

To: Nursing Homes, HMOs and Other Managed Care Programs

Nursing Home Services Under BadgerCare Plus

BadgerCare Plus, the new state-sponsored health care program, will be implemented in February 2008. This *Update* describes the policies for nursing home services under BadgerCare Plus.

BadgerCare Plus Overview

In January 2007, Governor Jim Doyle included in his 2007-09 Biennial Budget proposal an innovative state-sponsored health care program to expand coverage to Wisconsin residents and ensure that all children in Wisconsin have access to affordable health care. This new program is called BadgerCare Plus, and it will start on February 1, 2008.

BadgerCare Plus merges family Medicaid, BadgerCare, and Healthy Start into a single program. BadgerCare Plus will expand enrollment to:

- All uninsured children.
- More pregnant women.
- More parents and caretaker relatives.
- Parents with children in foster care who are working to reunify their families.
- Young adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain farmers and other self-employed parents and caretaker relatives.

All individuals enrolled in BadgerCare Plus and Wisconsin Medicaid will be referred to as “members.”

BadgerCare Plus is comprised of two benefit plans, the Standard Plan and the Benchmark Plan. The services covered under the BadgerCare Plus Standard Plan are the same as the current Wisconsin Medicaid program; therefore, the term “Standard Plan” will be used in all future *Updates* to

describe the shared policy and billing information. The BadgerCare Plus Benchmark Plan is a more limited plan, modeled after commercial insurance.

New services covered under BadgerCare Plus and Wisconsin Medicaid include over-the-counter tobacco cessation products for all members and mental health and substance abuse screening, preventive mental health counseling, and substance abuse intervention services for pregnant women at risk of mental health or substance abuse problems. Future *Updates* will describe these new benefits in detail.

Refer to the November 2007 *Update* (2007-79), titled “Introduction to BadgerCare Plus — Wisconsin’s New Health Care Program,” for general information on covered and noncovered services, copayments, and enrollment.

Covered and Noncovered Services

Standard Plan

Nursing home services covered under the Standard Plan are the same as those covered under the current Wisconsin Medicaid program. Refer to the appropriate publications for covered services, policies, and procedures.

Benchmark Plan

Nursing home services covered under the Benchmark Plan are the same as those covered under the current Wisconsin Medicaid program except for bedhold days. The Benchmark Plan will not cover bedhold days.

Under the Benchmark Plan, coverage limitations will apply to the following services that may be provided in nursing homes:

- Disposable medical supplies, including exceptional supplies.
- Durable medical equipment, including exceptional supplies.
- Therapies (i.e. occupational therapy, physical therapy [PT], and speech and language pathology).

Providers should refer to the appropriate *Updates* for coverage information about these services.

Service Limitations for the Benchmark Plan

Under the Benchmark Plan, nursing home services are limited to 30 days in a nursing home per member per enrollment year.

Nursing home providers may need to coordinate benefits with hospice providers for Benchmark Plan members residing in the nursing home who receive the hospice benefit. The 30-day limit applies to room and board billed either by a nursing home provider or a hospice provider. After a member reaches the 30-day limit, BadgerCare Plus will not reimburse providers for nursing home room and board.

Enrollment Year Under BadgerCare Plus

An enrollment year is defined as the continuous 12-month period beginning the first day of the calendar month in which a member is enrolled in the Benchmark Plan and ending on the last day of the 12th calendar month.

For example, a member completes their BadgerCare Plus application materials by September 25, 2008. During the month of October, the Department of Health and Family Services (DHFS) reviews the application materials and determines that the member is eligible for the Benchmark Plan effective September 1, 2008, the first day of the calendar month that the application materials were

completed; however, the enrollment year for this member will not begin until October 1, 2008, the first day of the calendar month in which the DHFS actively enrolled the member in the Benchmark Plan. The Benchmark Plan enrollment year for this member is defined as October 1, 2008, through September 30, 2009. **Services received after eligibility is established and before the enrollment year begins are covered under the Benchmark Plan but do not count toward the service limitations.**

Subsequent enrollment years begin on the first day of the calendar month immediately following the end of the previous enrollment year, if there is no coverage gap. If there is a coverage gap for more than one day, the enrollment year will reset to begin on the first day of the month in which the DHFS re-enrolls the member into the Benchmark Plan.

If a member switches from the Benchmark Plan to the Standard Plan, the Benchmark Plan enrollment year does not reset. For example, a member's enrollment year under the Benchmark Plan begins March 1, 2008. During the third month, the member's income status changes and she is now eligible for the Standard Plan effective June 1, 2008. During August, the DHFS determines that the member is no longer eligible for the Standard Plan and effective September 1, 2008, the member returns to the Benchmark Plan. Since there is not a gap in coverage, the initial Benchmark Plan enrollment year is still active. The member must adhere to limits for services received while covered under the Benchmark Plan during the enrollment year period March 1, 2008, through February 28, 2009.

The Benchmark Plan enrollment year is the time period used to determine service limitations for members in the Benchmark Plan. **Services received while covered under the Standard Plan do not count toward the enrollment year service limitations in the Benchmark Plan and vice versa.** If a member switches between the two plans during one enrollment year, service limitations will accumulate separately under each plan.

For example, assume a member receives 22 PT visits under the Standard Plan during the first six months of a calendar year (January 1, 2008, through June 30, 2008). Under the Standard Plan, the member is eligible to receive 35 PT visits before prior authorization is required.

Effective the first day of the seventh month of the calendar year (July 1, 2008), the member's coverage changes to the Benchmark Plan. The Benchmark Plan limits coverage to 20 PT visits per enrollment year. Although the member received 22 PT visits during the first six months of the calendar year while covered under the Standard Plan, these services do not count toward the limits under the Benchmark Plan. The member is eligible to receive 20 PT visits under the Benchmark Plan during the course of the Benchmark Plan enrollment year which is determined as July 1, 2008, through June 30, 2009.

Reimbursement

Providers will be reimbursed for services provided to members at the current Wisconsin Medicaid rate of reimbursement for covered services.

Note: Patient liability will be applied to claims for services provided to Standard Plan members following the same procedures as the current Wisconsin Medicaid program. Patient liability **will not be applied** to claims for services provided to Benchmark Plan members.

Copayment

Standard Plan

Under the Standard Plan, providers are prohibited from collecting copayments from members who are nursing home residents.

Benchmark Plan

Under the Benchmark Plan, members residing in a nursing home **are not** subject to copayment for nursing home services. Members **are** subject to copayment for other services they receive during their stay if the services require copayments (such as therapy visits or hospice care).

Information Regarding BadgerCare Plus HMOs

BadgerCare Plus HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. For managed care policy, contact the appropriate managed care organization.

The *BadgerCare Plus Update* is the first source of program policy and billing information for providers. All information applies to Medicaid and BadgerCare Plus unless otherwise noted in the *Update*.

Wisconsin Medicaid and BadgerCare Plus 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 dhfs.wisconsin.gov/medicaid/.

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