ForwardHealth
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Affected Programs: BadgerCare Plus, Medicaid
To: All Providers, HMOs and Other Managed Care Programs

Billing Members for Covered and Noncovered Services Under the BadgerCare Plus Core Plan for Childless Adults

The BadgerCare Plus Core Plan for Childless Adults will be implemented on January 1, 2009, as part of Wisconsin's comprehensive health care reform. This *ForwardHealth Update* describes coverage and policies for billing members for covered and noncovered services under the Core Plan.

Because of the recent downturn in the national economy, the expansion of the Core Plan will be implemented in phases. Phase I, which includes individuals already enrolled in Milwaukee County's General Assistance Medical Program (GAMP) and other counties' general assistance medical programs, will begin on January 1, 2009. The timeframe for adding new phases will be determined as the Department of Health Services moves forward.

Refer to the December 2008 *Update* (2008-199), titled "Introducing the BadgerCare Plus Core Plan for Childless Adults," for general information on covered and noncovered services, reimbursement, copayment, and enrollment.

BadgerCare Plus Core Plan Overview

The BadgerCare Plus Core Plan for Childless Adults covers basic health care services including primary and preventive care, generic drugs, and a limited number of brand name prescription drugs.

In Milwaukee County, members will receive benefits under the Core Plan on a fee-for-service basis from January 1, 2009, through March 31, 2009. Effective April 1, 2009, Core Plan members in Milwaukee County will be enrolled in the state-contracted HMOs that serve Wisconsin's Medicaid and BadgerCare Plus population. Members will be sent enrollment choice materials beginning in January 2009 and will enroll through Automated Health Systems, Inc., the State's enrollment broker, as they currently do with the BadgerCare Plus population.

Individuals that are converting to the Core Plan from non-Milwaukee County general assistance (GA) programs will receive their Core Plan benefits on a fee-for-service basis.

All members enrolled in the Core Plan will receive a ForwardHealth identification card.

Billing Members for Covered Services

Policy and procedures for billing members for services covered under the Core Plan are the same as they are under the BadgerCare Plus Standard Plan. Refer to the Online Handbook on the ForwardHealth Portal at *www.forwardhealth.wi.gov/* for information about covered services, policies, and procedures.

Billing Members for Noncovered Services

Some services are never covered by the Core Plan. Other services are not covered after a certain service limitation is reached. Refer to the December 2008 *ForwardHealth Update* (2008-199), titled "Introducing the BadgerCare Plus Core Plan for Childless Adults," or service-specific Core Plan *Updates* for more information about services that are not covered by the Core Plan.

Core Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service 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.

Core Plan Service Limitations and Billing Requirements

Services with Visit Limitations per Enrollment Year

Under the Core Plan, therapy visits (i.e., physical therapy, occupational therapy, and speech and language pathology) are covered until a member reaches a specified number of visits or days of service per enrollment year.

Visits that exceed the service limitations established by the Core Plan are not covered. 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 Core 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 not covered by the Core Plan.

If BadgerCare Plus reimburses any portion of the charges for the service, providers are required to accept the Core Plan 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 reimburses 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 reimbursed by BadgerCare Plus.

For example, the Core Plan reimburses up to $2,500.00 for durable medical equipment (DME) per member, per enrollment year. If a member has expended $2,200.00 of his or her DME coverage and requires a new DME item, the allowed reimbursement for this DME item will be $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 the Core Plan

For persons who transition from GA or a General Assistance Medical Program (GAMP), the Core Plan enrollment year will be a continuous period of enrollment that begins on January 1, 2009, and ends during January, February, or March of 2010. (The earliest end date for the enrollment year would be January 1, 2010, and the latest end date would be March 31, 2010.) The enrollment year is staggered over three months to allow adequate time for the Department of Health Services to process renewal applications.

If a member who transitioned from GA or GAMP loses eligibility for the Core Plan, that member cannot re-enroll in the Core Plan until the plan becomes available for new members.

If the member becomes eligible for and switches into the Benchmark Plan, the member's enrollment year will reset under the Benchmark Plan.

Copayments

Under the Core Plan, providers can bill a member for a noncovered service and deny services if the member fails to pay the copayment amount. Members enrolled in HMOs are subject to copayment for services.

For services with nominal copayments, copayments will range from $0.50 to $3.00. Copayments are applied the same way they are applied under the Standard Plan. Generally, the amount of the copayment is based on the maximum reimbursement for the service. The following table shows the ranges.

Maximum Fee	Copayment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

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

Enrollment Verification

It is imperative that providers verify a member's enrollment to determine if they are covered and in which plan the member is enrolled. Providers are reminded to *always* verify a member's enrollment *before* providing services, both to determine that the individual is enrolled for the current date and to discover any limitations to the member's coverage. Providers have several options to obtain enrollment information through Wisconsin's Enrollment Verification System and should refer to the Online Handbook for more information. Refer to the December 2008 *Update* (2008-200), titled "Member Enrollment Verification for BadgerCare Plus Core Plan for Childless Adults," for more information.

For More Information

For more information or questions regarding the Core Plan, providers may call Provider Services at (800) 947-9627.

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

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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