State of Wisconsin

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Joint Committee on Finance

MEMORANDUM

To: Members
Joint Committee on Finance

From: Senator Howard Marklein
Representative Mark Born

Date: February 12, 2024

Re: 5-Day Passive Review Approval – DHS

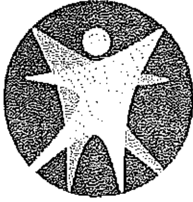
Pursuant to s. 49.45(2t), Stats., attached is a 5-day passive review request from the Department of Health Services, received on February 12, 2024.

Please review the material and notify **Senator Marklein** or **Representative Born** no later than **Friday, February 16, 2024,** if you have any concerns about the request or if you would like the Committee to meet formally to consider it.

Also, please contact us if you need further information.

Attachments

HM:MB:jm



State of Wisconsin
Department of Health Services
Tony Evers, Governor
Kirsten L. Johnson, Secretary

December 8, 2023

DEC 0 8 2023
Jt. Finance

The Honorable Howard L. Marklein, Senate Co-Chair
Joint Committee on Finance
Room 316 East
State Capitol
PO Box 7882
Madison, WI 53707

The Honorable Mark Born, Assembly Co-Chair
Joint Committee on Finance
Room 308 East
State Capitol
PO Box 8952
Madison, WI 53708

Dear Senator Marklein and Representative Born:

Per s. 49.45(2t), created by 2017 Act 370, I am requesting approval from the Committee, under 14-day passive review, to implement new policies and guidelines to be administered by the Wisconsin Department of Health Services (DHS) for Tribal Federally Qualified Health Centers (FQHCs) that operate in the State of Wisconsin. The new methodology will result in more federal funding and more prompt reimbursement for Tribal FQHCs.

The annualized amount of the new policies and guidelines, which includes the implementation of the new Tribal All-Inclusive Rate alternative payment methodology (APM), is $63.2 million All Funds effective October 1, 2023. Of the $63.2 million annual all funds cost, $57.5 million would be paid for by the federal government, and $5.7 million would be paid for with state GPR. The new policies and guidelines are funded primarily by federal funds because services covered by Medicaid for Tribal members and provided at a Tribal FQHC are 100% federally funded. The Department estimates that approximately 72% of services provided at Tribal FQHCs are to Tribal Members, with Non-Tribal members being reimbursed at the standard federal medical assistance percentage (FMAP).

The current Medicaid reimbursement methodology creates financial challenges for Tribal FQHCs in serving the Medicaid population. Under current policy, the Department initially pays Tribal FQHCs for each unit of service according to the Medicaid fee schedule, which is well below their cost of operations. Later, Medicaid pays a cost settlement to the FQHC that reflects the difference between the FQHC's actual cost for providing the services and the payments it initially received under the fee schedule. The Department calculates the settlement based on cost reports submitted by the FQHC. Tribal FQHCs must wait for the cost settlement after the cost report is complete, which is often a complex process and requires Tribal FQHCs to devote

significant resources to the effort. Cost reporting often has numerous delays that can take years to resolve before settlements are final and a Tribal FQHC can receive reimbursement.

The new policies and guidelines will amend the State Plan to enable Tribal FQHCs to choose between two options for reimbursement: the Prospective Payment System (PPS) and the Indian Health Service All-Inclusive Rate APM. Each reimbursement method will be made on a per encounter basis. The All-Inclusive Rate is published annually in the federal register and is only available to Indian Health Services Facilities and Tribal FQHCs.

For non-Tribal FQHCs, the state implemented the PPS reimbursement methodology in 2017, under which Medicaid pays the FQHC a per-encounter rate based on projected service costs, eliminating the need for after-the-fact cost settlement payments.

Overall, the replacement of the cost settlement APM with the All-Inclusive Rate APM will allow Tribal FQHCs to receive prompt payment, free up tribal resources from cost-reporting responsibilities, and provide a significant increase in federal funding for most tribes.

Attached is the State Plan amendment language. Please contact me with any questions.

Sincerely,

Kirsten Johnson
Secretary-designee

Wisconsin State Plan Amendment – Tribal Federally Qualified Health Centers Reimbursement Methodology

Supersedes Attachment 4.19-B Page 10.d. from 2018 06 21 WI 17-0010

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.

Option 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.

   ~~Each Prescription dispensed by a Tribally operated FQHC Pharmacy constitutes as an encounter and is reimbursed at their PPS rate which is calculated in the methodology described in section B. There is no limit to the number of encounters that may be reimbursed in a single day for prescription-based encounters. The encounter rate is inclusive of drug and dispensing costs. Tribal FQHC Pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing.~~
   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, Pages 5-5a - Pharmacy Fee Schedule.

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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 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 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. **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.

Option 2: 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.

~~Each prescription dispensed by a Tribally operated FQHC Pharmacy constitutes as an encounter is reimbursed at the Indian Health Services outpatient rate in accordance with the annual Federal Register Notice. There is no limit to the number of encounters that may be reimbursed in a single day for prescription based encounters. The encounter rate is inclusive of drug and dispensing costs. Tribal FQHC Pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing.~~
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, Pages 5-5a - Pharmacy Fee Schedule.

B. **Subsequent Year OMB All Inclusive Rate:**
Effective each year on January 1, the Department will adjust the OMB All-Inclusive Rate to the current rate on the Federal Register.

C. **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 AIR.

A Tribal FQHC will choose between option 1 (Prospective Payment System) and 2 (All Inclusive Rate) annually. Rates are adjusted with an effective date of January 1 of the calendar year as both the All-

Inclusive OMB Rate and inflation rates applied to the PPS rate are published in the Federal Register each fall.

Wisconsin Medicaid
Pharmacy Fee Schedule

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

1. **Brand name and generic drugs** and other drugs/products meeting the definition of covered outpatient drug in 42 CFR 447.502 will receive an ingredient cost based on AAC plus professional dispensing fee.
   a. MC 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. AU 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 including designated **340B Indian Health Service/Tribal/Urban (1/T/U) pharmacies** will receive an AAC Ingredient cost that is no more than the 340B ceiling pr1ce 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 3408 contract pharmacies are not covered.**
5. **Drugs acquired via the Federal Supply Schedule (FSS)** will be reimbursed ingredient cost based on MC 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 MG 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** ~~paid using encounter rates~~ will be reimbursed one of two options:

I. Prospective Payment System:

Each Prescription dispensed by a Tribally operated FQHC Pharmacy constitutes as an encounter and is reimbursed at their PPS rate which is calculated in the methodology described in section B of Option 1: Prospective Payment System (PPS) Rate 4.19-B Page 10.d. There is no limit to the number of encounters that may be reimbursed in a single day for prescription-based encounters. The encounter rate is inclusive of drug and dispensing costs. Tribal FQHC Pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing.

II. Indian Health Services (IHS) OMB All Inclusive Rate:

Each prescription dispensed by a Tribally operated FQHC Pharmacy constitutes as an encounter is reimbursed at the Indian Health Services outpatient rate in accordance with the annual Federal Register Notice. There is no limit to the number of encounters that may be reimbursed in a single day for prescription-based encounters. The encounter rate is inclusive of drug and dispensing costs. Tribal FQHC Pharmacies are paid the encounter rate by Wisconsin Medicaid regardless of their method of purchasing.

~~AAC for drug costs and reimbursed an FQHC-specific professional dispensing fee of $24.92 and cost reconciled to their approved federal encounter rates.~~ An IHS Tribal facility is defined as an FQHC that receives funds under the Indian Self-Determination Act.

~~1.~~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.

~~2.~~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.