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State/Territory Name: Wisconsin

State Plan Amendment (SPA) #: 21-0006

This file contains the following documents in the order

listed:1) Approval Letter

2) CMS 179 Form/Summary Form (with 179-like data)

3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601



Financial Management Group/ Division of Reimbursement Review

August 30, 2022

Lisa Olson, Director
Department of Health Services
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

RE: Wisconsin State Plan Amendment TN: #21-0006

Dear Ms. Olson,

We have reviewed the proposed Wisconsin State Plan Amendment, TN: #21-0006, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 31, 2021. This State Plan makes allowance for manual payments for Comprehensive Community Services.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Debi Benson at 312-886-0360 or Deborah.Benson@cms.hhs.gov

Sincerely,

A solid black rectangular box used to redact the signature of Todd McMillion.

Todd McMillion
Division of Reimbursement Review Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER WI-21-0006	2. STATE Wisconsin
	3. PROGRAM IDENTIFICATION: Title XIX Of The Social Security Act (Medicaid)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE 01/01/2021	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION 2 CFR 200, 413, and 447.202	7. FEDERAL BUDGET IMPACT a. FFY 2021 \$0 b. FFY 2022 \$0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-B pages 16a through 16a-4.....	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>) Same

10. SUBJECT OF AMENDMENT

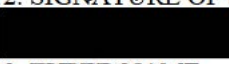
Modify CCS Cost-Reporting and Payments

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

DocuSigned by:

3/23/2021

12. SIGNATURE OF STATE AGENCY OFFICIAL  3/23/2021	16. RETURN TO Laura Brauer State Plan Amendment Coordinator Department of Health Services 1 W. Wilson St. P.O. Box 309 Madison, WI 53701-0309
13. TYPED NAME James D. Jones	
14. TITLE State Medicaid Director	
15. DATE SUBMITTED 3/31/2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 31, 2021	18. DATE APPROVED: August 30, 2022
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Todd McMillion	22. TITLE: Director, Division of Reimbursement Review

23. REMARKS:

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, AODA 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, 2015 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. Manual payments for the Comprehensive Community Services psychosocial rehabilitation benefit will be made annually on a one-time basis. The payment amount will be capped at no more than 120% of the prior year cost settlement amount. Manual payments will only be made at the request of local County Health, Human Services, Social Services and Community Programs Agencies and will count against the subsequent year's cost settlement.

To assure payments do not exceed cost, County Health, Human Services, Social Services and Community Programs Agency interim payments and manual payments will be cost settled annually to Medicaid incurred costs. Effective for cost reporting periods beginning on or after January 1, 2016, 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.

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.