BADGERCARE+
BadgerCare Plus Information for Providers

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To: All Providers, HMOs and Other Managed Care Programs

Billing Members for Covered Services, Noncovered Services, and Cost Sharing Under BadgerCare Plus

BadgerCare Plus, the new state-sponsored health care program, will be implemented in February 2008. This *Update* describes the policies for billing BadgerCare Plus members for covered services, noncovered services, and cost sharing.

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.

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.

Refer to the November 2007 *Update* (2007-79), titled "Introduction to BadgerCare Plus — Wisconsin's New Health Care Program," for general information on BadgerCare Plus.

Billing Members for Covered Services

Policy and procedures for billing BadgerCare Plus members for covered services are the same as they are under the current Wisconsin Medicaid program. Refer to the Wisconsin Medicaid All-Provider Handbook for more information about conditions that must be met in order to bill a member for a covered service.

Billing Members for Noncovered Services

Standard Plan

Policy and procedures for billing members for noncovered services are the same under the Standard Plan as they are under the current Wisconsin Medicaid program. Refer to the Wisconsin Medicaid All-Provider Handbook for more information about requirements for billing a member for a noncovered service.

Benchmark Plan

Some services are never covered under the Benchmark Plan. Other services are not covered after a certain service limitation is reached. Refer to service-specific *Updates* for more information about services that are considered noncovered under the Benchmark Plan.

Benchmark Plan members may request noncovered services from providers. In those cases, providers may collect payment for noncovered services from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charges for noncovered services.

Benchmark Plan Service Limitations and Billing Requirements

Services with Visit Limitations per Enrollment Year

Under the Benchmark Plan, some services are covered until a member reaches a specified number of visits or days of service per enrollment year. These services include:

- Inpatient hospital stays for substance abuse and mental health treatment.
- Home health visits.
- Nursing home stays.
- Routine eye exams.
- Therapy visits (physical therapy, occupational therapy, and speech and language pathology).

Note: Hospice services are subject to a lifetime limit under the Benchmark Plan.

Visits and days of service that exceed the service limitations established under the Benchmark Plan are considered noncovered. Services provided during a noncovered visit will not be reimbursed by BadgerCare Plus.

Providers are encouraged to inform the member when he or she has reached a service limitation.

If a member requests a service that exceeds the limitation, the member is responsible for payment. Providers should make payment arrangements with the member in advance.

Services with Dollar Amount Limits per Enrollment Year

Under the Benchmark Plan, some services are subject to a specified dollar amount service limitation per member per enrollment year. Any products or services that exceed the dollar amount limit are considered noncovered.

If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the BadgerCare Plus allowed reimbursement, which is the lesser of the provider's usual and customary charges or the maximum allowable fee, as payment in full. If BadgerCare Plus pays a portion of the claim and the claim exceeds the member's dollar amount service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

For example, the Benchmark Plan reimburses up to $2,500.00 for durable medical equipment (DME) per member per enrollment year. Suppose a member has expended $2,200.00 of his or her DME coverage and requires a new DME item. The BadgerCare Plus-allowed reimbursement for this DME item is $500.00. BadgerCare Plus will reimburse only $300.00 before the member has exhausted his or her coverage. The member is responsible for the additional $200.00. The provider must still accept $500.00 as payment in full because BadgerCare Plus reimbursed a portion of the charges. The provider must not bill the member for more than $200.00.

If a member has already met or exceeded his or her dollar limit, BadgerCare Plus will not reimburse providers for services provided to that member. Providers can bill

members up to their usual and customary charges for noncovered services.

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 his or her 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 physical therapy (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.

Copayment Under BadgerCare Plus

Standard Plan

Policy and procedures for collecting copayments are the same under the Standard Plan as they are under the current Wisconsin Medicaid program. Refer to previously-published

Wisconsin Medicaid publications for more information about copayment amounts and limits.

Some services do not have copayments under the Standard Plan; providers should consult their service-specific publications for more information about services that require copayments.

Policy regarding Standard Plan members who are subject to copayments and members who are exempt from copayments is different than that of the current Wisconsin Medicaid program.

Providers should note that the following Standard Plan members **are subject to copayment** for services where copayment applies:

- Members enrolled in BadgerCare Plus Standard Plan HMOs (previously referred to as Medicaid HMOs).
- Members under 18 years of age with incomes above 100 percent of the Federal Poverty Level (FPL).

Providers are prohibited from collecting copayments from the following BadgerCare Plus Standard Plan members:

- Nursing home residents.
- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.
- Members under 18 years of age with incomes at or below 100 percent of the Federal Poverty Level (FPL).

Federal law permits states to charge members a copayment for certain covered services. Providers are required to request copayments from members; however, a provider cannot deny services if the member fails to make his or her copayment.

Chapter 49.45(18), Wis. Stats., requires providers to make a reasonable attempt to collect copayments from the member unless the provider determines that the cost of collecting the copayment exceeds the amount to be collected.

Benchmark Plan

Copayment amounts are typically higher under the Benchmark Plan than they are under the Standard Plan and Wisconsin Medicaid. Providers should refer to their service-specific publications for information regarding copayment amounts under the Benchmark Plan.

Many services (such as physician visits, therapy sessions, and home health visits) apply a single copayment **per visit**. A visit is defined as all service provided by the same performing provider on the same date of service. Copayment is not applied based on the type of visit, on the services provided during the visit, or on the type or number of procedures performed during the visit. Service-specific publications provide more information about standard copayment amounts for visits. Some services are exempt from copayment under the Benchmark Plan.

Providers should always charge members the lesser of the copayment amount and the maximum allowable fee for the item or service.

Only the following members are exempt from copayment requirements under the Benchmark Plan:

- Pregnant women.
- Members under 18 years of age who are members of a federally recognized tribe.

No other members are exempt from the copayment requirement under the Benchmark Plan.

Under the Benchmark Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Deductibles Under BadgerCare Plus

Benchmark Plan members may be subject to deductibles and other cost-sharing expenses for dental services. Dental providers should refer to dental publications for more information regarding reimbursement for dental services.

Obtaining Information About Service Limitations and Cost Sharing

Providers should contact **Provider Services** toll free at **(800) 947-9627** or at **(608) 221-9883** for more information about a member's service limitations or cost sharing requirements.

Providers can refer members to **Member Services** at **(800) 362-3002** with inquiries about their service limitations.

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 Access and Accountability, 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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