BADGERCARE+
BadgerCare Plus Information for Providers

Update
January 2008

No. 2008-05

To: Advanced Practice Nurse Prescribers with Psychiatric Specialty, AODA Counselors, Community Support Programs, Comprehensive Community Services Providers, Crisis Intervention Providers, Day Treatment Providers, HealthCheck "Other Services" Providers, Inpatient Hospital Providers, Institutes for Mental Disease Providers, Master's-Level Psychotherapists, Mental Health/Substance Abuse Clinics, Narcotic Treatment Providers, Outpatient Hospital Providers, Physician Clinics, Physicians, Psychologists, HMOs and Other Managed Care Programs

Mental Health and Substance Abuse 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 mental health and substance abuse 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

Mental health and substance abuse services covered under the Standard Plan are the same as those covered under the current Wisconsin Medicaid program. Refer to the

appropriate publications for more information on covered services, coverage limitations, policies, and procedures.

Benchmark Plan

Mental health and substance abuse services covered under the Benchmark Plan include all of the following:

- Child/adolescent mental health day treatment. (This service is known as HealthCheck "Other Services" child/adolescent day treatment under Wisconsin Medicaid and the Standard Plan.)
- Inpatient hospital stays for mental health and substance abuse treatment at acute care general hospitals and institutes for mental disease (IMD). Refer to the December 2007 *Update* (2007-107), titled "Inpatient and Outpatient Hospital Services Under BadgerCare Plus," for additional information about hospital stays.
- Mental health day treatment for adults.
- Narcotic treatment.
- Outpatient mental health.
- Outpatient substance abuse.
- Substance abuse day treatment for adults and children.

For those mental health and substance abuse services covered under the Benchmark Plan, policies and procedures are the same as they are under the current Wisconsin Medicaid program except for the service limitations described later in this *Update*. Refer to the appropriate publications for more information on covered services, coverage limitations, policies, and procedures.

The following mental health and substance abuse services **are not covered** under the Benchmark Plan:

- Community Support Program services.
- Comprehensive community services.
- Crisis intervention.
- In-home mental health and substance abuse services for children.
- Outpatient services in the home and community for adults.

Note: Clozapine management is a covered service under the Benchmark Plan but is not considered part of mental health and substance abuse services. Refer to the January 2008 *Update* (2008-03), titled "Clozapine and Clozapine Management Services Under BadgerCare Plus," for more information about clozapine management.

Service Limitations for the Benchmark Plan

Under the Benchmark Plan, mental health and substance abuse services are subject to specified dollar amount service limitations. Dollar amount service limitations are applied per member per enrollment year. Services provided after a member's coverage exceeds a dollar limit are considered **noncovered**.

The dollar amount limits are as follows:

- $7,000.00 — Overall dollar amount limit for **all** substance abuse services. (Reimbursement for mental health services counts toward this limit.)
- $4,500.00 — Dollar amount limit for non-hospital substance abuse services. Substance abuse day treatment is also subject to a $2,700.00 limit within this category.
- $6,300.00 — Dollar amount limit for inpatient hospital stays for substance abuse treatment at an acute care general hospital.

Note: Dollar amount limits are calculated using the reimbursement paid by the Benchmark Plan for services. The reimbursement amount for a service is the lesser of the provider's usual and customary charge or the current Wisconsin Medicaid maximum allowable fee for covered services.

The overall dollar amount limit of $7,000.00 is calculated from reimbursement paid for all mental health and substance abuse services covered under the Benchmark Plan. After a member has received $7,000.00 worth of treatment, **all substance abuse services are considered noncovered**. Mental health services are not restricted by dollar amount limits. In most cases, mental health services are still covered after the $7,000.00 overall dollar amount limit has been reached. (Inpatient hospital stays for mental

health treatment may not be covered. The service limitations for hospital stays are explained later in this section.)

Within the $7,000.00 overall dollar amount limit, all non-hospital substance abuse services are subject to an additional $4,500.00 limit. Non-hospital substance abuse services counted toward the $4,500.00 limit include all three of the following:

- Narcotic treatment.
- Outpatient substance abuse.
- Substance abuse day treatment (up to $2,700.00).

Within the $4,500.00 limit, substance abuse day treatment will only be covered up to $2,700.00. After reimbursement for non-hospital services exceeds $2,700.00, substance abuse day treatment is considered **noncovered**. All three of the above services will be covered up to $2,700.00. Outpatient substance abuse and narcotic treatment services will continue to be covered up to $4,500.00. After the $4,500.00 limit has been reached, **all non-hospital substance abuse services are considered noncovered.**

Reimbursement by the Benchmark Plan for non-hospital substance abuse services also counts toward the $7,000.00 overall dollar amount limit. Services that exceed the $7,000.00 limit are considered noncovered even if the other limits have not been reached.

Inpatient hospital stays for substance abuse treatment at an acute care general hospital are subject to a dollar amount limit of $6,300.00. After reimbursement exceeds $6,300.00, inpatient hospital stays for substance abuse treatment at a general hospital are considered **noncovered**.

Reimbursement by the Benchmark Plan for hospital services also counts toward the $7,000.00 overall dollar amount limit. Services that exceed the $7,000.00 limit are considered noncovered even if other applicable limits have not been reached.

Inpatient hospital stays for mental health and substance abuse treatment are subject to a service limitation of 30 days per member per enrollment year. Additional days of inpatient hospital services are considered **noncovered**. The 30-day service limitation applies to inpatient hospital days in a general hospital or an IMD. This is the only service limitation that restricts coverage of mental health services.

Providers should refer to Attachment 1 of this *Update* for an additional explanation of the service limitations for mental health and substance abuse services under the Benchmark Plan. Attachment 2 includes examples of how the limits apply in different scenarios.

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.

Prior Authorization

Prior authorization policy and procedures are the same under the Standard Plan and the Benchmark Plan as they are under the current Wisconsin Medicaid program.

Reimbursement

Terms of Reimbursement

The terms of reimbursement (TOR) for mental health and substance abuse services have been revised for BadgerCare Plus. Refer to Attachment 3 for the Mental Health/Substance Abuse Services Terms of Reimbursement for mental health and substance abuse service providers. The TOR describes how BadgerCare Plus will reimburse providers for services rendered. The conditions outlined in the TOR will automatically take effect; providers do not need to resubmit certification materials.

Standard Plan

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

Benchmark Plan

Providers will be reimbursed for services provided to Benchmark Plan members at the lesser of the provider's usual and customary charge or the current Wisconsin Medicaid maximum allowable fee until the member reaches any of his or her dollar amount service limitations for the enrollment year.

If BadgerCare Plus covers any portion of the service charges, providers are required to accept the BadgerCare Plus allowed reimbursement, which is the lesser of the provider's usual and customary charge 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 service limitation, providers can balance bill the member for the difference between the allowed reimbursement and the dollar amount actually paid by BadgerCare Plus.

If a member has already met or exceeded a dollar amount service limitation, 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.

Copayments

Standard Plan

Copayment amounts under the Standard Plan are the same as they are under the current Wisconsin Medicaid program. Refer to previously published service-specific publications for more information on copayment amounts.

Policy regarding 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 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 FPL.

Under the Standard Plan, providers **cannot** deny a service if a member fails to make his or her copayment.

Benchmark Plan

Under the Benchmark Plan, copayment for mental health and substance abuse services is applied on a **per visit** basis. A visit is defined as all services delivered on the same date of service by the same performing provider. A single copayment applies regardless of the number or type of procedures and services administered during the visit. There are no limits on copayments for mental health and substance abuse services under the Benchmark Plan.

Copayment amounts for mental health and substance abuse services under the Benchmark Plan are as follows:

- All day treatment services (substance abuse and mental health for adults and children) — $10.00 per day.
- Inpatient hospital — $50.00 per hospital stay. During an inpatient hospital stay for mental health or substance abuse, no other copayments will apply.
- Narcotic treatment services — $15.00 per visit. Lab tests do not require a copayment.
- Outpatient mental health services — $15.00 per visit. Electroconvulsive therapy and pharmacological management do not require copayments.
- Outpatient substance abuse services — $15.00 per visit.

If the BadgerCare Plus reimbursement for the visit or procedure is less than the copayment amount listed above, the member must be charged the lesser amount. For example, suppose a member has a narcotic treatment visit for dosing and dosing is the only procedure performed at the visit. If the dosing costs $10.00 and the copayment for the visit is set at $15.00, the member must be charged the lesser amount ($10.00).

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.

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 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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ATTACHMENT 1
Service Limitations for Mental Health and Substance Abuse Services Covered Under the BadgerCare Plus Benchmark Plan

The following tables describe the service limitations for all mental health and substance abuse services covered under the BadgerCare Plus Benchmark Plan. All service limitations are applied per member per enrollment year.

Reimbursements by the Benchmark Plan for covered services are counted toward the dollar amount limits. Reimbursement will be the lesser of the provider's usual and customary charge and the maximum allowable fee for the service.

TABLE 1: Overall Dollar Amount Limit for Substance Abuse Services Covered Under the Benchmark Plan

Overall Dollar Amount Limit	Services Counted Toward the Overall Dollar Amount Limit	How to Apply the Overall Dollar Amount Limit
$7,000.00	All covered mental health services*, including the following: • Child/adolescent mental health day treatment. • Inpatient hospital stays for mental health treatment at acute care general hospitals and institutes for mental disease (IMD). • Mental health day treatment for adults. • Outpatient mental health services. All covered substance abuse services**, including the following: • Inpatient hospital stays for substance abuse treatment at acute care general hospitals and IMDs. • Narcotic treatment. • Outpatient substance abuse services. • Substance abuse day treatment.	After the $7,000.00 limit is reached, all additional substance abuse services are considered **noncovered**.

* After the $7,000.00 limit is reached, most mental health services are still covered under the Benchmark Plan. See Table 3 of this attachment for more information about service limitations for mental health services.

** The tables on the following pages explain other dollar amount limits that may further restrict coverage of substance abuse services.

TABLE 2: Dollar Amount Limits for Non-Hospital Substance Abuse Services Covered Under the Benchmark Plan		
Dollar Amount Limit	**Services Counted Toward the Dollar Amount Limit**	**How to Apply the Dollar Amount Limit**
$4,500.00 — All non-hospital substance abuse services **$2,700.00** — Substance abuse day treatment services	Non-hospital substance abuse services, including the following: • Narcotic treatment services. • Outpatient substance abuse services. • Substance abuse day treatment for adults and children.	After $2,700.00 has been spent on non-hospital substance abuse services, **substance abuse day treatment will not be covered**. After the $4,500.00 limit is reached, all additional non-hospital substance abuse services are considered **noncovered**. These dollars count towards the $7,000.00 overall dollar amount limit. Non-hospital substance abuse services that exceed the $7,000.00 limit are considered **noncovered** even if the other limits have not been reached.

TABLE 3: Service Limitations for Inpatient Hospital Stays for Mental Health and Substance Abuse Treatment Covered Under the Benchmark Plan		
Service Limitation	**Services Counted Toward the Service Limitation**	**How to Apply the Service Limitation**
30 days inpatient hospital treatment	All inpatient hospital stays for mental health and substance abuse treatment, such as the following: • Inpatient hospital stays for mental health treatment at an acute care general hospital or an IMD. • Inpatient hospital stays for substance abuse treatment at an acute care general hospital or an IMD.	After the 30-day limit is reached, all additional inpatient hospital stays for mental health and substance abuse treatment are considered **noncovered**. The 30-day limit for inpatient hospital stays is the **only** service limitation that might result in a noncovered mental health service under this plan.

TABLE 3: Service Limitations for Inpatient Hospital Stays for Mental Health and Substance Abuse Treatment Covered Under the Benchmark Plan (Continued)		
Service Limitation	**Services Counted Toward the Service Limitation**	**How to Apply the Service Limitation**
$7,000.00 — Overall dollar amount limit*	All covered mental health and substance abuse services, including the following: • Inpatient hospital stays for mental health treatment at an acute care general hospital or an IMD. • Inpatient hospital stays for substance abuse treatment at an acute care general hospital or an IMD. • All other covered mental health and substance abuse services (i.e., outpatient treatment and day treatment).	After the $7,000.00 limit is reached, all additional substance abuse services are considered **noncovered**. After the $7,000.00 overall dollar limit is reached, additional mental health services are covered unless an inpatient hospital stay for mental health treatment exceeds the 30-day limit listed above.
$6,300.00 — Inpatient substance abuse dollar limit for acute care general hospitals	Inpatient hospital stays for substance abuse treatment at a general hospital only.	After the $6,300.00 limit is reached, all additional inpatient hospital substance abuse services at general hospitals are considered **noncovered**. Hospital stays for substance abuse treatment are also subject to a 30-day limit; these services may be considered uncovered if either limit has been reached.

* Information about the overall dollar amount limit is also summarized on Table 1 of this attachment.

ATTACHMENT 2
Applying the Service Limitations for Mental Health and Substance Abuse Services Covered Under the BadgerCare Plus Benchmark Plan

This table describes how service limitations may apply to a BadgerCare Plus Benchmark Plan member's coverage for mental health and substance abuse services. All service limitations are calculated per member per enrollment year.

Examples for Applying the Benchmark Plan Service Limitations
Scenario 1: Mental Health Services A 16-year-old member enrolled in the Benchmark Plan receives mental health services: • The member is hospitalized for three days and receives $5,000.00 worth of inpatient mental health treatment. • The member is discharged from the hospital and enters child/adolescent mental health day treatment. She receives $2,000.00 worth of day treatment. • The total dollar amount paid for this member is now $7,000.00. For the duration of the enrollment year: • Most mental health services will be covered for this member as necessary; however, the member only has 27 days of inpatient mental health treatment before she reaches the 30-day service limitation and her hospital stays for mental health are considered noncovered. • Any substance abuse services that the member might require are not covered because she has already reached the $7,000.00 overall dollar amount limit for this enrollment year.
Scenario 2: Substance Abuse Services A member enrolled in the Benchmark Plan has a diagnosis of alcohol dependence and receives substance abuse treatment: • The member receives $1,700.00 worth of outpatient substance abuse treatment. • The member subsequently enters substance abuse day treatment. He receives $1,000.00 worth of day treatment services. • The total dollar amount paid for this member is now $2,700.00. This amount accumulates toward both the overall dollar amount limit of $7,000.00 and the non-hospital substance abuse dollar limits. For the duration of the enrollment year: • The member has reached the $2,700.00 limit that restricts substance abuse day treatment services. Any further substance abuse day treatment services will not be covered. • The member still has $1,800.00 worth of other outpatient substance abuse coverage available. • If the member requires mental health treatment at any point, the mental health services will be covered; however, the amount paid for them will accumulate toward the $7,000.00 overall dollar amount limit and may restrict substance abuse service coverage if the $7,000.00 limit is exceeded.

Examples for Applying the Benchmark Plan Service Limitations

Scenario 3: Hospitalization

A member enrolled in the Benchmark Plan has a substance abuse problem that requires hospitalization:

- The member is admitted as an inpatient to an acute care general hospital for substance abuse treatment. Within five days, he has received $6,500.00 worth of inpatient treatment and is released from the hospital.
- The dollar amount limit for inpatient substance abuse treatment at an acute care general hospital is $6,300.00 so the member is responsible for the additional $200.00. The member only has $500.00 left until he reaches his overall dollar amount limit for the enrollment year.
- The member follows up his hospitalization with outpatient substance abuse counseling.

For the duration of the enrollment year:

- The member could receive up to $500.00 worth of substance abuse treatment, such as the outpatient substance abuse counseling, day treatment services, or a hospital stay in an IMD. After that, all further substance abuse treatment is considered noncovered.
- The five days in the general hospital also count toward the inpatient mental health service limitation. If the member requires a hospitalization for mental health treatment, he has 25 days of available coverage before he reaches the 30-day limit.

Scenario 4: Mental Health Services, Substance Abuse Services, and Reimbursement

A member enrolled in the Benchmark Plan seeks help for depression, an opiate addiction, and alcohol dependence. She receives both mental health and substance abuse services:

- The member is briefly hospitalized for depression and receives $4,000.00 worth of inpatient mental health treatment.
- The member enters outpatient mental health treatment after her hospital stay. The member simultaneously receives narcotic treatment services for an opiate addiction. The amount paid toward the outpatient mental health treatment totals $1,000.00. The narcotic treatment totals $500.00. She has now received $5,500.00 worth of treatment.
- The member is diagnosed with alcohol dependence and enters substance abuse day treatment to manage her substance abuse problems. The amount paid toward substance abuse day treatment is $1,000.00. The member continues her mental health counseling, which totals an additional $700.00. The member has now expended a total of $7,200.00 on mental health and substance abuse services.

Reimbursement procedures for this situation are as follows:

- The mental health provider in the previous bullet point submitted a claim for services before the day treatment provider. The member had received $5,500.00 worth of treatment before these two services were billed.
- The mental health provider's claim is processed first and the provider is reimbursed in full. That brings the total reimbursement to $6,200.00.
- The substance abuse day treatment provider is only reimbursed for $800.00, which is the amount remaining before the overall dollar amount limit ($7,000.00) is reached.
- The member can be balance billed for the difference between the Benchmark Plan reimbursement rate and the amount paid by the Benchmark Plan. (In this case, $1,000.00 reimbursement - $800.00 paid = $200.00 billed to the member.)

Examples for Applying the Benchmark Plan Service Limitations

Scenario 4: Mental Health Services, Substance Abuse Services, and Reimbursement (Continued)

For the duration of the enrollment year:

- Any further substance abuse services will not be covered. Even though the dollar limits for inpatient hospital stays for substance abuse and for non-hospital substance abuse services have not been reached, coverage has exceeded the overall dollar amount limit of $7,000.00.
- Mental health services will still be covered as long as the member does not exceed her 30-day limit on inpatient hospital days.

ATTACHMENT 3
Mental Health/Substance Abuse Services Terms of Reimbursement

(A copy of the "Mental Health/Substance Abuse Services Terms of Reimbursement" is located on the following pages.)

DIVISION OF HEALTH CARE ACCESS AND ACCOUNTABILITY
WISCONSIN MEDICAID AND BADGERCARE
PROVIDER SERVICES
6406 BRIDGE ROAD
MADISON WI 53784

Telephone: 800-947-9627
608-221-9883
dhfs.wisconsin.gov/medicaid
dhfs.wisconsin.gov/badgercare

Jim Doyle
Governor

Kevin R. Hayden
Secretary

State of Wisconsin

Department of Health and Family Services

MENTAL HEALTH/SUBSTANCE ABUSE SERVICES
TERMS OF REIMBURSEMENT

For mental health and/or substance abuse outpatient services (including services provided by Ph.D. psychologists, Master's-level therapists, Alcohol and Other Drug Abuse counselors, narcotic treatment service nurses), mental health day treatment for adults, substance abuse day treatment, and HealthCheck "Other Services" in the mental health and/or substance abuse areas:

- The Department of Health and Family Services (DHFS) will establish maximum allowable fees for all covered services provided to Medicaid recipients eligible on the date of service (DOS). The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to Medicaid, the Wisconsin Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.
- For each covered service, the DHFS shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the DHFS. Medicaid reimbursement, minus appropriate copayments and payments by other insurers, will be considered to be payment in full.
- If the BadgerCare Plus Benchmark Plan reimburses any portion of the charges for the service, providers generally must accept the lesser of the provider's usual and customary charge or the maximum allowable fee as payment in full and may not charge the member for any part of the difference between the Benchmark Plan payment and the provider's costs or usual charges. However, providers can charge the member above the amount paid by the Benchmark Plan in one situation: when payment of a claim filed by a provider for a particular service will cause a reimbursement limit under the Benchmark Plan to be exceeded. In these circumstances, the provider may charge the member only for the difference between the amount of reimbursement allowed due to application of the limit and the dollar amount normally paid by the Benchmark Plan. The provider may not charge the member any amount above the normal BadgerCare Plus reimbursement rate for the service.

For crisis intervention services, community support program services, comprehensive community services, and mental health and/or substance abuse outpatient services in the home or community:

- The DHFS will establish contracted rates for all covered services provided to Medicaid recipients eligible on the DOS. The contracted rates are applicable to all service components provided for certified agencies by providers under contract to that agency. The contracted rates shall be based on various factors, including provider costs submitted to Wisconsin Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Contracted rates may be adjusted to reflect reimbursement limits or limits on the availability of federal funding as specified in federal law.

- Providers will be reimbursed by Wisconsin Medicaid only for that portion of allowable costs for which federal financial participation is available. The state share will come from non-federal funds or federal funds authorized for use as match to other federal funds available to the agency. The agency will be responsible for maintaining an audit trail to document their contribution of this state share.

For services covered in this reimbursement:

- Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.
- The DHFS will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to ch. 49, Wis. Stats.
- Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with s. 49.46(2)(c), Wis. Stats.
- In accordance with federal regulations contained in 42 CFR 447.205, the DHFS will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting rates for services.