



Introducing the Medicaid Purchase Plan

Wisconsin Medicaid announces the Medicaid Purchase Plan, a new program created to provide health care coverage to Wisconsin residents with disabilities. Under the Medicaid Purchase Plan, which begins on March 15, 2000, adults with disabilities and net family income below 250% of the federal poverty level (FPL) can purchase Medicaid coverage.

The Medicaid Purchase Plan offers people with disabilities who are working or are interested in working, the opportunity to:

- Earn more income without risking loss of their health and long term care (LTC) coverage (such as home health care services).
- Maintain higher asset levels.
- Save more earnings in Independence Accounts, allowing participants to save for retirement, a new home, or other goods and services that increase personal and financial independence.
- Receive the same health benefits offered under Wisconsin Medicaid.
- Receive Wisconsin home and community-based waiver services (COP, CIP, etc.) if eligible.

People most likely to benefit from the Medicaid Purchase Plan include:

- People with disabilities who want to work or increase their hours but have been unable to do so for fear of losing their health care coverage.
- Social Security Disability Insurance (SSDI) beneficiaries who need Medicaid to cover LTC services not covered by Medicare.
- People with disabilities who have not qualified for Medicaid in the past due to earnings or assets that were higher than allowable limits.
- People who have lost Supplemental Security Income (SSI) due to increased earnings.

Eligibility criteria

To become eligible for the Medicaid Purchase Plan, an individual must meet the following financial and non-financial requirements.

Financial eligibility requirements

- The family's net income must be less than 250% of the federal poverty level (FPL), based on family size.

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Family Care to begin in Portage and La Crosse counties

On April 1, 2000, Family Care pilot programs will begin in Portage and La Crosse counties. Family Care is Wisconsin's new voluntary long term care managed care program. Family Care started in Fond du Lac County in February.

For more information about Family Care, refer to the December 1999 and January 2000 *Wisconsin Medicaid and BadgerCare Updates*, which can be found in the "Provider Publications" section of the Department of Health and Family Services' Web site at www.dhfs.state.wi.us/medicaid/. For more detailed information about Family Care, refer to the Family Care Web site at www.dhfs.state.wi.us/LTCare/.

Portage County

Portage County's Family Care-Care Management Organization (CMO) is Community Care of Portage County. For more information about Family Care in Portage County, contact the network developer at (715) 345-5978.

La Crosse County

La Crosse County's Family Care-CMO is the La Crosse County Care Management Organization. For more information about Family Care in La Crosse County, contact the network developer at (608) 785-6059.

Family Care eligibility groups

Family Care pilots in Portage and La Crosse counties will initially cover Medicaid recipients with long term care needs who are:

- Elderly.
- Adults with physical disabilities.
- Adults with developmental disabilities.

Individuals who are not eligible for Medicaid may be eligible for Family Care in the future. ✦

Long term care services covered under Family Care

Family Care, Wisconsin's long term care managed care program being piloted in several counties throughout the state, covers only *long term care services*. Family Care does not cover primary and acute care services such as pharmacy, hospital, and physician services.

Attachment 1 of this *Update* contains a comprehensive list of covered and noncovered services in the Family Care benefit package.

Primary and acute care providers

Primary and acute care services are covered as fee-for-service for Family Care members. Therefore, primary and acute care providers such as pharmacists, hospitals, and physicians may treat Family Care members. Look for more information in future *Updates* on how providers may work with Family Care-Care Management Organizations (CMOs) to ensure patients receive the care they need.

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Primary and acute care providers should understand that members will receive comprehensive case management from a Family Care-CMO. Primary and acute care providers are encouraged to work closely with the CMO to coordinate care to achieve the best health and long term care outcomes for members.

Long term care providers

To receive reimbursement for Family Care services, a long term care provider must be part of the Family Care-CMO network or receive prior approval from the CMO.

Eligibility verification

Since members can enroll in, or disenroll from, a Family Care-CMO at any time during the month, providers should *always* check member eligibility for Family Care enrollment *before* providing services.

Providers can access Medicaid's Eligibility Verification System (EVS) in the following ways:

- Automated Voice Response at (800) 947-3544 or (608) 221-4247.
- Provider Services at (800) 947-9627 or (608) 221-9883.
- Magnetic stripe card reader (also known as a point-of-service device or terminal) or personal computer software. Card readers and software are available for purchase from commercial eligibility verification vendors.
- Direct Information Access Line with Updates for Providers (DIAL-UP) at (608) 221-4746.

The EVS will indicate managed care codes of 58 or 59 if members are enrolled in a Family Care-CMO.

Additional information about Family Care

More information on Family Care will be available in future *Wisconsin Medicaid and BadgerCare Updates*. Information about Family Care is also available on the Department of Health and Family Services' Web site at www.dhfs.state.wi.us by clicking on "Long Term Care." ✦

What's new on the Medicaid Web site

The Wisconsin Medicaid Web site includes provider and recipient publications, Medicaid contacts and statistics, and eligibility and benefit information. You may visit the Medicaid Web site at www.dhfs.state.wi.us/medicaid/.

The following is a list of what has recently been added to the Medicaid Web site:

- Updated Medicaid and BadgerCare caseload statistics.
- Revised commercial eligibility verification vendor list.
- March 2000 *Wisconsin Medicaid and BadgerCare Update*.

Keep in mind that if you do not have a computer with Internet access, many libraries have access available. ✦

Medicaid Purchase Plan

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- The individual must not own countable assets exceeding \$15,000. Countable assets are determined using the SSI-related Medicaid rules. If the individual is married, his or her spouse's assets will not be counted.

Non-financial eligibility requirements

The individual must be:

- At least 18 years of age.
- Determined to have a disability by the Department of Health and Family Services Disability Determination Bureau.
- Employed in a paid position *or* enrolled in a certified Health and Employment Counseling program.

Note: Family coverage is not available under the Medicaid Purchase Plan. However, multiple individuals within a household may enroll, provided they each meet eligibility criteria.

Eligibility verification and claims submission

Forward ID cards for Medicaid and Medicaid Purchase Plan recipients are identical. It is not necessary for providers to identify whether a person is covered by Medicaid or the Medicaid Purchase Plan because they receive the same benefits and have the same claims procedure. **Providers should submit claims for Medicaid Purchase Plan recipients exactly as they do for other Medicaid recipients.**

Monthly premiums

At the time of application, the county or tribal human or social services department will determine whether the individual is required to pay a premium. The premium amount is based on a sliding-fee scale. A monthly premium is not required for individuals with gross earned and unearned income less than 150% of the FPL (adjusted annually) for the applicable family size. If the individual is married, his or her spouse's income will not be considered in the premium determination.

Where to refer potential recipients

Providers should refer potential Medicaid Purchase Plan recipients to their county or tribal human or social services department. If potential applicants or recipients have questions about Wisconsin Medicaid or Medicaid Purchase Plan coverage, they may call Recipient Services at (800) 362-3002 (recipient use only).

In addition, recipients may refer to the Department of Health and Family Services' (DHFS) Web site at www.dhfs.state.wi.us/MAPP for more information about the Medicaid Purchase Plan.

Provider questions

Providers who have questions about the Medicaid Purchase Plan may call Provider Services at (800) 947-9627 or (608) 221-9883. Providers may also refer to the DHFS Web site at www.dhfs.state.wi.us/MAPP for more information about the Medicaid Purchase Plan. ✦

It is not necessary for providers to identify whether a person is covered by Medicaid or the Medicaid Purchase Plan because they receive the same benefits and have the same claims procedure.

Special advisory bulletin describes exclusion from federal health care programs

Health care providers should determine whether potential and current employees and contractors have been excluded from participation in federal health care programs, including Medicare and Medicaid, according to the attached special advisory bulletin issued by the Department of Health and Human Services' Office of Inspector General.

Wisconsin Medicaid strongly recommends that all providers read the attached bulletin (Attachment 2) titled "The Effect of Exclusion From Participation in Federal Health Care Programs," dated September 1999, in its entirety.

The Office of Inspector General maintains a list of excluded individuals/entities at the following Web site: www.hhs.gov/oig/cumsan/index.htm and urges health care providers to check the list before hiring or contracting with individuals or entities.

Wisconsin Medicaid cannot answer questions about this issue. Providers may contact Alwyn Cassil or Judy Holtz of the Office of Inspector General at (202) 619-1343 for additional information. ✦

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

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at www.dhfs.state.wi.us/medicaid/.

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Attachment 1

Medicaid Services Included/Not Included in the Family Care Benefit Package

Medicaid Services Included in the Family Care Benefit Package

The following Medicaid-covered services are available through the Family Care-Care Management Organizations (CMOs).

- **Case Management** - provided by case management agencies.
 - ✓ Except Discharge Planning provided in a hospital inpatient setting.
- **Home Care Services** - provided by home health agencies, personal care agencies, independent nurses, and respiratory therapists.
 - ✓ Home health aide services.
 - ✓ Personal care.
 - ✓ Skilled nursing (including independent nursing services).
 - Intermittent (less than 8 hours per day).
 - Private duty nursing (8 or more hours per day).
 - Respiratory care.
 - ✓ Occupational and physical therapy, and speech and language pathology services (*see Therapy Services on the next page*).
- **Mental Health/Substance Abuse and Related Services** - provided by mental health providers, substance abuse (alcohol and other drug abuse) treatment providers, day treatment programs, community support programs.
 - ✓ Mental health and substance abuse services.
 - Except those services provided by a physician.
 - Except those services provided in an inpatient hospital setting.
 - ✓ Day treatment (mental health and substance abuse).
 - ✓ Child/adolescent mental health day treatment.
 - ✓ Community Support Program services.
 - Except when provided by a physician.
 - Except non-psychiatric medication and treatment services.
 - ✓ In-home intensive psychotherapy.
 - ✓ In-home autism treatment.
- **Nursing Facilities** – all nursing facility stays (including Intermediate Care Facility for People with Mental Retardation [ICF/MR] and Institution for Mental Disease [IMD]).
 - ✓ Except lab and radiology ancillary services.
- **Supplies and Equipment** - provided by any provider.
 - ✓ Disposable medical supplies.
 - Except supplies used in a hospital or physician clinic.
 - ✓ Durable medical equipment (DME) purchased or rented in all settings.
 - Except for hearing aids, hearing aid accessories, hearing aid batteries, and assistive listening devices.
 - Except for prosthetics.
 - ✓ Repair and maintenance of DME.
 - Except for repair and maintenance of hearing aids and assistive listening devices.
 - Except for repair and maintenance of prosthetics.
 - ✓ Orthotics (purchase and repair).

Therapy Services - provided by therapy and speech and language providers.

- ✓ Occupational therapy.
 - Except those services provided by physicians in clinic settings.
 - Except those services provided in an inpatient hospital setting.
- ✓ Physical therapy.
 - Except those services provided by physicians in clinic settings.
 - Except those services provided in an inpatient hospital setting.
- ✓ Speech and language pathology services.
 - Except those services provided by physicians in clinic settings.
 - Except those services provided in an inpatient hospital setting.

- **Transportation** - provided by specialized medical vehicle providers.

Medicaid Services Not Included in the Family Care Benefit Package

The following Medicaid services are not included in the Family Care benefit package. Providers and counties should continue to bill these services to Wisconsin Medicaid for Medicaid-eligible Family Care members.

- Ambulance transportation.
- Audiology.
- Chiropractic.
- Crisis intervention services.
- Dentistry.
- Eyeglasses.
- Family planning services.

- Hearing aids (including batteries, accessories, and assistive listening devices, and repair and maintenance of hearing aids and assistive listening devices).
- Hospice.
- Hospital: Inpatient (except DME).
- Hospital: Outpatient (except physical therapy, occupational therapy, speech and language pathology, mental health services, and substance abuse treatment).
- Independent nurse practitioner services.
- Lab and X-ray.
- Mental health services provided by a physician or provided in an inpatient hospital setting.
- Nurse midwife services.
- Optometry.
- Pharmaceuticals.
- Physician services.
- Podiatry.
- Prenatal care coordination.
- Prosthetics (including repair and maintenance).
- School-based services.
- Substance abuse services provided by a physician or provided in an inpatient hospital setting.
- Transportation by common carrier (the billing method for this service remains unchanged).

Attachment 2

Special Advisory Bulletin

The Effect of Exclusion From Participation in Federal Health Care Programs

September 1999

A. Introduction

The Office of Inspector General (OIG) was established in the U.S. Department of Health and Human Services to identify and eliminate fraud, waste, and abuse in the Department's programs and to promote efficiency and economy in Departmental operations. The OIG carries out this mission through a nationwide program of audits, inspections, and investigations. In addition, the OIG has been given the authority to exclude from participation in Medicare, Medicaid and other Federal health care programs⁽¹⁾ individuals and entities who have engaged in fraud or abuse, and to impose civil money penalties (CMPs) for certain misconduct related to Federal health care programs (sections 1128 and 1128A of the Social Security Act (the Act)).

Recent statutory enactments have strengthened and expanded the OIG's authority to exclude individuals and entities from the Federal health care programs. These laws also expanded the OIG's authority to assess CMPs against individuals and entities that violate the law. With this expanded authority, the OIG believes that it is important to explain the effect of program exclusions under the current statutory and regulatory provisions.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, authorized the OIG to provide guidance to the health care industry to prevent fraud and abuse, and to promote high levels of ethical and lawful conduct. To further these goals, the OIG issues Special Advisory Bulletins about industry practices or arrangements that potentially implicate the fraud and abuse authorities subject to enforcement by the OIG.

In order to assist all affected parties in understanding the breadth of the payment prohibitions that apply to items and services provided to Federal program beneficiaries,⁽²⁾ this Special Advisory Bulletin provides guidance to individuals and entities that have been excluded from Federal health care programs, as well as to those who might employ or contract with an excluded individual or entity to provide items or services reimbursed by a Federal health care program.

B. Statutory Background

In 1977, in the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Public Law 95-142, Congress first mandated the exclusion of physicians and other practitioners convicted of program-related crimes from participation in Medicare and Medicaid (now codified at section 1128 of the Act). This was followed in 1981 with Congressional enactment of the Civil Monetary Penalties Law (CMPL), Public Law 97-35, to further address health care fraud and abuse (section 1128A of the Act). The CMPL authorizes the Department and the OIG to impose CMPs, assessments and program exclusions against individuals and entities who submit false or fraudulent, or otherwise improper claims for Medicare or Medicaid payment. "Improper claims" include claims submitted by an excluded individual or entity for items or services furnished during a period of program exclusion.

The enactment of HIPAA in 1996 and the Balanced Budget Act (BBA) of 1997, Public Law 105-33, further expanded the OIG's sanction authorities. These statutes extended the application and scope of the current CMP and exclusion authorities beyond programs funded by the Department to all "Federal health care programs." BBA also authorized a new CMP authority to be imposed against health care providers or entities that employ or enter into contracts with excluded individuals for the provision of services or items to Federal program beneficiaries.

In the discussion that follows, it should be understood that the prohibitions being described apply to items and services provided, directly or indirectly, to Federal program beneficiaries. The ability of an excluded individual or entity to render items and services to others is not affected by an OIG exclusion.

C. Exclusion from Federal Health Care Programs

The effect of an OIG exclusion from Federal health care programs is that no Federal health care program payment may be made for any items or services (1) furnished by an excluded individual or entity, or (2) directed or prescribed by an excluded physician (42 CFR 1001.1901). This payment ban applies to all methods of Federal program reimbursement, whether payment results from itemized claims, cost reports, fee schedules or a prospective payment system (PPS). Any items and services furnished by an excluded individual or entity are not reimbursable under Federal health care programs. In addition, any items and services furnished at the medical direction or prescription of an excluded physician are not reimbursable when the individual or entity furnishing the services either knows or should know of the exclusion. This prohibition applies even when the Federal payment itself is made to another provider, practitioner or supplier that is not excluded.

The prohibition against Federal program payment for items or services furnished by excluded individuals or entities also extends to payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Federal program beneficiaries. This prohibition continues to apply to an individual even if he or she changes from one health care profession to another while excluded.⁽³⁾ In addition, no Federal program payment may be made to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care.

Set forth below is a listing of some of the types of items or services that are reimbursed by Federal health care programs which, when provided by excluded parties, violate an OIG exclusion. These examples also demonstrate the kinds of items and services that excluded parties may be furnishing which will subject their employer or contractor to possible CMP liability.

- Services performed by excluded nurses, technicians or other excluded individuals who work for a hospital, nursing home, home health agency or physician practice, where such services are related to administrative duties, preparation of surgical trays or review of treatment plans if such services are reimbursed directly or indirectly (such as through a PPS or a bundled payment) by a Federal health care program, even if the individuals do not furnish direct care to Federal program beneficiaries;
- Services performed by excluded pharmacists or other excluded individuals who input prescription information for pharmacy billing or who are involved in any way in filling prescriptions for drugs reimbursed, directly or indirectly, by any Federal health care program;
- Services performed by excluded ambulance drivers, dispatchers and other employees involved in providing transportation reimbursed by a Federal health care program, to hospital patients or nursing home residents;
- Services performed for program beneficiaries by excluded individuals who sell, deliver or refill orders for medical devices or equipment being reimbursed by a Federal health care program;
- Services performed by excluded social workers who are employed by health care entities to provide services to Federal program beneficiaries, and whose services are reimbursed, directly or indirectly, by a Federal health care program;
- Administrative services, including the processing of claims for payment, performed for a Medicare intermediary or carrier, or a Medicaid fiscal agent, by an excluded individual;

- Services performed by an excluded administrator, billing agent, accountant, claims processor or utilization reviewer that are related to and reimbursed, directly or indirectly, by a Federal health care program;
- Items or services provided to a program beneficiary by an excluded individual who works for an entity that has a contractual agreement with, and is paid by, a Federal health care program; and
- Items or equipment sold by an excluded manufacturer or supplier, used in the care or treatment of beneficiaries and reimbursed, directly or indirectly, by a Federal health care program.

D. Violation of an OIG Exclusion By an Excluded Individual or Entity

An excluded party is in violation of its exclusion if it furnishes to Federal program beneficiaries items or services for which Federal health care program payment is sought. An excluded individual or entity that submits a claim for reimbursement to a Federal health care program, or causes such a claim to be submitted, may be subject to a CMP of \$10,000 for each item or service furnished during the period that the person or entity was excluded (section 1128A(a)(1)(D) of the Act). The individual or entity may also be subject to treble damages for the amount claimed for each item or service. In addition, since reinstatement into the programs is not automatic, the excluded individual may jeopardize future reinstatement into Federal health care programs (42 CFR 1001.3002).

E. Employing an Excluded Individual or Entity

As indicated above, BBA authorizes the imposition of CMPs against health care providers and entities that employ or enter into contracts with excluded individuals or entities to provide items or services to Federal program beneficiaries (section 1128A(a)(6) of the Act; 42 CFR 1003.102(a)(2)). This authority parallels the CMP for health maintenance organizations that employ or contract with excluded individuals (section 1857(g)(1)(G) of the Act). Under the CMP authority, providers such as hospitals, nursing homes, hospices and group medical practices may face CMP exposure if they submit claims to a Federal health care program for health care items or services provided, directly or indirectly, by excluded individuals or entities.

Thus, a provider or entity that receives Federal health care funding may only employ an excluded individual in limited situations. Those situations would include instances where the provider is both able to pay the individual exclusively with private funds or from other non-federal funding sources, and where the services furnished by the excluded individual relate solely to non-federal program patients.

In many instances, the practical effect of an OIG exclusion is to preclude employment of an excluded individual in any capacity by a health care provider that receives reimbursement, indirectly or directly, from any Federal health care program.

F. CMP Liability for Employing or Contracting with an Excluded Individual or Entity

If a health care provider arranges or contracts (by employment or otherwise) with an individual or entity who is excluded by the OIG from program participation for the provision of items or services reimbursable under such a Federal program, the provider may be subject to CMP liability if they render services reimbursed, directly or indirectly, by such a program. CMPs of up to \$10,000 for each item or service furnished by the excluded individual or entity and listed on a claim submitted for Federal program reimbursement, as well as an assessment of up to three times the amount claimed and program exclusion may be imposed. For liability to be imposed, the statute requires that the provider submitting the claims for health care items or services furnished by an excluded individual or entity “knows or should know” that the person was excluded from participation in the Federal health care programs (section 1128A(a)(6) of the Act; 42 CFR 1003.102(a)(2)). Providers and contracting entities have an affirmative duty to check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships, or run the risk of CMP liability if they fail to do so.

should know” that the person was excluded from participation in the Federal health care programs (section 1128A(a)(6) of the Act; 42 CFR 1003.102(a)(2)). Providers and contracting entities have an affirmative duty to check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships, or run the risk of CMP liability if they fail to do so.

G. How to Determine If an Individual or Entity is Excluded

In order to avoid potential CMP liability, the OIG urges health care providers and entities to check the OIG List of Excluded Individuals/Entities on the OIG web site (www.hhs.gov/oig) prior to hiring or contracting with individuals or entities. In addition, if they have not already done so, health care providers should periodically check the OIG web site for determining the participation/exclusion status of current employees and contractors. The web site contains OIG program exclusion information and is updated in both on-line searchable and downloadable formats. This information is updated on a regular basis. The OIG web site sorts the exclusion of individuals and entities by: (1) the legal basis for the exclusion, (2) the types of individuals and entities that have been excluded, and (3) the State where the excluded individual resided at the time they were excluded or the State where the entity was doing business. In addition, the entire exclusion file may be downloaded for persons who wish to set up their own database. Monthly updates are posted to the downloadable information on the web site.

H. Conclusion

In accordance with the expanded sanction authority provided in HIPAA and BBA, and with limited exceptions⁽⁴⁾, an exclusion from Federal health care programs effectively precludes an excluded individual or entity from being employed by, or under contract with, any practitioner, provider or supplier to provide any items and services reimbursed by a Federal health care program. This broad prohibition applies whether the Federal reimbursement is based on itemized claims, cost reports, fee schedules or PPS. Furthermore, it should be recognized that an exclusion remains in effect until the individual or entity has been reinstated to participate in Federal health care programs in accordance with the procedures set forth at 42 CFR 1001.3001 through 1001.3005. Reinstatement does not occur automatically at the end of a term of exclusion, but rather, an excluded party must apply for reinstatement.

If you are an excluded individual or entity, or are considering hiring or contracting with an excluded individual or entity, and question whether or not the employment arrangement may violate the law, the OIG Advisory Opinion process is available to offer formal binding guidance on whether an employment or contractual arrangement may be in violation of the OIG’s exclusion and CMP authorities. The process and procedure for submitting an advisory opinion request can be found at 42 CFR 1008, or on the OIG web site at www.hhs.gov/oig.

1. A Federal health care program is defined as any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program) (section 1128B(f) of the Act). The most significant Federal health care programs are Medicare, Medicaid, Tricare and the Veterans programs.
2. A Federal program beneficiary is an individual that receives health care benefits that are funded, in whole or in part, by a Federal health care program.
3. For example, the prohibition against Federal program payment for items and services would continue to apply in the situation where an excluded pharmacist completes his or her medical degree and becomes a licensed physician.
4. In certain instances, a State health care program may request a waiver of an exclusion if an individual or entity is the sole community physician or the sole source of essential specialized services in a community (42 CFR 1001.1801(b)).