wisconsin Medicaid update
and BadgerCare

June 2000
PHC 1726

Wisconsin Medicaid and BadgerCare Information for Providers

Special Medicaid eligibility programs for Medicare recipients

This Update explains eligibility requirements and benefit limitations for five special Medicaid eligibility categories. Providers are encouraged to inform patients who are potentially eligible for Medicaid benefits about these programs. The programs offer limited benefits; providers should make payment arrangements with patients when services are not covered.

Inside this Update:

The following five categories of eligibility were created to assist low-income Medicare recipients with premiums or out-of-pocket medical expenses. However, many potentially eligible Medicare recipients are not aware of the programs.

Providers are encouraged to inform patients who are potentially eligible for Medicaid benefits about these programs. The Health Care Financing Administration (HCFA) has produced an informational brochure (see attached) for Medicare recipients about special Medicaid eligibility programs. The brochure is also available in PDF format on a HCFA-sponsored Web site at *www.nmep.org*. Use the following steps to navigate to the brochure:

1. Go to *www.nmep.org*.
2. Click on "Our Library."
3. Click on "Savings for Medicare Beneficiaries - Outreach Kit and Resource Guide."
4. Click on "Outreach Kit - Savings for Medicare Beneficiaries."
5. Click on "Brochure."

Attachment 1 of this *Update* is a table outlining eligibility and coverage for each category. Providers should encourage Medicare patients to contact their county or tribal human or social services department to determine if they are eligible for these benefits.

The special categories are:

- Qualified Medicare Beneficiary Only (QMB Only).
- Specified Low Income Medicare Beneficiary (SLMB).
- Qualifying Individual 1 (QI-1).
- Qualified Disabled Working Individual (QDWI).
- Qualifying Individual 2 (QI-2).

Eligibility verification

Providers should use the Automated Voice Response (AVR) system to verify current Medicaid eligibility of recipients at every visit, as eligibility can change between visits. Although SLMB, QI-1, QDWI, and QI-2 recipients are not issued a Forward identification card, recipients may present a Forward card they received from an earlier Medicaid eligibility period. When calling the AVR system, make sure you listen to the full response message before hanging up so you are sure to receive all of the information about the coverage limitations for these eligibility categories.

Continued on page 5

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:

- June 2000 *Wisconsin Medicaid and BadgerCare Update*.
- Updated Medicaid and BadgerCare caseload statistics.
- Specialized link to all Family Care articles.
- *Wisconsin Medicaid and BadgerCare Update* titled "Common prior authorization problems for dentists."
- *Wisconsin Medicaid and BadgerCare Update* titled "Wheelchairs and durable medical equipment: Changes in maximum allowable fees and life expectancies."
- *Wisconsin Medicaid and BadgerCare Update* titled "Clarification of Birth to 3 and the Individualized Family Service Plan."
- *Wisconsin Medicaid and BadgerCare Update* titled "One percent reimbursement increase for noninstitutional services - Effective July 1, 2000."

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

Family Care available to people not on Medicaid

On July 1, 2000, eligibility for Family Care, a voluntary long term care managed care program, will expand to include individuals who are not eligible for Wisconsin Medicaid. Until this occurs, Family Care is available only to individuals who are eligible for Medicaid.

For individuals who are not eligible for Medicaid, Family Care has two eligibility criteria: functional eligibility and financial eligibility. An individual must meet both criteria to be eligible for Family Care.

Family Care provides long term care (LTC) services (for example, home health care services, physical therapy, occupational therapy, and speech therapy). A member may also be charged a monthly cost-share (refer to the financial eligibility section in this article). The member's Family Care-Care Management Organization (CMO) must authorize the service before the member receives it for Family Care to cover the service.

Acute and primary care services, including physician and inpatient hospital, are not covered by Family Care. Unless the Family Care member is also eligible for Medicaid, Wisconsin Medicaid will not reimburse providers for acute and primary care services.

Family Care is currently available to residents of Fond du Lac, La Crosse, Portage, and Milwaukee counties.

Family Care eligibility groups

In general, Family Care is available to individuals with long term care needs who are any of the following:

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

Eligibility criteria

For individuals who are not eligible for Medicaid, Family Care has two eligibility criteria: functional eligibility and financial

eligibility. An individual must meet *both* criteria to be eligible for Family Care.

Functional eligibility is based on the degree to which an individual can independently manage the everyday activities of living, such as eating, bathing, and dressing.

Financial eligibility means the projected cost of the individual's care plan is more than the amount that Family Care would require the individual to pay each month for LTC services. The amount a member is required to pay for Family Care is called the member's cost-share. Family Care determines the member's cost-share from available income and assets. An individual is ***not*** eligible for Family Care if the individual's monthly cost-share would be greater than the projected monthly cost of the care plan.

Eligibility verification

Providers may verify eligibility for ***all*** Family Care members (whether or not they are also eligible for Medicaid) by using the Eligibility Verification System (EVS). Refer to the "Family Care Eligibility Verification for Members not on Medicaid" table in this article for the Family Care messages from eligibility verification vendors and the Automated Voice Response (AVR) system. The EVS will indicate managed care codes of 58 or 59 if members are enrolled in a Family Care CMO. (As indicated in previous *Updates*, providers may use the EVS and AVR to verify eligibility for Wisconsin Medicaid, if appropriate.)

Wisconsin Medicaid will *not* issue Forward ID cards to Family Care members who are also not eligible for Medicaid fee-for-service. Each CMO will determine what, if any, identification cards it will issue to members who are not eligible for Medicaid. However, individuals who were eligible for Medicaid in the past may present the Forward card they received when on Medicaid. The EVS would show the person is eligible for Family Care but not for Medicaid.

All services covered by Family Care must be authorized by the CMO **before** the services are provided. Providers should contact the CMO **prior** to providing any of the services included in the Family Care benefit package.

For more information about verifying Family Care eligibility, refer to the January 2000 *Wisconsin Medicaid and BadgerCare Update*.

Family Care Eligibility Verification for Members not on Medicaid	
Automated Voice Response (AVR) system	"Recipient eligible only for services provided by Family Care - Care Management Organization. No Medicaid card services are payable. Family Care - Care Management Organization"
Eligibility verification vendor (magnetic-stripe reader or computer software)	"Services thru Family Care CMO. Not elig for MA card services. Family Care - Care Management Organization"

Authorization for services

All services covered by Family Care must be authorized by the CMO ***before*** the services are provided. Providers should contact the CMO ***prior*** to providing any of the services included in the Family Care benefit package.

For more information

Refer to the January 2000, March 2000, and May 2000 *Wisconsin Medicaid and BadgerCare Updates* about Family Care, which can be found in the "Provider Publications" section of the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

The January 2000 *Update* also lists telephone numbers for Family Care CMOs. Providers may call the specific CMO for more information about the county's Family Care services. ✦

Commonly asked Family Care questions

The following are general questions providers have had about Family Care, Wisconsin's voluntary long term care managed care program. Family Care is currently being piloted in Fond du Lac, Portage, La Crosse, and Milwaukee counties.

What are the goals of Family Care?

A major goal of Family Care is to increase access to services. Local Aging and Disability Resource Centers will help any individuals with long term care (LTC) needs, including Medicaid recipients, to "one-stop shop" for LTC information, such as available services and housing. Resource Centers will also help people to apply for government benefits, including Medicaid.

Another goal of Family Care is to improve the coordination of LTC services by creating a single, flexible benefit for all LTC services. Family Care consolidates several different funding sources, such as Medicaid, home and community-based waivers, and the Community Options Program. This single, flexible benefit will foster recipients' independence and quality of life, while recognizing the need for support to remain independent.

Why is it important to identify Family Care members?

Only providers affiliated with or authorized by Care Management Organizations (CMOs) will be reimbursed for LTC services covered by Family Care. Please refer to Attachment 1 of the January 2000 *Wisconsin Medicaid and BadgerCare Update* for a list of covered and noncovered services in the Family Care benefit package. The *Update* can also be found in the "Provider Publications" section of the Medicaid 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/*.

How can providers identify a Family Care member?

Providers may verify eligibility for *all* Family Care members (whether or not they are eligible for Medicaid) by using the Eligibility Verification System (EVS). For more information about eligibility verification for Family Care members not on Medicaid, refer to the article "Family Care available to people not on Medicaid" in this *Update*.

Providers may verify eligibility and enrollment in a Family Care CMO via the following resources:

- Automated Voice Response (AVR) system 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.

(For more information on these resources, refer to the September 1999 *Wisconsin Medicaid Update*.)

What happens when a member enrolls in or disenrolls from a Family Care CMO and doesn't tell the provider?

Since members can enroll in, or disenroll from, a Family Care CMO at any time during the month, providers should *always* check eligibility *before* providing services. If an individual disenrolls from a Family Care CMO, the provider should bill Medicaid services provided after disenrollment to Medicaid for recipients who are Medicaid eligible. If the individual is not eligible for Medicaid, the provider should bill the individual or the individual's commercial health insurance for services.

A major goal of Family Care is to increase access to services... Another goal of Family Care is to improve the coordination of LTC services by creating a single, flexible benefit for all LTC services.

Can I use an existing Medicaid prior authorization to provide services to a Family Care member?

No. Existing Medicaid prior authorization for services included in the Family Care benefit package will not be applicable when a recipient enrolls in Family Care. Providers are required to obtain prior authorization from the CMO to provide services included in the Family Care benefit package.

Watch for more "Commonly asked Family Care question" articles in future *Wisconsin Medicaid and BadgerCare Updates*. ✦

Special Medicaid eligibility

Continued from page 1

Qualified Medicare Beneficiary Only (QMB Only)

To qualify, QMB Only recipients must:

- Be entitled to but not necessarily enrolled in Medicare Part A.
- Have income under 100% of the federal poverty level.
- Not be receiving other Medicaid benefits.

Although (QMB Only) recipients receive a Forward card, they are not eligible for any other Medicaid benefits.

For QMB Only recipients, Wisconsin Medicaid pays:

- Medicare insurance premium for Part B and Part A (if required).
- Coinsurance and deductibles for Medicare-covered services.

Although these recipients *receive a Forward card*, they are *not* eligible for any other Medicaid benefits. Providers should verify current Medicaid eligibility and potential Medicaid benefit limitations, as well as other coverage information, prior to delivering services at each visit.

Medicare-covered services

Providers are to bill Medicare for Medicare-covered services provided to QMB Only recipients. Medicare will then send the claim to Wisconsin Medicaid for payment of the coinsurance and deductible. A provider's Medicare number must be on file with Wisconsin Medicaid for a claim to automatically cross over to Medicaid for processing. Medicare-covered services that fail to cross over to Wisconsin Medicaid within 30 days of the Explanation of Medicare Benefits (EOMB) may be submitted to Wisconsin Medicaid by the provider.

Services not covered by Medicare

Providers are encouraged to inform QMB Only recipients prior to delivering the service that the service is *not* covered by Medicare or that the provider is not Medicare certified. Payment arrangements should then be made between the provider and the patient. For services that Medicare does not allow, providers will not receive coinsurance or deductible reimbursement from Wisconsin Medicaid.

Specified Low Income Medicare Beneficiary (SLMB)

To qualify, SLMB recipients must:

- Have income under 120% of the federal poverty level.
- Be entitled to but not necessarily enrolled in Medicare Part A.
- Have income or assets too high to qualify for other Medicaid benefits.

Wisconsin Medicaid pays for only the Medicare Part B premium for SLMB recipients. Specified Low Income Medicare Beneficiary recipients receive no other Medicaid benefits and *do not receive a Forward card.*

Providers are to bill Medicare for services provided to SLMB recipients. The recipient is responsible for paying the Medicare coinsurance and deductible payment.

Qualifying Individual 1 (QI-1)

To qualify, QI-1 recipients must:

- Have income between 120 and 135% of the federal poverty level.
- Be entitled to but not necessarily enrolled in Medicare Part A.
- Have income or assets too high for other Wisconsin Medicaid benefits.

Wisconsin Medicaid pays for only the Medicare Part B premium for QI-1 recipients. Qualifying Individual 1 recipients receive no other Medicaid benefits and *do not receive a Forward card.*

Providers are to bill Medicare for services provided to QI-1 recipients. The recipient is responsible for paying the Medicare coinsurance and deductible payment.

Qualified Disabled Working Individual (QDWI)

To qualify, QDWI recipients must:

- Have income under 200% of the federal poverty level.
- Be entitled to but not necessarily enrolled in Medicare Part A.
- Have income or assets too high to qualify for other Medicaid benefits, including QMB Only and SLMB.

Wisconsin Medicaid pays for only the Medicare Part A premiums for QDWI recipients. Qualified Disabled Working Individual recipients receive no other Medicaid benefits and *do not receive a Forward card*.

Providers are to bill Medicare for services provided to QDWI recipients. The recipient is responsible for paying the Medicare coinsurance and deductible payment.

Qualifying Individual 2 (QI-2)

To qualify, QI-2 recipients must:

- Have income between 135 and 175% of the federal poverty level.
- Have Medicare Part B coverage.

Wisconsin Medicaid will only refund a portion of the Medicare Part B premium for QI-2 recipients. Qualifying Individual 2 recipients receive no other Medicaid benefits and *do not receive a Forward card*.

Providers are to bill Medicare for services provided to QI-2 recipients. The recipient is responsible for paying the Medicare coinsurance and deductible payment.

If you have any questions, please call Provider Services at (800) 947-9627 or (608) 221-9883. ✦

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/*.

ATTACHMENT 1

Table of Medicaid special eligibility programs

Coverage is limited to out-of-pocket Medicare-related Part A and/or Part B costs only. No additional Medicaid services are covered.

Category	Forward card?	Income requirements	Medicare coverage needed for recipient to qualify	Medicaid benefits
QMB Only	Yes	• Under 100% of the federal poverty level.	Must be entitled to but not necessarily enrolled in Medicare Part A.	• Wisconsin Medicaid pays the Medicare premium for Part B and Part A (if required). • Wisconsin Medicaid pays the coinsurance and deductibles for covered Medicare services.
SLMB	No	• Under 120% of the federal poverty level. • Income or assets too high to qualify for other Medicaid benefits.	Must be entitled to but not necessarily enrolled in Medicare Part A.	Wisconsin Medicaid pays the Medicare Part B premium.
QI-1	No	• Between 120 and 135% of the federal poverty level. • Income or assets too high to qualify for other Medicaid benefits.	Must be entitled to but not necessarily enrolled in Medicare Part A.	Wisconsin Medicaid pays the Medicare Part B premium.
QDWI	No	• Under 200% of the federal poverty level. • Income or assets too high to qualify for other Medicaid benefits, including QMB Only and SLMB.	Must be entitled to but not necessarily enrolled in Medicare Part A.	Wisconsin Medicaid pays the Medicare Part A premium.
QI-2	No	• Between 135 and 175% of the federal poverty level.	Must have Medicare Part B coverage.	Wisconsin Medicaid will refund a portion of the Medicare Part B premium.

Dept. of Health & Family Services
Division of Health Care Financing
1 West Wilson Street
PO Box 309
Madison, WI 53701-0309