



Update
February 2018

No. 2018-08

Affected Programs: BadgerCare Plus, Medicaid

To: Federally Qualified Health Centers, HMOs and Other Managed Care Programs

New Reimbursement Methodology for Community Health Centers

Overview

This *ForwardHealth Update* announces changes to ForwardHealth's reimbursement methodology for non-tribal federally qualified health centers (FQHCs), also known as Community Health Centers (CHCs).

ForwardHealth previously reimbursed CHCs under either a cost-settlement process or a prospective payment system (PPS). Under the cost-settlement process, ForwardHealth calculated a cost-based encounter rate for each CHC that reflected the CHC's actual reasonable costs of providing services as reported by the CHC on an annual cost report. Under the PPS, ForwardHealth established a prospective encounter rate for each CHC that reflected the CHC's estimated reasonable costs of providing care.

Effective July 1, 2017, ForwardHealth reimburses all CHCs under the PPS and no longer reimburses CHCs under the cost-settlement process. The PPS project is a result of 2015 Wisconsin Act 55. The following dates reflect reimbursement expectations:

- For services rendered from July 1, 2017, through March 31, 2018, CHCs are required to follow existing claims submission procedures and processes and will be reimbursed the PPS rate through a reconciliation process. ForwardHealth will reconcile with CHCs on an individual basis for this time period.
- Effective for dates of service (DOS) on and after April 1, 2018, CHCs are required to submit claims for services

per guidelines provided in this *Update* and will automatically be reimbursed the PPS rate through the claims processing system for each allowable encounter.

- For services rendered prior to July 1, 2017, CHCs will be reimbursed under the previous reimbursement process in place prior to PPS implementation.

Tribal FQHCs are not affected by the changes detailed in this *Update*.

This *Update* provides information on PPS rates and CHC encounters, new instructions for submitting claims for CHC encounters including information on the procedure code to represent the encounter, and information on changes to provider enrollment. Coverage of services and prior authorization (PA) requirements are not changing.

Note: For the dates indicated, this *Update* supersedes any previous ForwardHealth communication that may conflict with information included in this *Update*.

Provider Enrollment Changes and Requirements

As part of the PPS implementation, ForwardHealth has created a new provider specialty of FQHC Non-Tribal (CHC) to represent CHCs.

Note: Tribal FQHCs are **not** affected by this change. All tribal FQHCs will continue to retain their existing provider type and specialty.

CHC Main Service Locations

ForwardHealth will automatically update the provider specialty of each CHC's Medicaid provider enrollment that represents its main service location to the new provider specialty of FQHC Non-Tribal (CHC), effective on and after April 1, 2018.

Note: No action is required from CHC main service locations that are currently Medicaid-enrolled as part of this specialty change. Providers who are newly enrolling as FQHC Non-Tribal providers will automatically be enrolled as the main CHC service location. Providers with questions about which provider enrollment is considered the CHC main service location should contact their Provider Relations representative.

CHC Off-Site Clinic

ForwardHealth defines an "off-site clinic" as a CHC's delivery site that is a location other than the CHC's main facility and is approved by the Health Resources and Services Administration (HRSA) for the provision of CHC services. More information about HRSA is available at <https://www.hrsa.gov/>.

Effective on and after April 1, 2018, ForwardHealth will require a CHC to separately enroll each of its off-site clinics for billing and reimbursement purposes.

Medicaid-Enrolled CHC Off-Site Clinics

ForwardHealth will automatically update the provider specialty of each CHC's Medicaid provider enrollment that represents an off-site clinic to FQHC Non-Tribal (CHC), effective on and after April 1, 2018. Each of these CHC off-site clinics will also automatically be associated with the CHC's main service location as part of this specialty change.

Note: No action is required from CHC off-site clinics that are currently Medicaid-enrolled as part of this specialty change.

Non-Medicaid-Enrolled CHC Off-Site Clinics

CHCs will be required to complete a Medicaid provider enrollment for each off-site clinic that is not already separately enrolled in Wisconsin Medicaid. To enroll, access the Provider Enrollment Information home page from the Become a Provider link in the Providers menu on the ForwardHealth Portal at www.forwardhealth.wi.gov/. Each new CHC enrollment will be subject to an application fee per Affordable Care Act requirements. This fee is federally mandated and may be adjusted annually. The fee is used to offset the cost of conducting federally mandated screening activities and is non-refundable.

Providers may begin the CHC provider enrollment process effective February 28, 2018. During the provider enrollment process, each new CHC off-site clinic will be associated with the CHC's main service location.

Note: All CHC off-site clinics must have the same tax ID as that of the associated CHC main service location.

CHC Retail Pharmacies

If a CHC also submits claims for retail pharmacy, a separate Medicaid provider enrollment is required to reflect the applicable individual provider type and specialty of Pharmacy.

Medicaid-Enrolled CHC Retail Pharmacies

All CHC retail pharmacies that are already Medicaid-enrolled will continue to retain their existing provider type and specialty of Pharmacy.

Non-Medicaid-Enrolled CHC Retail Pharmacies

CHC retail pharmacies that are not already enrolled in Wisconsin Medicaid with the applicable individual provider type and specialty of Pharmacy will be required to enroll with Wisconsin Medicaid to reflect the applicable individual provider type and specialty of Pharmacy.

CHC Encounters

Description

Under the PPS, ForwardHealth will reimburse CHCs a PPS rate for each allowable CHC encounter. A CHC encounter is defined as a face-to-face visit on a single DOS between a member and a Medicaid-enrolled CHC provider to provide diagnosis, treatment, or preventive service(s) at the CHC HRSA-approved location including main and off-site locations.

Each CHC encounter is classified as either a medical, dental, or behavioral health encounter based on the provider type of the rendering provider. Encounters include the following:

- Direct services, which are defined as the core service(s) provided during the encounter. For example, preventive or routine office visits constitute direct services.
- Indirect services, which are defined as supplies and/or diagnostic or therapeutic ancillary services that are furnished as an adjunct to the core service(s) provided during the encounter. Indirect services include, but are not limited to, radiology, laboratory tests, medical supplies, durable medical equipment, and ancillary provider services.

Allowable indirect costs are included as a portion of the total cost for encounter rate development under the PPS rate-setting methodology. Indirect services are Medicaid-covered services that serve to support core services provided during the encounter, but they do not count as individual encounters on their own.

Costs for CHC activities and services that are not required by ForwardHealth and not part of CHC-related services, included in state statute or administrative code, may not be submitted to ForwardHealth and are therefore non-reimbursable.

Costs categorized as non-reimbursable under the cost-based reimbursement method in effect prior to PPS implementation are not considered indirect costs. Non-reimbursable costs are not included in the PPS rate setting methodology.

Note: An indirect service is always considered part of the encounter and is not reimbursed separately, even if provided on a different DOS or at a different location than the associated encounter.

A service that is considered an encounter when performed in a CHC location is also considered an encounter when performed by a CHC provider in one of the following locations:

- Mobile units
- School visits
- Hospitals
- Members' homes
- Extended care facilities
- Primary sites of identified contracted clinicians

Any services provided to CHC members through referrals to a provider with whom the CHC has no contractual relationship and in which funding for the services is not borne by the CHC is **not** a CHC service or encounter.

All services provided as part of the CHC encounter must meet all applicable ForwardHealth program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription requirements, and documentation requirements; however, all CHC services reimbursed under the PPS rate structure are exempt from member cost share and copayment requirements. CHCs should refer to the Online Handbook for more information about these requirements.

CHCs will identify encounters by indicating Healthcare Common Procedure Coding System (HCPCS) procedure code T1015 (Clinic visit/encounter, all-inclusive) on claims for services rendered. ForwardHealth will assign the appropriate encounter type to the claim detail associated with procedure code T1015 based on the provider type of the rendering provider. Refer to the CHC Claim Submission Requirements section of this *Update* for more information about submitting claims with procedure code T1015.

Rates and Reimbursement

The PPS rate for a given encounter type is inclusive of all direct and indirect services provided to the member during the encounter.

ForwardHealth calculates a separate PPS rate for each CHC in accordance with the Benefits Improvement and Protection Act of 2000. At the end of each CHC fiscal year, ForwardHealth adjusts the PPS rate by the Medicare Economic Index (MEI) in effect at that time. In addition, ForwardHealth may adjust a CHC's PPS rates to account for changes in the CHC's scope of service. The change in scope process for CHCs will be addressed in the future *Update*.

ForwardHealth reimburses a CHC a maximum of one PPS rate per encounter type, per member, per DOS, unless the member, subsequent to the first encounter, suffers an illness or injury that requires additional diagnosis or treatment on the same day. A subsequent encounter is a unique situation that cannot be planned or anticipated. For example, a member sees their provider in the morning for a medical condition and later in the day has a fall and returns to the CHC. Subsequent encounters can be medical, dental, or behavioral health when the encounter satisfies the subsequent encounter requirements. Refer to the Subsequent Encounters section of this *Update* for more information.

When a CHC member receives services of the same encounter type from more than one of the CHC's locations (e.g., the main clinic, an off-site clinic, and/or a contracted facility) on a single day, the CHC will be reimbursed for only one encounter type, per DOS, unless the additional encounter qualifies as a subsequent encounter as specified in this *Update*.

ForwardHealth will apply the PPS rate for the encounter type to the claim detail associated with HCPCS procedure code T1015. All other payable claim details for direct and indirect services on the claim associated with the encounter will process in a paid status with a \$0 allowed amount. Refer to the CHC Claim Submission Requirements section of this *Update* for more information about submitting claims with procedure code T1015.

Services "Carved-Out" of the PPS Rate

Provider-administered drugs, telehealth distant site services, and certain retail pharmacy services are considered "carved out" of the PPS rate and are reimbursed separately.

Provider Administered Drugs

Provider-administered drugs are defined as drugs administered by a provider in an office setting. A list of procedure codes classified as provider-administered drugs that may be reimbursed outside the PPS rate can be found on the Physician Provider-specific Resources page on the Portal. These services are subject to change and must meet all applicable ForwardHealth program requirements, including, but not limited to, medical necessity, PA, claims submission, prescription requirements, and documentation requirements.

Telehealth Services

As indicated in the ForwardHealth Online Handbook, the following apply to telehealth services:

- Telehealth services include "originating site" services and/or "distant site" services.
- Telehealth services will not be counted as encounters and will not require following PPS methodology guidelines.
- "Distant site" telehealth services provided by a CHC will instead be reimbursed per the appropriate maximum allowable fee schedule.

CHC costs associated with telehealth services may be reported for change in scope adjustment consideration; therefore, telehealth service costs may be used for future rate setting purposes.

Retail Pharmacy Services

Some CHCs also provide retail pharmacy services billed on a ForwardHealth noncompound or compound claim. Pharmacy services consist of a professional dispensing fee and an ingredient drug cost. The professional dispensing fee is considered part of an encounter and is not reimbursed separately, even if provided on a different DOS or at a different location than the associated encounter. The

ingredient drug cost is carved out of the PPS rate and reimbursed separately on a pharmacy claim.

CHC Claim Submission Requirements

When submitting claims to ForwardHealth for encounters, the CHC is required to do the following:

- Submit claims for encounters on either a professional claim form or the electronic equivalent (e.g., 1500 Health Insurance Claim Form, 837 Health Care Claim: Professional) or a dental claim form or the electronic equivalent (e.g., American Dental Association Claim Form, 837 Health Care Claim: Dental), as applicable.
- Submit each encounter using HCPCS procedure code T1015 (Clinic visit/encounter, all-inclusive). If a single claim is used to bill multiple encounter types, the claim should include a separate detail with procedure code T1015 for each encounter per DOS.
- The billed amount for procedure code T1015 representing each encounter should be billed as the amount assigned for the CHC per encounter type.
- Procedure code T1015 will be allowable for one DOS per the detail(s) associated with one encounter type (i.e., span billing is not allowed).
- The diagnosis most applicable to the encounter type must be associated with procedure code T1015.
- Include separate details for all direct and indirect services rendered as part of the encounter, in addition to billing procedure code T1015 for each encounter type. CHCs should use the most appropriate procedure codes to represent direct and indirect services. Each detail should identify the practitioner who delivered the direct or indirect service as the rendering provider. These services should be billed with the applicable charges.
- Include at least one allowable direct service associated with the encounter with the same rendering provider as procedure code T1015. Claims not meeting these requirements will not have a PPS rate applied.

Note: Indirect services alone, without an accompanying allowable direct service, are not encounters. Thus, claims for such instances may not submit procedure code T1015. If procedure code T1015 is present with indirect services only, procedure code T1015 will deny

and all payable indirect services will process in a paid status with a \$0 allowed amount. Refer to information on direct services covered under the CHC Encounters section of this *Update* for further information about what constitutes an indirect service.

- List as the rendering provider for procedure code T1015 the practitioner who delivered the services during the encounter. If multiple providers rendered services during a single encounter, the CHC should use its judgment based on its reporting capabilities to identify which provider is the most appropriate to list as the rendering provider for procedure code T1015.
- Submit claims for CHC services under the Medicaid enrollment of the physical CHC site where the service was provided. The appropriate billing provider will be determined by the location of the service as follows:
 - ✓ If the service was provided at the CHC's main service location, use the Medicaid enrollment of the CHC main site as the billing provider.
 - ✓ If the service was provided at a CHC off-site clinic, use the Medicaid enrollment of that CHC off-site clinic as the billing provider.
 - ✓ If the service was provided at a location other than the CHC's main service location or a CHC off-site clinic (e.g., at a primary site of an identified contracted clinician), use the Medicaid enrollment of the CHC main site as the billing provider.
- If the service was provided at a CHC retail pharmacy, use the Medicaid enrollment of the separate retail pharmacy as the billing provider.

Services rendered by ancillary providers are considered indirect services. If a service by an ancillary provider is the only service provided during a visit, the CHC should not bill the ancillary provider service as an encounter with procedure code T1015. Instead, the CHC should bill the ancillary provider service per existing guidelines found in the Ancillary Providers topic (topic #647) of the Amounts chapter of the Reimbursement section of the Physician service area of the Online Handbook. The claim detail for the ancillary provider service will process in a paid status with a \$0 allowed amount.

Billing Guidelines

It is the CHC's responsibility to ensure that an encounter is only counted once across all providers involved in the encounter and to ensure documentation exists that supports the methodology used to assign the encounter to the most appropriate rendering provider. Services may not be arbitrarily delayed or split across multiple DOS in order to bill additional encounters.

Contracted Provider/Facility

As with other services, when a CHC member receives services from a CHC contracted provider or facility, the rendering provider listed on the claim detail should represent the contracted provider performing the service.

Subsequent Encounters

Claims that indicate more than one encounter for a given encounter type for the same member, same CHC organization, and same DOS will be denied. However, if the additional encounter represents a subsequent encounter as defined previously, providers may resubmit the claim, applicable medical documentation supporting the subsequent encounter, and the Written Correspondence Inquiry form, F-01170 (07/12), via paper to ForwardHealth to review. On the Written Correspondence Inquiry form, providers should check the "Other" box in the Reason for Inquiry field and indicate "Request for review of medical necessity for subsequent encounter" in the space provided. Providers should follow the instructions on the form for submitting the claim, medical documentation, and form to ForwardHealth. A copy of the claim, medical documentation, and form should be retained by providers for their records.

Telehealth Services

CHCs may serve as originating site and distant site providers for telehealth services. CHC claims for services provided via telehealth must qualify as telehealth, as defined in the Online Handbook.

CHCs may not report services provided via telehealth as encounters. Instead, CHCs are required to submit claims for distant site services on a professional claim form and will be

reimbursed in accordance with the fee schedules, which are available by clicking the Fee Schedules link in the Providers quick links box on the home page of the ForwardHealth Portal at www.forwardhealth.wi.gov/. Claims for services provided by distant site providers via telehealth must be billed with the same procedure code as would be used for a face-to-face encounter along with HCPCS modifier GT. Claims must also include place of service (POS) code 02 (Telehealth: the location where health services and health-related services are provided or received through a telecommunication system).

CHCs should submit claims for originating site services on a professional claim form with HCPCS procedure code Q3014 (Telehealth originating site facility fee) and a POS code that represents where the member is located during the service. Modifier GT should not be included with procedure code Q3014. ForwardHealth will not separately reimburse the CHC for originating site services because all costs for providing originating site services have already been incorporated into the PPS rates for CHCs. However, claims billed by CHCs for originating site services may be used for future rate setting purposes, and CHC costs associated with telehealth services may be reported for change in scope adjustment consideration.

For more information about telehealth services, providers may refer to the Online Handbook.

Dental Care

Global billing is not allowed under PPS reimbursement for dental services. CHCs providing orthodontic and prosthodontic dental services are required to submit claims for dental procedure codes per visit. CHCs will be reimbursed an encounter rate for each allowed dental visit.

Obstetric Care

ForwardHealth offers providers choices of how and when to file claims for obstetric care. Providers may choose to submit claims using one of the following methods:

- Separate obstetric component procedure codes as they are performed (CHCs will be reimbursed an encounter for each component billed.)

- An appropriate global obstetric procedure code with the date of delivery as the DOS (CHCs will be reimbursed for only one encounter.)

All ForwardHealth policy on global vs. component coding remains in effect. Wisconsin Medicaid will not reimburse individual antepartum care, delivery, or postpartum care procedure codes if a provider also submits a claim for global obstetric care procedure codes for the same member during the same pregnancy or delivery. The exception to this rule is in the case of multiple births, where more than one delivery procedure code may be reimbursed. Refer to the An Overview topic (topic #1260) of the Obstetric Care chapter of the Covered and Noncovered Services section of the Physician service area of the Online Handbook for details.

Carved-Out Services

Carved out services may be submitted on the same claim as the encounter. Carved-out services will be reimbursed separately from the PPS rate at the same reimbursement rate as non-CHC providers.

CHCs that also submit claims for retail pharmacy services should continue to submit these services on a ForwardHealth noncompound or compound claim. Pharmacy services submitted by a CHC related to an encounter will be reimbursed at the normal amount for the ingredient fee. Pharmacy professional dispensing fees are not separately reimbursable and will price at \$0. Payment for the professional dispensing fee is considered bundled into the PPS rate for the encounter. The interim professional dispensing fee for SeniorCare members remains in effect.

Medicare Crossover Claims

Medicare crossover claims will process and reimburse outside the PPS reimbursement structure.

Coordination of Benefits

All ForwardHealth policies regarding other payers remain in effect.

Consistent with current policy, CHCs are required to bill commercial health insurance first, with all applicable

procedure codes, including T1015 as appropriate. After commercial health insurance has acted on a claim, the CHC may submit the claim to ForwardHealth using the same *Current Procedural Terminology* or HCPCS procedure codes used on the commercial health insurance claim. CHCs are required to indicate the appropriate other insurance information on the claim or include a completed Explanation of Medical Benefits form, F-01234 (11/14), if the claim was submitted on paper. CHCs are required to submit the commercial health insurance information at the level it was processed by the primary payer.

Effective for DOS on and after April 1, 2018, all payments from commercial health insurance, per encounter type, will be deducted from the PPS rate, per encounter type, authorized by ForwardHealth under HCPCS procedure code T1015.

ForwardHealth is implementing its CHC coordination of benefits (COB) systems logic in two phases. Phase one applies to commercial health insurance submitted at the header level. Phase two applies to commercial health insurance submitted at the detail level.

In the first phase, when commercial health insurance is submitted at the header level, ForwardHealth will deduct those payments from the PPS rate when appropriate, effective on and after April 1, 2018. In the second phase, when commercial health insurance payment is submitted at the detail level, ForwardHealth will deduct those payments from the PPS rate when appropriate. ForwardHealth will implement the second phase at a later date.

Initially, all CHC claims submitted on and after April 1, 2018, with detail-level commercial health insurance payments will not have the commercial health insurance payment deducted from the PPS reimbursement. Upon implementation of the second phase, all CHC claims containing detail-level commercial health insurance payments for DOS on and after April 1, 2018, will be reprocessed to collect commercial health insurance payments when appropriate. Some CHCs may have funds recouped as a result of these claims adjustments.

Outstationed Enrollment

Following the end of the CHC's fiscal year, the CHC will complete and submit to ForwardHealth the Federally Qualified Health Center Outstationed Enrollment Expenses Worksheet 5 form, F-11129H (04/09). The CHC will have 120 days to fill out the form following its fiscal year end.

ForwardHealth will review reported outstationed enrollment expenditures and calculate the difference between the known portions of the PPS rate that is outstationed enrollment and the actual outstationed enrollment cost incurred during the fiscal year.

Through the reconciliation process, Medicaid payments associated with outstationed enrollment will equal 100 percent of CHC allowable outstationed enrollment expenditures.

Managed Care Impact

CHCs that contract with a managed care organization (MCO) should continue to bill the MCO as they currently do and will be reimbursed pursuant to the MCO's current contract with ForwardHealth and CHC. When services are rendered to MCO members, CHCs are not required to follow the PPS claim submission process as outlined in this *Update*; therefore, CHCs should not include separate details with procedure code T1015 when submitting claims to MCOs.

When services are rendered to MCO members, those services that are carved out of the MCO rate (such as most provider-administered drugs) are not required to follow PPS claims submission as outlined in this *Update*; therefore, CHCs should not include separate details with procedure code T1015 when submitting claims for MCO members to ForwardHealth.

Supplemental Interim Reports (WRAP Payments) will be made pursuant to a payment schedule agreed to by ForwardHealth and the CHC, but in no case less frequently than every four months, for the difference between the payment amounts paid by the MCO and the amount to which the CHC is entitled under the PPS rate. WRAP

Payments for MCO encounters will continue until the Medicaid Management Information System is updated to pay the PPS rate in real time for MCO encounters. There are no immediate plans to change WRAP payments at this time.

Terms of Reimbursement

ForwardHealth has created the Non-Tribal Federally Qualified Health Center Terms of Reimbursement, P-02098 (04/2018), to reflect the new provider type of FQHC Non-Tribal (CHC) to represent CHCs, effective for DOS on and after April 1, 2018.

Refer to the Attachment of this *Update* for the new Non-Tribal Federally Qualified Health Center Terms of Reimbursement. This document will be available on the Terms of Reimbursement page of the Provider Enrollment Information area of the Portal on April 2, 2018.

For More Information

For CHC rate setting information, refer to the Resources for Federally Qualified Health Centers page in the Providers area of the Portal.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Medicaid Services, the Wisconsin Department of Health Services (DHS). The Wisconsin AIDS Drug Assistance Program and the Wisconsin Well Woman Program are administered by the Division of Public Health, DHS.

For questions, call Provider Services at 800-947-9627 or visit our website at www.forwardhealth.wi.gov/.

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ATTACHMENT

New Non-Tribal Federally Qualified Health Center Terms of Reimbursement

(A copy of the “Non-Tribal Federally Qualified Health Center Terms of Reimbursement” is located on the following pages.)

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NON-TRIBAL FEDERALLY QUALIFIED HEALTH CENTER TERMS OF REIMBURSEMENT

The Wisconsin Department of Health Services (DHS) will establish an encounter-specific reimbursement rate for covered services furnished by or on behalf of a non-tribal federally qualified health center (FQHC) (community health center [CHC]) to eligible Wisconsin Medicaid members. The encounter-specific reimbursement rate reflects the CHC's estimated reasonable costs of providing care.

A CHC encounter is defined as a face-to-face visit on a single date of service (DOS) between a member and a Medicaid-enrolled CHC provider to provide diagnosis, treatment, or preventive service(s) at a Health Resources and Services Administration-approved FQHC location.

A service that is considered an encounter when performed in the CHC is also considered an encounter when performed outside the CHC and is payable to the CHC when the service meets all ForwardHealth program and service location requirements.

Any services provided to CHC members through referral to a provider with whom the CHC has no contractual relationship and in which funding for the services is not borne by the CHC is not a CHC service or encounter.

ForwardHealth reimburses a CHC a maximum of one prospective payment system (PPS) rate per encounter type, per member, per DOS, unless the member, subsequent to the first encounter, suffers an illness or injury that requires additional diagnosis or treatment on the same day. A subsequent encounter is a unique situation that cannot be planned or anticipated.

The PPS rate for a given encounter type is inclusive of all direct and indirect services provided to the member during the encounter.

It is the CHC's responsibility to ensure that an encounter is only counted once across all providers involved in the encounter and to ensure supporting documentation for the methodology used to assign the encounter to the most appropriate rendering provider. Services may not be arbitrarily delayed or split across multiple DOS in order to bill additional encounters.

Note: Only FQHC services are eligible for PPS reimbursement.

FQHC services are defined as the services described in the Rural Health Clinic Act and any other ambulatory service included in a state's Medicaid plan that are provided to Medicaid members. Such costs cannot exceed the reasonable costs as determined by applicable Medicare cost reimbursement principles set forth in 42 C.F.R. Part 413, Health Insurance Manual 15, and any additional mandated regulations when published as final rule in the Federal Register.

At the end of each CHC fiscal year, ForwardHealth will adjust the PPS rate by the Medicare Economic Index in effect at the end of the CHC's fiscal year. In addition, ForwardHealth may adjust a CHC's PPS rates to account for changes in the CHC's scope of service.

Following the end of the CHC's fiscal year, the CHC will complete the Federally Qualified Health Center Outstationed Enrollment Expenses Worksheet 5 form, F-11129H. The CHC will have 120 days to fill out the form following its fiscal year end.

ForwardHealth will reconcile outstationed enrollment expenditures incurred during the fiscal year such that Medicaid payments associated with outstationed enrollment will equal 100 percent of CHC allowable outstationed enrollment expenditures.

FQHC reimbursement for services shall not be made in the absence of a signed Medicaid provider agreement for the FQHC and shall be determined by DHS pursuant to the State Plan for Title XIX Reimbursement, effective April 1, 1990, for FQHCs identified by the federal Department of Health and Human Services as eligible on that date or as may be amended. Medicaid reimbursement, less appropriate copayment and payments by other insurers, will be considered to be payment in full.

DHS may adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to Wis. Stat. ch. 49. Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Wis. Stat. § 49.46(2)(c).

In accordance with federal regulations contained in 42 C.F.R. § 447.205, DHS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting encounter rates for services.

P-02098 (04/2018)



Wisconsin
Department of Health Services