made at the lesser of usual and customary charges or maximum allowable fees to certified prenatal care coordination agencies. A maximum amount per recipient is paid for all prenatal care coordination, health education, nutrition counseling and outreach services. (Prenatal care coordination outreach services are administrative services.) This maximum amount for all services was established by multiplying the hourly rate by the typical number of hours needed to provide services. The maximum amount is sufficient to ensure adequate levels of service for very high risk recipients.

Effective 1-1-93

19.

~~19.~~ Private Duty Nursing Reimbursement for Children

Private duty nursing services for children under age 21 are reimbursed at the provider's usual and customary charges or maximum allowable fees, whichever is less.

The maximum allowable fees were established to reflect the fragile medical condition of children receiving private duty nursing services. These conditions result in more complex care, requiring a higher level of skill by providers.

The maximum allowable fees are based primarily on the average hourly costs from sample data reported on the Medicare cost reports filed with the Medicare fiscal intermediary, United Government Services, by providers providing private duty nursing services for children. Based on this data, the fees are calculated to assure providers' reasonable costs will be met for skilled nursing direct care, which includes nurse salaries and fringe benefits, transportation, payroll taxes, and nurse supervision when it includes patient care and for at least 15% of providers' administrative costs for this care. The base rate was initially established years ago and is periodically increased by legislative action. The fees apply on a state-wide basis.

Effective 10-1-99

20. Dental Services

The Department establishes maximum allowable fees for dental services. For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDownload.aspx#Dental

Enhanced Reimbursement for Certain Dental Providers

Effective January 1, 2019, dental providers who render 90 percent or more of their services annually to individuals with cognitive and/or physical disabilities, as defined by the Department as "developmental disability" and "physically or sensory disabled" will receive enhanced reimbursement rates for all dental services provided to Medicaid beneficiaries to account for an increase in intensity and duration of services. The enhanced rate will be equivalent to 200 percent of the state plan fee schedule rate for dental services. Qualification for enhanced payment will be completed through provider self-attestation as well as verification by the state through a claims review process.

Qualification will occur annually based on the calendar year, beginning January 1, 2019 through December 31, 2019. Enhanced reimbursement rates are in effect January 1st of the following calendar year.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services.

21. Nurse Midwife and Licensed Midwife Services

The Department establishes maximum allowable fees for Nurse Midwife and Licensed Midwife services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of midwifery services.

All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

22. Primary Care Provider Incentive Payment

Primary care providers are reimbursed at a rate, when annualized, that is an estimated 2 percent over and above the established maximum allowable fee for all services they provide. For this enhanced payment, primary care providers are defined as physician assistants, nurse midwives, nurse practitioners and physician specialists in general and family practice, internal medicine, pediatrics, obstetrics and gynecology.

The intent of this rate increase is to improve Medical Assistance recipient access to primary care services, including pediatric and obstetric services, by increasing compensation to those providing primary care. In addition, many studies document that primary care providers furnish high quality health care at lower cost than other specialists.

The findings of the Physician Payment Review Commission indicate that over the past decades physician reimbursement for primary care services has grown at a much slower rate than reimbursement for other specialists. This increased reimbursement is an effort to begin to correct the imbalance in payment between primary care and other specialist providers.

Effective for payments made on and after 10-16-93 for dates of service on and after July 1, 1993

23. Specialized Medical Vehicle (SMV) Multiple Carry

On trips where more than one recipient is being transported at the same time, providers are paid at a lower rate for the second and subsequent recipients.

Effective 4-1-95

24. Reimbursement for Special Tuberculosis (TB) Related Services.

Reimbursement for these services is limited to those claims with a TB-related diagnosis. Reimbursement is through an hourly rate and a maximum amount per recipient depending on whether the recipient was TB-infected only or a suspected or confirmed TB case. Prior authorization is required for claims that exceed the maximum limitations to assure the medical necessity of exceeding these limits. Hourly rates and maximums are based on current averages to provide tuberculosis-related services by public health nursing staff at local health departments.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

State: Wisconsin

25. Reimbursement to County Health, Human Services, Social Services and Community Programs Agencies for Certain Services

Programs operated by local County Health, Human Services, Social Services and Community Programs Agencies provide outpatient mental health and alcohol and other drug abuse treatment and other services, including services by a psychiatrist, medical day treatment services, ADDA day treatment, child/adolescent day treatment, personal care services, case management services, psychosocial services mental health crisis intervention services, prenatal care coordination services and/or home health services (or nursing services if home health services are not available). Covered services are defined in Attachment 3.1-A.

A. Payments for Covered services covered under Attachment 3.1-A rendered by providers other than local County Health, Human Services, Social Services and Community Programs Agencies are equal to the lower of the submitted charge or the appropriate maximum fee from the Wisconsin Department of Health Services Fee Schedule. The agency's fee schedule rate was set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published on the Department of Health Services Forward Health website at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx.

B. Payments to Local County Health, Human Services, Social Services and Community Programs Agencies

Local County Health, Human Services, Social Services and Community Programs Agencies will be paid reconciled cost. Interim payments will be made using the Wisconsin fee schedule.

To assure payments do not exceed cost, County Health, Human Services, Social Services and Community Programs Agency interim payments will be cost settled annually to Medicaid incurred costs. Effective for cost reporting periods beginning on or after January 1, 2015, Medicaid incurred cost will be determined by the Department of Health Services using a cost reporting methodology and cost report approved by CMS in accordance with 2 CFR 200.

Counties shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or state definition of **a** *qualified Medicaid provider. Additionally, counties shall not claim FFP for non-Medicaid covered services or non-allowed cost such as room and board.*

A. Direct Medical Services Payment Methodology:

The annual cost settlement methodology will consist of a CMS approved cost report and reconciliation. If Medicaid payments exceed Medicaid incurred costs, the excess will be recouped and the Federal share will be returned on the CMS-64 report.

25. Reimbursement to County Health, Human Services, Social Services and Community Programs Agencies for Certain Services, continued

A. Direct Medical Services Payment Methodology:

The annual cost settlement methodology will consist of a CMS approved cost report and reconciliation. If Medicaid payments exceed Medicaid incurred costs, the excess will be recouped and the Federal share will be returned on the CMS-64 report.

To determine the Medicaid incurred direct and indirect costs of providing direct medical services to Medicaid recipients receiving Covered services the following steps are performed:

Allowable Cost Centers

(1) Direct costs for medical service include direct medical service provider costs and other costs that can be directly charged to direct medical services. Direct medical service costs include total salary, benefits and contract costs associated with personnel providing direct medical services.

(2) Other direct service non-personnel costs include non-personnel costs directly related to the delivery of medical services, such as clinician travel, training and direct medical service materials and supplies. These direct costs are accumulated on the annual cost report.

(3) Direct support costs include payroll costs and other costs which directly support medical service personnel furnishing direct medical services. Direct support payroll costs include total compensation of clinical administrative personnel furnishing direct support services. In compliance with 2 CFR § 200, Subpart E, Section 200.413(c) direct support costs also include the salaries of administrative and clerical staff in instances where the following conditions are met: administrative or clerical services are integral to a project or activity; individuals involved can be specifically identified with the project or activity, and these costs are not also recovered as indirect costs.

(4) Indirect costs include payroll costs and other costs related to the administration and operation of the county or tribe. Indirect payroll costs include total compensation of Health, Human Services, Social Services and Community Programs Department administrative personnel providing administrative services.

Other indirect costs include non-personnel costs related to the administration and operation of the Health, Human Services, Social Services and Community Programs Department such as purchased services, capital outlay, materials and supplies. Other indirect costs also include indirect costs allocated from the county to the Health, Human Services, Social Services and Community Programs Department via the county Cost Allocation Plan.

25. Reimbursement to County Health, Human Services, Social Services and Community Programs Agencies for Certain Services, continued

Determination of Direct Medical Cost

(5) A CMS approved time tracking methodology meeting the requirements of 2 CFR 200.430 is used to determine the percentage of time spent by medical service personnel from item A1 above and direct support personnel from item A3 above on direct service activities for each individual service, direct support activities for each individual service, and non-reimbursable activities.

(6) The total allowable direct support cost for each clinician providing allowable direct support services is allocated to each applicable program by multiplying the percentage of actual time spent on direct support for each program from Item A5 by the accumulated cost in direct support cost centers for that individual clinician from Items A3 above.

(7) Total indirect costs from Item A4 above are allocated based on FTEs or other approved allocation methodology to covered programs as well as non-reimbursable cost centers.

Reductions

(8) Total direct, direct support and indirect costs allocated to individual covered programs are reduced on the cost report by any restricted public health service grant payments as defined in CMS Publication 15-1 resulting in adjusted allowable costs for direct medical services.

B. Certification of Expenditures:

On an annual basis, each local County Health, Human Services, Social Services and Community Programs Agency providing covered services will certify through its cost report its total actual, incurred Medicaid allowable costs. Providers are only permitted to certify Medicaid allowable costs.

25. Reimbursement to County Health, Human Services, Social Services and Community Programs Agencies for Certain Services, continued

C. Annual Cost Report Process:

For Medicaid covered services each local County Health, Human Services, Social Services and Community Programs Agency shall file an annual cost report as directed by the Department of Health Services in accordance with 42 CFR 413 Subpart B and 42 CFR 447.202. The Medicaid cost report is due nine (9) months after the calendar year end. Providers that fail to fully and accurately complete Medicaid cost reports within the time period specified by the Department of Health Services or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Department, may be subject to withhold penalties for non-compliance.

Providers that fail to fully and accurately complete the Medicaid cost reports within the time period specified by the Department of Health Services or that fail to furnish required documentation and disclosures for Medicaid cost reports required under this Plan within the time period specified by the Division, may be subject to withhold penalties for non-compliance. At the discretion of the Department of Health Services, a 20 percent withhold of Medicaid payments may be imposed upon the delinquent provider 30 days after the Medicaid cost report filing deadline unless the provider has made a written request for an extension of the Medicaid cost report filing due date to the Department of Health Services and has received a written approval from the Department of Health Services. The withholding of monies may continue until the Medicaid cost report filing requirements have been satisfied. Once all requirements have been satisfied, withheld monies will be released to the provider. Any monies withheld will not accrue interest to the benefit of the provider.

The primary purposes of the governmental cost report are to:

(1) Document the provider's total CMS-approved, Medicaid incurred costs of delivering Medicaid covered services using a CMS-approved cost allocation methodology and cost report.
(2) Reconcile annual interim payments and manual payments to total CMS-approved, Medicaid incurred costs using a CMS approved cost allocation methodology and cost report.

D. The Cost Reconciliation Process:

Total direct medical service cost for the County Health, Human Services, Social Services and Community Programs Agency including direct cost, direct support and indirect program cost net of reductions is divided by total units of direct medical service calculated based on reported direct service hours to determine a per unit rate for each covered service.

Total Medicaid incurred cost is calculated by multiplying the per unit rate, based on cost as calculated in item A8 above, by fee for service claims which are also based on the same unit of service, reimbursed by Medicaid for each program to ensure that only cost associated with units of service reimbursed by Medicaid are eligible for cost settlement.

The cost reconciliation process must be completed within fourteen (14) months of the end of the reporting period covered by the annual county Cost Report. The total Medicaid incurred costs are determined based in accordance with 42 CFR 413 Subpart B and the CMS Provider Reimbursement Manual methodology and are compared to the Health Department Medicaid interim payments and manual payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

E. The Cost Settlement Process:

If a provider's interim fee schedule payments and manual payments exceed the provider's certified cost for Medicaid services furnished in health departments to Medicaid recipients, the Department of Health Services will remit excess federal share of the overpayment at the time the cost report is submitted. The federal share will be returned via CMS-64 Report. State recoveries for the collection of overpayment will be conducted in compliance with 42 CFR §433.316.

If the certified cost of a Health, Human Services, Social Services and Community Programs Department provider exceeds the interim payments and manual payments, the Department of Health Services will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

25a. Reimbursement to Local Governments for Emergency Ambulance Services

To establish base rates for ambulance services where comparable Medicare procedure codes exists, Wisconsin Medicaid rates shall be adjusted on a one-time basis for ground ambulance transport services (advanced life support levels one and two, advanced life support level one emergency, basic life support, basic life support emergency, and specialty care transport) to ~90.6% of the applicable Wisconsin specific Part B CY2023 Medicare urban base rate approved by CMS with an effective date of February 1, 2023. See table below:

A0426	90.614%	of CY2023 Urban Base Rate
A0427	90.614%	of CY2023 Urban Base Rate
A0428	90.610%	of CY2023 Urban Base Rate
A0429	90.614%	of CY2023 Urban Base Rate
A0433	90.613%	of CY2023 Urban Base Rate
A0434	90.612%	of CY2023 Urban Base Rate

These rates are available at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDynamicSearch.aspx

All other ambulance services where comparable Medicare procedure codes exists, Wisconsin Medicaid rates shall be adjusted on a one-time-basis to 89.353.% of the applicable Wisconsin specific Part B CY2023 Medicare base rate approved by CMS with an effective date of February 1, 2023. These rates are available at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeDynamicSearch.aspx

Ambulance services for which no comparable Medicare procedure code exists, the Department shall use a compounded inflation factor accounting for inflation that has occurred between January 1, 2004 – January 1, 2021, plus an additional 10%(Inflation factors used will be those published in the Federal Register through January 1, 2021 and available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData)

Reimbursement for ambulance services will be made through initial and supplemental payments. Current base rates for the impacted ambulance procedure codes are listed in the ForwardHealth handbook. The Department shall distribute supplemental payments to specific local governmental units for the provision of transportation for medical care during the state fiscal year. The annual available pool for the distribution to local government ambulance providers is $5,000,000. Payments are distributed evenly based on a calculation of utilization across the specific governmental units using the difference between the Medicaid base rates described above compared to the annual Medicare base rate. This supplemental payment will occur between October 1 and December 31 of each year for services provided during the previous state fiscal year.

26. Medication Management

The maximum allowable fee for medication management is based on the maximum fee for home health skilled nursing as well as the relative amount of time and the relative level of skill to provide the service. The fee is adjusted for travel time, overhead costs and indirect costs. The maximum allowable fee for medication management is the same for all providers because the service is virtually the same whoever provides it.

Effective 01/01/2022

27. Clozapine Management

The maximum allowable fee for Clozapine management is based on the average salaries for Clozapine management providers as well as the relative amount of time and the relative level of skill to provide the service. The maximum allowable fee is adjusted for travel time, overhead costs and indirect costs. The maximum allowable fee is the same for all providers because the service is essentially the same whoever provides it.

Effective 7-1-95

28. Medicaid-Covered Services Included in Medicaid-eligible Students' Individualized Education Programs (IEPs) Provided by Local Education Agencies

Overview

This section of the plan describes how:

1. The Department establishes rates for interim Medicaid reimbursement,
2. Local education agency providers (LEA providers) identify total allowable Medicaid costs, including the Federal and non Federal share of expenditures for Medicaid covered services provided by Medicaid qualified providers.
3. The Department reconciles interim payments to total, allowed cost as reported on the CMS-approved cost report for direct medical services and specialized transportation services.

This section of the plan applies only to Medicaid covered services identified in the child's individualized education program (IEP).

Payment for Medicaid-Covered Services Included in Medicaid-eligible Students' Individualized Education Programs (IEPs) Provided by Local Education Agencies

Local education agency (LEA) providers shall be reimbursed on an interim basis and those payments shall retrospectively be reconciled to cost. Section A and B cover the interim payment process. Sections C through F cover the process for certification and reconciliation.

Interim Payment for Covered Services Provided by LEA Providers

A. Before July 2007 statewide rates will be set on an interim basis using the July 2004 school year's reimbursement updated for inflation at a rate not to exceed the qualified economic offer (QEO) annual rate. In negotiating teacher's contracts, the QEO identifies the minimum offer required by state statute that a local school district may make to avoid binding arbitration on salaries and fringe benefits.

B. After July 2007, LEA specific rates will be set on an interim basis using the LEA's most recent cost information updated to the current year for inflation at a rate not to exceed the QEO.

Identification of Total Allowed Cost

C. LEA providers are required to report annually total allowed cost, including the Federal and non federal share of expenditures using a CMS-approved cost report. The following steps will be used to determine cost:

1. The provider will identify cost to be included in the direct services cost pool.

   The pool of cost will consist of compensation to practitioners and some additional cost for clinical materials and supplies. Practitioners are licensed medical providers and other qualified providers doing delegated medical tasks under the school-based services section Attachment 3.1-A Supplement 1 and 3.1-B Supplement 1 of the Wisconsin Medicaid State Plan. Only those practitioners who are expected to deliver hands-on services to clients and who are expected to generate a service unit that may be attributed through the medical record may be included in the direct services cost pool. The cost of supervisors, program coordinators, special education teachers, administrators and other personnel are included in the cost pool only to the extent they are qualified providers and are expected to provide hands-on care. The LEA will identify individually the practitioners eligible for inclusion in the direct services cost pool. Their compensation data will be reported on a subsidiary spreadsheet of the CMS-approved cost report and will reflect offsetting amounts to the extent required by law for all other sources of revenue.

   Only Medicaid qualified providers that are the direct practitioners may be included in the direct services cost pool. The following practitioners must meet the requirements of 42 CFR 440.110 to report their costs: physical therapist, occupational therapist, speech language pathologist and aides providing medical services under the direction of physical therapist, occupational therapist and speech language pathologist.

   The Department shall specify the method for identifying these costs using the CMS-approved cost report which employs the use of data derived from the Wisconsin Uniform Financial Accounting Requirements (WUFAR), the Special Education Fiscal Report project codes and other data classifications maintained by the Department of Public Instruction (DPI). These costs shall be identified in compliance with the scope of cost that CMS has approved.

2. The provider/LEA will identify the amount of cost in the direct services cost pool that may be attributed to the provision of medical services.

   To allocate this cost, the provider multiplies the statewide direct medical services time study percentage by the total direct services cost pool amount. The source of the direct medical services time study percentage is the expanded Medicaid Administrative Claiming Time Study for Schools (MACS). The State will supply the time study percentage for direct medical services to providers. The use of this CMS-approved time study assures that no more than 100 percent of time is captured for administrative activities and direct medical services and that the time study is statistically valid.

3. The indirect cost is determined through use of the cognizant agency unrestricted indirect cost rate.

   One plus the cognizant agency's unrestricted indirect cost rate assigned to each LEA provider is multiplied by total direct medical services cost as determined under the previous step.

4. Medicaid's portion of total direct services cost will be calculated.

   The results of the previous step are multiplied by the ratio of the total number of IEP students receiving medical services and eligible for Medicaid to the total number of IEP students receiving medical services. One IEP ratio is applied to cost for each practitioner type.

Methodology for Determining Specialized Transportation Cost

D. Transportation is reimbursed only on days when a covered Medicaid service was provided pursuant to an IEP and only if specialized transportation is listed as a service in the IEP.

Each LEA provider shall report to the Department, on an annual basis, the total allowed costs incurred under the Special Education Transportation account using the following steps.

1. Each LEA will use the CMS-approved cost report to accumulate annually direct cost, which will include some personnel cost, contracting cost, and special education school bus depreciation, fuel, repairs and servicing costs necessary for the provision of school-based IEP transportation services.

2. Total specialized transportation cost will be determined by multiplying cost identified under Step 1 by one plus the cognizant agency's unrestricted indirect cost rate.

3. Medicaid's portion of specialized transportation cost will be identified by multiplying the results of Step 2 by the ratio of the total number of one-way Medicaid specialized transportation trips pursuant to the IEP over all one-way specialized transportation trips that were provided. The provider is responsible to maintaining one-way trip documentation.

E. Cost Reconciliation and Cost Settlement

Each LEA provider shall be required to do all of the following activities:

1. Each LEA provider must complete annually the CMS-approved cost report for direct medical services and specialized transportation. It will contain total cost incurred to provide Medicaid covered services to Medicaid beneficiaries, including the Federal and non-Federal share of incurred cost. This cost report will be filed with the Department by March 31, 2007 for the 2005-06 state fiscal year, and the December 31 following the end of the state fiscal year for all other school years. The Department will inform the provider of whether there has been an over- or underpayment.

2. The LEA provider is required to keep, maintain and have readily retrievable financial records that fully either identify or support its allowable costs eligible for FFP in accordance with Federal and Wisconsin Medicaid records requirements. The LEA provider is also required to participate in statewide time studies conducted by the Department.

3. The LEA provider shall be paid at cost. Using the reconciled cost as reported on the CMS-approved cost report any settlement amount will be identified. LEA providers shall be required to reimburse overpayment of interim payments. If the interim payments underpay an LEA provider, the Department will reimburse the provider up to its cost. All cost will be settled no later than 24 months after the close of the applicable state fiscal year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

4. Special Rule for Cost Reconciliation and Cost Settlement

   Applicable to the Fiscal Year July 2005-June 2006

   For the fiscal year July 2005 -June 2006 only, cost reconciliation will be performed in accordance with a methodology submitted by the Department and approved by CMS.

F. Department's Responsibilities

1. The Department shall assure that it utilizes the CMS-approved scope of cost as reflected in the CMS-approved cost report. For costs that were reported using invoices instead of object codes, the State will assure that by 7/1/07 all cost will be reported using object codes. The changes in coding will be made in consultation with CMS. The Department shall review future changes in the DPI WUFAR and Special Education Fiscal Report project codes and other data and procedures as they occur to assure that costs included in cost reports are consistent with CMS-approved cost categories. Whenever there is a change in the object codes used in the cost report, the State will seek approval from CMS. This action may or may not result in the required submission of a state plan amendment. The Department shall conduct time studies that meet CMS guidelines for approved Administrative Claiming Time Studies to determine that percentage of time that school staff spend on activities related to the provision of Medicaid allowable medical services.

2. All cost will be settled no later than 24 months after the close of the applicable school year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment separately within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

3. As part of the financial oversight responsibilities, the Department shall develop review procedures for the certified expenditures that include procedures for assessment of risk that expenditures and other information submitted by the LEAs is incorrect. The financial oversight of all LEA providers shall include reviewing the allowable costs in accordance with the scope of cost approved by CMS.

If the Department becomes aware of potential instances of fraud, misuse, or abuse, it shall perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problems.

29. Reimbursement for Unusual High Cost Home Care Cases

The Department, in its sole discretion, may establish an alternative payment for home health, personal care, private duty nursing and respiratory care services provided to a recipient if all the following requirements are met:

a. Medically necessary community based services, such as home health, personal care, respiratory care and private duty nursing services, are appropriate;

b. All applicable prior authorization requirements are met; and

c. The Department, in its sole discretion, determines, on an individual basis, that the recipient meets all the following criteria:

   i. Annual cost of home care services is greater than $100,000;
   ii. Institutional services are inappropriate; and
   iii. Medical condition is not expected to improve; as a result, the need for services is not expected to change.

The home care services that may be considered for alternative payment include home health, personal care, private duty nursing and respiratory care services using the definitions and limitations described in the state plan. Services selected for an alternative payment will be those that are provided to the individual recipient consistently with little day-to-day variation and in relatively large quantities. Development of the per diem amount will include a determination of what proportion of the per diem is for which category of service. Claims for FFP for the per diem amounts will be separated into claims for each category of services based on the proportions.

The per diem amounts, which are interim payments, will be adjusted to reflect changes in services provided and provider-incurred costs on an as-needed basis, but no less than annually. Providers will be required to submit to the Department on at least an annual basis documented, audited costs for provision of services to individuals who qualify for alternative payments. The Department will also review the recipient's care plan and the prior authorization request. The per diem amount will not exceed the prevailing charges in the locality for comparable services under comparable circumstances. Per diem amounts will be redetermined annually, or earlier if there are changes in circumstances, such as changes in the recipient's condition or need for services, or in the quantity, quality, or cost of services being provided.

Upon determining the amount of an alternate payment to a provider, the Department will sign an agreement with that provider requiring appropriate recordkeeping and documentation. The Department will conduct periodic audits to assure that the recipient is receiving the authorized services, that the circumstances continue unchanged, and that FFP is claimed in appropriate portions. The Department will reconcile provider billing with provider-incurred cost at some specified point in time at least annually, and make necessary adjustments to reflect any over or under payment.

Effective 10-1-95

30. Reimbursement for Mental Health Crisis Intervention (MHCI) Services

Reimbursement for MHCI services will be based on the provider's actual cost to provide MHCI services. Interim rates will be established and providers will be required to complete yearly cost reports which will be used to make settlements. Cost reporting will be based on the allowable cost and cost findings principles detailed in the Office of Management and Budget Circular A-87. Costs will be based on the hourly cost to provide allowable services and will be determined for various levels of professionals and paraprofessionals working in the program (e.g., psychiatrist, psychologist, registered nurse). All the requirements of 42 CFR 447.325 will be met.

Effective 10-1-96

Replacement page - Revised 1-31-97

31. Ambulatory Surgery Centers

The Department establishes maximum allowable fees for ambulatory surgery centers. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ambulatory surgery center services.

The agency's fee schedule rates were set as of July 1, 2024 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

Last updated July 1, 2024.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

32. Audiology Services

The Department establishes maximum allowable fees for audiology services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of audiology services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin Forward.Health website:
https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

These rates were last updated on January 1, 2022

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

33. Chiropractic Services

The Department establishes maximum allowable fees for chiropractic services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of chiropractic services.

All rates are published on the Wisconsin ForwardHealth website:

www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

Last updated January 1, 2024.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

34. Family Planning Clinics

The Department establishes maximum allowable fees for family planning services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of family planning services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department. Providers participating in the federal 340B Drug Discount Program (340B Program) are required to bill no more than the actual acquisition cost for drugs purchased under the 340B program.

35. Laboratory and X-Ray Services

The Department establishes maximum allowable fees for laboratory and x-ray services. As required by section 1903(i)(7), payments for clinical diagnostic laboratory services are limited, on a per test basis, to no more than the amount paid by Medicare for those services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of laboratory and x-ray services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

36. Mental Health and AODA Counseling Services

The Department establishes maximum allowable fees for mental health and AODA counseling services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of mental health and AODA counseling services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

37. Nurse Practitioner – Family and Pediatric Services

The Department establishes maximum allowable fees for family and pediatric nurse practitioner services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of family and pediatric nurse practitioner services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

38. Other Nurse Practitioner and Clinical Nurse Specialist Services

The Department establishes maximum allowable fees for other nurse practitioner and clinical nurse specialist services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of other nurse practitioner and clinical nurse specialist services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

State; Wisconsin

Other Practitioners' Services

"Other Practitioners' Servic.es" refers to other practitioners of behavioral treatment services defined in section 6.d. of Attachment 3.1-A Supplement I and Attachment 3.1-B Supplement 1.

The Department establishes maximum allowable fees for all other practitioners for behavioral treatment services. Except as otherwise noted in the plan, state-developed fee schedule rates a:re the same for both governmental and private providers of behavioral treatment services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

For each covered service, the Department shall pay the lesser of the provider's usual and customary charge or the maximum fee established by the Department.

Provider travel time is not separately reimbursed.

39. Occupational Therapy Services

The Department establishes maximum allowable fees for occupational therapy services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of occupational therapy services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin Forward.Health website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

These rates were last updated on January 1, 2022.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

40. Optometrist/Optician Services

The Department establishes maximum allowable fees for optometrist/optician services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of optometrist/optician services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

41. Personal Care Services

The Department establishes maximum allowable fees for personal care services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of personal care services.

All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeHome.aspx

Last updated January 1, 2024.

For each covered service, the Department shall pay the lesser of a usual and customary charge or the maximum fee established by the Department.

42. Physical Therapy Services

The Department establishes maximum allowable fees for physical therapy services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physical therapy services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin Forward.Health website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

These rates were last updated on January 1, 2022.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

43. Podiatry Services

The Department establishes maximum allowable fees for podiatry services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of podiatry services.

The agency's fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

These rates were last updated on July 1, 2008.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

44. Speech Therapy

The Department establishes maximum allowable fees for speech therapy services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of speech therapy services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

These rates were last updated on January 1, 2022.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

45. Transportation– Emergency Ambulance

The Department establishes maximum allowable fees for emergency ambulance services. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of emergency ambulance services.

The agency's fee schedule rates were set as of January 1, 2022 and are effective for services provided on or after that date. All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/publications/maxfeehome.aspx

These rates were last updated on January 1, 2022.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

1. Ambulance Service Provider Fee Reimbursement Program

(a) Reimbursement rates for Emergency Service Transporters are outlined in Attachment 4.19-B, Page 16.h-15.

(b) SUPPLEMENTAL PAYMENT FOR ELIGIBLE PRIVATE EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

I. Effective July 1st, 2023, any eligible private ground emergency medical transport (GEMT) providers that meet the specified provider eligibility requirements outlined in Section A below and provide emergency ambulance services to Medicaid recipients as defined in Attachment 3.1A will be eligible for a rate add-on for ambulance services. Calculated rate add-ons are effective January 1 of each year and will be published annually on the ForwardHealth portal. This rate add-on applies to ambulance services rendered to Medicaid recipients by eligible GEMT private providers on or after July 1, 2023. Participation in this program is required for all eligible private GEMT providers.

A. To qualify for supplemental payments, providers must meet the following criteria:
   i. Provide emergency Ambulance Services to Wisconsin Medicaid beneficiaries;
   ii. Enroll as a Wisconsin Medicaid provider for the period being claimed; and
   iii. Be a privately owned and operated ambulance service provider that is not owned by any municipality or group of municipalities.

B. Over the period July 1st, 2023, to December 31st, 2023, the rate add-on will be calculated based on all eligible ambulance services provided to Medicaid recipients under fee-for-service reimbursement methodologies only. For January 2024 onward, the rate add-on will be based on both fee for service and managed care.

II. This program will provide enhanced payments to eligible private GEMT providers by implementing a rate add-on to the base rates for eligible ambulance services. The reimbursement rate add-on will cover ambulance services and will be paid on an ongoing basis, as interim claims are processed, to eligible ambulance service Healthcare Common Procedure Coding System (HCPCS) codes as defined in Section III, below. For the retroactivity period preceding the implementation date of rate add-ons as well as the approval date of this SPA, one or more lump sum payments will be made. The base rates for GEMT will not change with this amendment to Wisconsin's Medicaid's State Plan.

III. The following is a comprehensive list of eligible ambulance service HCPCS codes subject to the rate add-on:

Emergency Ambulance Services

A. A0429 BLS Emergency,
B. A0427 ALS Emergency (Level 1),
C. A0433 ALS Emergency (Level 2),
D. A0434 Specialty Care Transport,
E. A0225 Neonatal Emergency Transport

Non-Emergency Ambulance Services
In addition to emergency ambulance transports, the following non-emergency ambulance service codes will be reimbursed at 50% of the rate add-on, when rendered by providers of emergency ambulance services.

F. A0426 ALS Non-emergency (Level 1), and
G. A0428 BLS Non-emergency.

Providers based in a county with a population greater than 750,000 individuals will receive 20% of the rate add-ons for eligible emergency and non-emergency transports, respectively.

IV. Total funds available will be calculated annually so that the total amount of fees collected from an eligible ambulance service provider in a state fiscal year is an amount not less than one quarter of 1 percent lower than the maximum limit for a provider fee under 42 CFR 433.68 (f) but does not exceed the maximum limit. As described in further detail below, actual funds disbursed will be the lesser of the total funds available in a given Calendar Year or the Upper Payment Limit calculated based on Average Commercial Rates.

V. A provider's assessment will be calculated as a uniform percentage of total net patient revenues, across all payors, received for ground emergency ambulance services (as in III) during the preceding state fiscal year. Assessments are to be paid quarterly and calculated annually.

A. There will be an annual data collection period, during which time all privately owned providers of ground emergency medical transports will submit organizational data including net patient revenues and the average commercial payments received. The State will use this data to calculate the assessment amounts as well as the Upper Payment Limits.
B. If a provider fails to submit their data within thirty days of the data submission deadline, the assessment will be calculated using the statewide average ratio of net patient revenues as a percentage of Medicaid revenues from the state's MMIS system, applied to the individual provider's Medicaid revenues.
    i. In cases where a provider has no Medicaid revenues, the statewide average net patient revenues will be applied to determine the provider's assessment.

VI. The rate add-on for the period 7/1/2023-12/31/2023 will be calculated and applied as follows:

A. The total supplemental funds available for the six-month period will be calculated based on provider data pertaining to State Fiscal Year 2023.

B. The total volume of eligible ambulance service claims for Medicaid recipients under fee-for-service reimbursement methodologies for the six-month period, will be calculated as the service claims paid to all eligible GEMT providers over the period 7/1/2023-12/31/2023 as determined through the Medicaid Management Information System (MMIS). Discount factors will be applied to the relevant categories of transports as defined in III when calculating the total annual volume of eligible transports.

C. The total funds available for the six-month period will then be divided by the total volume of eligible fee for service ambulance service transport claims for the six-month period to determine the rate add-on for the period 7/1/2023-12/31/2023.

D. The Upper Payment Limit (UPL) gap is defined as the Average Commercial Rate (ACR) for GEMT services across all eligible private GEMT providers net of the average Medicaid interim payments received across all Medicaid fee-for-service claims.

E. Each eligible provider will receive a rate add-on for all Medicaid fee for service claims equal to the lesser of the rate add-on calculated in C or the UPL gap calculated in D. The rate add-on will be applied to transport claims with dates of payment spanning 7/1/2023-12/31/2023.

VII. The rate add-on from the effective date 1/1/2024 onward will be calculated and applied as follows:

A. The total supplemental funds available for the calendar year period will be calculated based on provider data pertaining to the preceding State Fiscal Year. A subset of total funds available will be apportioned to Medicaid Fee for Service (FFS) claiming activity to determine total funds available for fee for service supplemental payments.

B. The total annual volume of eligible ambulance service claims for Medicaid recipients will be calculated as the service claims paid to all eligible GEMT providers during the preceding state fiscal year as determined through the Medicaid Management Information System (MMIS). Discount factors will be applied to the relevant categories of transports as defined in III when calculating the total annual volume of eligible transports.

C. The total annual funds available will be divided by the total annual volume of eligible ambulance service Medicaid claims to determine the rate add-on for the period.

D. The Upper Payment Limit (UPL) gap is defined as the Average Commercial Rate (ACR) for GEMT services across all eligible private GEMT providers net of the average Medicaid interim payments received across all Medicaid claims.

E. Every quarter, each eligible provider will receive a rate add-on for all Medicaid

Fee-For-Service claims paid during the preceding quarter, equal to the lesser of the rate add-on calculated in C or the UPL gap calculated in D.

45-a. Ground Emergency Medical Transportation (GEMT) Reimbursement Program

(a) Reimbursement rates for Emergency Service providers are outlined in Attachment 4.19- B.

(b) SUPPLEMENTAL PAYMENT FOR GROUND EMERGENCY MEDICAL TRANSPORTATION PROVIDERS

Effective January 1, 2023, Ground Emergency Medical Transportation (GEMT) providers that meet the specified requirements outlined in Section 3(c) below and provide ground emergency transportation services to Medicaid recipients as defined in Attachment 3.1A, will be eligible for a supplemental payment. This supplemental payment applies to Emergency Transportation Services rendered to Medicaid recipients by eligible GEMT providers on or after January 1, 2023. The GEMT Reimbursement Program is a voluntary program, and GEMT providers are not required to participate. The approval of the GEMT Reimbursement Program will render 25a. Reimbursement to Local Governments for Emergency Ambulance Services under Attachment 4.19-B concluded as of January 1, 2023.

Supplemental payments provided by this program are available only for allowable costs that are in excess of Medicaid reimbursement rates paid to GEMT providers in accordance with Attachment 4.19-B, that eligible entities receive for GEMT services rendered to eligible Medicaid recipients. Total reimbursements under the GEMT program are capped (including supplemental payments) at one hundred percent of actual costs. The Wisconsin Department of Health Services (the Department) will recognize a supplemental payment equal to the total allowable Medicaid costs of eligible GEMT services for providing services as set forth below.

(c) To qualify for supplemental payments, providers must meet all of the following:

1. Provides Ground Emergency Medical Transportation services to Wisconsin Medicaid members.

2. Is a provider that is enrolled as a Wisconsin Medicaid provider for the period being claimed.

3. Is owned or operated by an eligible governmental entity, to include the state, a city, county, fire protection district, community services district, health care district, federally recognized Indian tribe or any unit of government as defined in 42 C.F.R. Sec. 433.50.

Providers meeting all these qualifications will be considered “Eligible Providers.”

(d) Supplemental Reimbursement Methodology – General Provisions

1. Computation of allowable costs and their allocation methodology must be determined

in accordance with the Centers for Medicare and Medicaid Services (CMS) Provider Reimbursement Manual (CMS Pub. 15-1), applicable CMS reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 C.F.R. Part 200 as implemented by HHS at 45 C.F.R., part 75, which establish principles and standards for determining allowable costs and the methodology for allocation and apportioning those expenses to the Medicaid program, except as expressly modified below.

2. The total Medicaid shortfall will be equal to the difference between the actual Medicaid allowable costs and the state plan reimbursement for Medicaid services. Each Eligible Provider's Medicaid shortfall available to be reimbursed under this supplemental reimbursement program will equal the difference between the allowable costs determined using the Cost Determination Protocols for each Eligible Provider providing GEMT to Wisconsin Medicaid recipients, net of the amounts received and payable from the Wisconsin Medicaid program and all other sources of reimbursement for such services provided to Wisconsin Medicaid recipients.

(e) Cost Determination Protocols

1. An Eligible Provider's specific allowable cost per-GEMT service rate will be calculated based on the provider's financial data reported on the state-approved cost report. The per-GEMT service cost rate will be the sum of actual allowable direct and indirect costs of providing GEMT services divided by the actual number of GEMT services provided for the applicable service period.
    a. The cost report will include Direct Cost consistent with 2 CFR 200.413 and 2 CFR 200.405 which may include costs such as ambulance depreciation, salaries and benefits of paramedics and Emergency Medical Technicians (EMTs) providing GEMT services and medical supplies utilized in the delivery of GEMT services. Direct cost centers which support GEMT in addition to one or more non-GEMT functions, must be allocated.
        i. Direct costs can be reported if discretely tracked to GEMT services and otherwise in alignment with the definition of Direct Cost in 200.413. Unlike indirect costs as defined in 45 C.F.R. § 75.2, all direct costs must be readily assignable to GEMT, without effort disproportionate to the results achieved.
        ii. The cost of personnel providing GEMT in addition to other programs and services can be allocated based on a percentage of total hours logged performing GEMT activities versus activities identified with other cost objectives.
    b. The costs and related basis used to determine the allocated indirect costs must

be in compliance with Medicaid cost principles specified within 2. C.F.R. Part 200. Indirect costs are determined in one of two ways:

i. GEMT providers with a federally approved indirect cost rate will be required to apply the cognizant agency specific approved indirect cost rate to their total direct costs (Paragraph e.1.a)

ii. GEMT providers that do not have a cognizant agency specific approved indirect cost rate can identify indirect costs by applying the prevailing de minimis rate for the applicable service period to their total direct costs (Paragraph e.1.a).

c. All costs associated with a direct service cost objective other than GEMT that are readily assignable to the cost objectives specifically benefitted will be unallowable.

d. The provider specific per-GEMT service cost rate is calculated by dividing the total net GEMT services allowable costs (Paragraph e.1.a and e.1.b) of the specified provider by the total number of GEMT services provided by the provider for the applicable service period.

(f) Cost Settlement Process

1. The payments and the number of GEMT services reported in the as-filed cost report will be reconciled with the Department's Medicaid Management Information System (MMIS) reports generated for the cost reporting period within twelve months of the cost report deadline. The Department will make adjustments to the as-filed cost report based on the reconciliation results of the most recently retrieved MMIS report.

2. Each Eligible Provider will receive an annual lump sum payment in an amount equal to the total of the Medicaid shortfall as defined in the above Supplemental Reimbursement Methodology – General Provisions Section 3(d)(2).

1. The Department will perform a final reconciliation where it will settle the Eligible Provider's annual cost report as reviewed. The Department will compute the net GEMT allowable costs using DHS-reviewed per-GEMT cost, and the number of fee-for-service GEMT services reflected in the updated MMIS reports. Actual net allowable costs will be compared to the total Medicaid reimbursement paid to the provider for eligible services, including claims payments, third party liability, copayments, settlement payments made, and any other source of reimbursement received by the Eligible Provider for the period for applicable Medicaid services. If, at the end of the final reconciliation, it is determined that the Eligible Provider has been overpaid, the provider will return the overpayment to the Department and the Department will return the overpayment to the federal government pursuant to 42 CFR 433.316. If an underpayment is determined, then the Eligible Provider will receive a final supplemental payment in the amount of the underpayment.

(g) Eligible Provider Reporting Requirements

1. The reporting period will be based on a Calendar Year (CY) spanning January to December. Cost reports are due no later than six months after the last day of the Calendar Year. A request for an extension shall only be approved when a provider's operations are significantly and/or adversely affected due to extraordinary circumstances, of which the provider has no control, such as flood or fire. The written request must include a detailed explanation of the circumstances supporting the need for additional time and be postmarked within six months after the last day of the applicable State Fiscal Year. Filing extensions may be granted by the Department for good cause, but such extensions are made at the discretion of the Department.

2. Only cost reports from Eligible Providers as defined in Section 3(c) will be accepted.

3. Participating Eligible Providers who meet the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with 3(c) through 3(f) for services provided on or after January 1, 2023.

    a. Eligible Providers will be paid interim rates equal to the Medicaid reimbursement rates paid to other GEMT providers in accordance with Attachment 4.19-B. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

    b. Eligible Providers will submit a state approved cost report annually, on a form approved by the Department.

    c. "Allowable costs" will be determined in accordance with the CMS Provider Reimbursement Manual (CMS Pub. 15-1), CMS non-institutional reimbursement policies, Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR), Part 413 and Section 1861 of the Federal Social Security Act (42 USC, Section 1395x), and 2 CFR, part 200 as implemented by HHS at 45 CFR, part 75.
        i. "Direct costs" are those costs that are identified by 45 CFR 75.413 that:
            1. Can be identified specifically with a particular final cost objective (to meet emergency transportation service requirements), such as a federal award, or other internally or externally funded activity; or
            2. Can be directly assigned to such activities relatively easily with a high degree of accuracy.
        ii. "Indirect costs" means the costs that cannot be readily assigned to a

particular cost objective and are those that have been incurred for common or joint purposes.

d. Eligible Provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio. The Medicaid utilization statistic ratio is based on paid GEMT claims based on billing data associated with the dates of service covered by the submitted cost report.

46. **1905(a)(29)** Medication-Assisted Treatment (MAT)

The Department establishes maximum allowable fees for MAT services. For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of MAT services.

All rates are published on the Wisconsin ForwardHealth website:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/MaxFeeSearch.aspx

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for prescribed drugs located in Attachment 4.19-B, pages 5-5b for drugs that are dispensed or administered.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)
☒	Housing Consultation - Housing Consultation is paid at $84.36 per consultation, based on an average time estimate of 1.5 hours per consultation provided by supportive housing agencies. Medicaid will pay the lower of billed charges or the max fee schedule rate set by the state agency. Housing Consultation is reimbursed at a per 15-minute rate. The rate was validated against a number of unit-based case management rates for programs in Wisconsin Medicaid.
☒	Housing transition services are reimbursed at $14.06 per 15 minutes of service. Medicaid will pay the lower of billed charges or the max fee schedule rate set by the state agency. The rate was calculated using averages of the following information provided by supportive housing agencies: • Staff hourly salary and benefits • Administrative costs • Average time spent providing the following categories of service: Direct - Direct time includes any time spent administering housing transition services with

	the member (individual receiving transition) present, whether that is face-to-face, over the phone, or via video conference, etc. Member Specific Indirect - This includes any time spent providing housing transition services that can be attributed to a specific member, but where said member is not present. Travel - This includes time spent traveling to and from in-person meetings with a member or a collateral contact such as a landlord. Other - This includes all time spent working on housing transition services that is not member specific. For example, trainings on how to deliver housing transition services and team meetings that are not about a specific member. Providers cannot bill for travel time or time not specific to a given member. The rate was designed to cover this time.
☒	Housing sustaining services are reimbursed at $14.06 per 15 minutes of service. Medicaid will pay the lower of billed charges or the max fee schedule rate set by the state agency. This rate was calculated using averages of the following information provided by supportive housing agencies: • Staff hourly salary and benefits • Administrative costs • Average time spent providing the following categories of service: Direct - Direct time includes any time spent administering housing sustaining services with the member (individual receiving housing sustaining services) present, whether that is face-to-face, over the phone, or via video conference, etc. Member Specific Indirect - This includes any time spent providing housing sustaining services that can be attributed to a specific member, but where said member is not present. Travel - This includes time spent traveling to and from in-person meetings with a member or a collateral contact such as a landlord. Other - This includes all time spent working on housing sustaining services that is not member specific. For example, trainings on how to deliver housing sustaining services and team meetings that are not about a specific member. Providers cannot bill for travel time or time not specific to a given member. The rate was designed to cover this time.
☒	Relocation Supports- Relocation supports are reimbursed at cost up to a $2,000 limit set by the state agency. The $2,000 relocation supports service was established based upon the estimated costs of security deposits, utilities activations and essential home furnishings and health and safety services The $2,000 is the maximum for this service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE WISCONSIN

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item_____. Payment of Title XVIII Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual		Medicare-Medicaid/QMB Individual		Medicare-QMB Individual	
Part A Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part A Coinsurance	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Deductible	___	limited to State plan rates*	___	limited to State plan rates*	___	limited to State plan rates*
	X	full amount	X	full amount	X	full amount
Part B Coinsurance	X	limited to State plan rates*	X	limited to State plan rates*	X	limited to State plan rates*
	___	full amount	___	full amount	___	full amount

* For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) outpatient hospital.

** Legal authority to implement is pending in state legislature, to be effective 7/1/89.