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

Inpatient and Outpatient Hospital Services Covered 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 the coverage and policies for inpatient and outpatient hospital services under the Core Plan.

As a result of the recent downturn in the national economy, the expansion of the Core Plan will be implemented in phases. Phase I, which includes individuals currently 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 about 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.

Covered and Noncovered Services

Outpatient hospital services, including emergency room services, covered under the Core Plan are the same as those covered under the BadgerCare Plus Standard Plan, with the following exceptions:

- Outpatient substance abuse services are only covered when a physician is the rendering provider.
- Outpatient mental health services are only covered when the rendering provider is a psychiatrist.

This policy will be reviewed on a post-pay basis. Providers should refer to the December 2008 *ForwardHealth Update* (2008-202), titled "Coverage of Certain Medical Services Under the BadgerCare Plus Core Plan for Childless Adults," for more information.

Inpatient hospital services covered under the Core Plan are the same as those covered under the Standard Plan, with one exception. A hospital stay in an acute care hospital or an Institute for Mental Disease when the member has an admitting diagnosis of either mental illness or substance abuse is not covered by the Core Plan.

Refer to the Online Handbook on the ForwardHealth Portal for covered services, policies, and procedures.

Prior Authorization

Prior authorization (PA) policy and procedures are the same under the Core Plan as they are under the Standard Plan.

Providers are required to obtain PA separately for the Core Plan, the Standard Plan, and the Benchmark Plan for the same or similar services. If a member's enrollment status changes, PA granted under one plan will not be valid for the other plans. Providers are required to submit new PA requests in these cases to obtain a valid PA for the member. Separate PAs are required due to differences in coverage between the Core Plan, the Standard Plan, and the Benchmark Plan.

Reimbursement

Providers will be reimbursed for services provided to members enrolled in the Core Plan using the same pricing methodology used by Wisconsin Medicaid.

Copayments

The following copayment amounts apply for Core Plan members:

- Emergency room services — No copayment.
- Inpatient hospital services — $3.00 per day, with a limit of $75.00 per hospital stay.
- Outpatient hospital services — $3.00 per visit. A visit is defined as all services provided by the same rendering provider on the same date of service, regardless of the number or type of procedures administered.

Copayment for all inpatient and outpatient hospital services is capped at $300.00 per member, per enrollment year.

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

Enrollment Year Under the Core Plan

For persons that transition from GA or 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.

Enrollment Verification

It is imperative that providers verify a member's enrollment to determine if the member is covered and the plan in which 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.

Enrollment or Disenrollment Between BadgerCare Plus Plans During a Hospital Stay

Providers are required to follow the policies, procedures, and cost sharing of the plan the member was enrolled in on the first day of the hospitalization admittance even if the member changes plans mid-stay.

For example, a member enrolled in the Core Plan is admitted to the hospital on March 30, 2009. The member switches from the Core Plan to the Standard Plan as of April 1, 2009, and is discharged from the hospital on April 3, 2009. The provider should follow the policies and procedures for hospitalization under the Core Plan for the entire hospitalization. The member is responsible for copayments under the Core Plan.

Hospitalization in this section is defined as an inpatient stay at a certified hospital as defined in HFS 101.03(76), Wis. Admin. Code. Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

Coverage for Members Transitioned from General Assistance or Milwaukee County General Assistance Medical Program

If a member was transitioned from GA or GAMP into the Core Plan and the discharge date for a hospitalization is on or after January 1, 2009, the hospital stay will be covered by Core Plan fee-for-service. Hospital providers may submit the claim to fee-for-service for reimbursement.

If a member who was transitioned from GA or GAMP is admitted to a hospital between January 1, 2009, and March 31, 2009, the hospital stay will be covered by fee-for-service, regardless of the date of discharge.

If a member who was transitioned from GA or GAMP is admitted to a hospital on or after April 1, 2009, reimbursement for the hospital stay will be the responsibility of the HMO if the member is enrolled in an HMO. If the member is not enrolled in an HMO, providers should submit the claim to fee-for-service.

For More Information

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