

**Affected Programs:** BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, Medicaid

**To:** Case Management Providers, HMOs and Other Managed Care Programs

## **New Comprehensive Care Coordination Benefit for Members with Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome**

This *ForwardHealth Update* provides information on a new comprehensive care coordination benefit for members diagnosed with Human Immunodeficiency Virus infection or Acquired Immune Deficiency Syndrome. The new benefit was created by 2009 Wisconsin Act 221 and will be effective for dates of service on and after October 1, 2012.

This *ForwardHealth Update* provides information on a new comprehensive care coordination benefit for members diagnosed with Human Immunodeficiency Virus (HIV) infection or Acquired Immune Deficiency Syndrome (AIDS). The new benefit was created by 2009 Wisconsin Act 221 and will be effective for dates of service (DOS) on and after October 1, 2012. It will be available to eligible members who are enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, or Wisconsin Medicaid.

Providers who render services under the new benefit will be located in Milwaukee, Kenosha, Dane, and Brown counties once the Wisconsin Department of Health Services (DHS) determines that a provider meets the requirements outlined under the Health Home Provider Requirements subsection of this *Update*. Services will *not* be restricted based on a member's county of residence.

The following information about the new benefit is included in this *Update*:

- Use of a health home model.
- Qualifying providers.
- Eligible members.
- Member outreach and communication.
- Members' freedom of choice.
- Covered health home services.
- Frequency of member contacts.
- Reimbursement.
- Limitations.
- Program evaluation and data reporting.
- Program monitoring, review, and audit activities.

### **Use of Health Home Model**

The new care coordination benefit for members diagnosed with HIV infection or AIDS will be established using a patient-centered health home model as described under s. 1945 of the Social Security Act. Health homes provide comprehensive care coordination for individuals with chronic conditions. Health home providers coordinate care across all health care settings, including medical, behavioral, dental, pharmaceutical, and institutional. They also coordinate care between health and community care settings.

Covered health home services for members diagnosed with HIV infection or AIDS will include all of the following:

- Comprehensive care management.
- Care coordination, monitoring, and follow-up.
- Health promotion and self-care.
- Comprehensive transitional care.
- Member and family support (including authorized representatives).
- Referral to community and social support services, as appropriate.

These services are described in greater detail in the Covered Health Home Services section of this *Update*.

*Note:* Members will continue to receive other covered Medicaid and BadgerCare Plus services on a fee-for-service basis. Providers should refer to the appropriate service area of the Online Handbook on the ForwardHealth Portal for related coverage and reimbursement policies.

## Qualifying Providers

Providers qualified to offer the new care coordination benefit for members diagnosed with HIV infection or AIDS are Medicaid-enrolled targeted case management providers funded by the DHS under s. 252.12(2)(a)8, Wis. Stats., for purposes of providing life care services to members diagnosed with HIV infection.

Qualified providers in the selected counties are required to submit written proof that they meet the requirements outlined under the Health Home Provider Requirements subsection of this *Update* if they would like to offer these services to members. The DHS will then evaluate and make a determination as to whether the provider meets these requirements.

*Note:* Medicaid-enrolled providers who offer the new benefit will continue to be required to meet all other Medicaid or BadgerCare Plus program requirements.

## Health Home Provider Requirements

Under the new care coordination benefit for members diagnosed with HIV infection or AIDS, qualifying health home providers are subject to a number of system, documentation, and quality assurance requirements. To meet these requirements, health home providers are required to comply with all three of the following criteria:

1. Be located in a setting that integrates medical, behavioral health, pharmaceutical, oral health, and psychosocial care.
2. Be accredited by a nationally recognized accreditation program as a patient-centered health home, or meet the requirements detailed below:
  - Have systems and infrastructure in place to provide comprehensive health home services (as required under the Covered Health Home Services section of this *Update*) to members diagnosed with HIV infection or AIDS.
  - Provide written support, from the highest level of the provider organization, for coordinated care through the use of a health home model.
  - Meet all of the qualification standards outlined below:
    - ✓ Adopt written standards, based on best practices, for member access and member communication.
    - ✓ Use data to show that standards for member access and member communication are being met.
    - ✓ Use electronic charting tools to organize clinical information.
    - ✓ Use data to identify diagnoses and conditions among individual providers' patients that have a lasting detrimental effect on health.
    - ✓ Adopt and implement guidelines that are based on evidence for treating and managing HIV- and AIDS-related conditions.
    - ✓ Actively support and promote member self-management.
    - ✓ Systematically track member test results, and have a systematic way to identify abnormal member test results.

- ✓ Establish procedures to systematically accept referrals from hospitals (inpatient and outpatient) that treat individuals diagnosed with HIV infection or AIDS.
  - ✓ Systematically track referrals using an electronic system.
  - ✓ Measure the quality of the performance of individual providers, and of individuals who perform services on behalf of these providers. This includes measuring the provision of clinical services, member outcomes, and member safety.
  - ✓ Report on the quality of the performance of individual providers, and of individuals who perform services on behalf of these providers. These reports should be made available to employees and contractors of the provider, as well as other persons, as appropriate.
3. Agree to the following practices in providing services:
- Provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health home services.
  - Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
  - Coordinate and provide access to preventive and health promotion services, including services to help prevent mental illness and substance use disorders.
  - Coordinate and provide access to medication management and mental health and substance abuse services.
  - Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
  - Coordinate and provide access to chronic disease management, including self-management support to members and their families.
  - Coordinate and provide access to member and family supports, including referral to community, social support, and recovery services.
  - Coordinate and provide access to long-term care supports and services.
  - Develop a patient-centered care plan for each member that coordinates and integrates all of his or her clinical and non-clinical health-care-related needs and services.
  - Use health information technology, as feasible and appropriate, to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to providers.
  - Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management. (*Note: The DHS will identify specific quality indicators and specific outcomes to be measured in a separate communication to the provider.*)

### ***Requirements for Core Team***

Health home providers will be required to identify a core team of health care professionals for each member that includes professionals who are experienced in the care and treatment of individuals diagnosed with HIV infection or AIDS. The member's primary health care provider (physician, physician assistant, or nurse practitioner) is *required* to be a part of the core team.

At a minimum, the core team must also include the following professionals:

- A registered nurse.
- A social worker or nurse case manager.
- A mental health or substance abuse professional.
- A dentist.
- A pharmacist.

The core team will be central to the initial comprehensive assessment, annual reassessments, and the development of the care plan. The team should include other professionals

as dictated by the member's health status and social and personal situation.

### *Designation of a Team Lead and Care Coordinator*

From the group of core team members, health home providers will be required to designate a team lead and a care coordinator. The role of the team lead will include, but will not be limited to, the following:

- Ensuring that the member's care and treatment needs are addressed using a multidisciplinary team approach. This includes identifying individuals the member deems central to addressing his or her health care and social services needs.
- Ensuring that the member is at the center of the team and is identified as an active and informed participant in his or her own care.
- Ensuring that the member and providers on the team know each other.
- Ensuring that the role and responsibility of each person on the team is defined for the member.
- Ensuring that there is communication, consultation, and coordination among individuals on the team. For example, the team lead is required to ensure that team members share information regarding the member's care, treatment, medications prescribed, and recommended self-care.
- Ensuring that each member has an identified care coordinator.

The team lead and the care coordinator can be the same individual.

The responsibilities of the care coordinator are outlined under the Care Coordination, Monitoring, and Follow-up section of this *Update*.

### **Eligible Members**

Members eligible for the new care coordination benefit are those members enrolled in the BadgerCare Plus Standard Plan, BadgerCare Plus Benchmark Plan, BadgerCare Plus Core Plan, or Wisconsin Medicaid who have a diagnosis of

HIV infection and who meet one of the following two criteria:

1. Are infected with HIV and have at least one other chronic condition. Chronic conditions include, but are not limited to, the following:
  - Mental health conditions.
  - Substance use disorders.
  - Asthma.
  - Diabetes.
  - Heart disease.
  - Being overweight (having a body mass index [BMI] greater than 25 kg/m<sup>2</sup>).
2. Are infected with HIV and are at risk of having a second chronic condition. Members "at risk" for developing a second chronic condition include:
  - Members having a CD4 (T-cell) count of less than 200 cells/ $\mu$ L or CD4 cells accounting for fewer than 14 percent of all lymphocytes.
  - Members with a BMI less than 18.5 kg/m<sup>2</sup>.
  - Members whose fasting plasma blood sugar is 100-125 mg/dL or hemoglobin A1c 5.7 percent to 6.4 percent.
  - Members with systolic pressure between 120 and 139 mm Hg or diastolic pressure between 80 and 89 mm Hg.
  - Members with hyperlipidemia:
    - ✓ Total cholesterol greater than 200 mg/dL.
    - ✓ High-density lipoprotein levels below 40 mg/dL for men and below 50mg/dL for women.
    - ✓ Low-density lipoprotein levels above 130 mg/dL.

Health home providers are required to retain documentation showing both of the following:

- The member's eligibility for health home services.
- That the member requires comprehensive care management services to attain or maintain stability and optimal health status. This includes care coordination to prevent progression of the disease, deterioration, or gaps in care.

*Note:* For the purposes of this benefit, a chronic condition is defined as one that has lasted at least six months, can reasonably be expected to continue for six months, or is likely to recur.

### **Members Not Eligible**

Coverage for coordinated care under the new benefit will *not* be available to any member who is:

- Receiving targeted case management services.
- Receiving prenatal care coordination services.
- Participating in a home and community-based (1915[c]) waiver program.
- Enrolled in an HMO or other managed care program. (*Note:* Members interested in this benefit who are enrolled in an HMO will need to disenroll from the HMO in order to participate in this benefit.)
- Residing in an institution, unless the care is provided within 30 days from the date of discharge.

### **Member Outreach and Communication**

Health home providers will be responsible for member outreach and communication. Outreach and communication efforts will include, but will not be limited to, the following:

- Identifying potential eligible members.
- Educating members regarding the enrollment process and freedom of choice. Freedom of choice includes allowing the member to decide between receiving health home services or other case management/care coordination services.
- Contacting enrolled members to explain the patient-centered health home model of care. Communication with the member should be made in language that is clear, straightforward, and culturally appropriate.
- Explaining the patient-centered health home model to other health care providers and the community, as appropriate.

*Note:* There is no separate reimbursement for outreach and communication activities.

### **Members' Freedom of Choice**

Health home providers will be able to automatically enroll any member meeting the eligibility criteria; however, providers will be required to explicitly inform members, in writing and verbally, that their participation in the health home is voluntary and that they have the right to “opt out” at any time.

Health home providers will be required to assist members in making an informed decision regarding continued participation in the health home. If a member is receiving targeted case management or prenatal care coordination services, the health home provider will be required to specifically notify the member that he or she will need to make a choice between those services and health home services. Members agree to health home services by actively participating in the development and execution of the care plan and by maintaining contact with the health home.

Health home providers may not “lock in” a member or deny a member’s freedom to choose his or her providers of care. Coverage of other Medicaid and BadgerCare Plus services is determined by the individual service policies.

Members must be allowed to participate, to the full extent of their ability, in all decisions regarding appropriate services and providers. A member may designate an authorized representative to help make decisions on his or her behalf.

A member’s participation in the process must be specifically documented. The documentation should include, but should not be limited to, the following:

- Documentation regarding notice to the member of his or her right to “opt out” and his or her freedom to choose service providers.
- Documentation of the member’s acceptance of the responsibility to participate in the care program and maintain contact with the health home.

Members diagnosed with HIV infection or AIDS may be currently receiving services through a BadgerCare Plus or Medicaid SSI HMO. If a member would like to discuss the

option of continued HMO enrollment or enrolling in the health home, the member should be directed to the HMO enrollment specialist at (800) 291-2002. The enrollment specialist will assist the member in making an informed choice.

### **Covered Health Home Services**

Health home services for members diagnosed with HIV infection or AIDS will be comprehensive and, at a minimum, will include all of the activities outlined below. These activities must be provided using a “whole person” approach and within a culture of continuous quality improvement. Health home services must also be provided in accordance with national and state best practices for person-centered health home services.

### **Comprehensive Care Management**

Comprehensive care management will involve the use of evidence-based guidelines to provide systematic, responsive, and coordinated management of all aspects of primary and specialty care (physical and behavioral) for members diagnosed with HIV infection or AIDS.

The responsibilities of health home providers for comprehensive care management will include, but will not be limited to, the following:

- Early identification of members who meet the eligibility criteria.
- The identification of a core team of health care professionals, including a team lead and care coordinator, involved in each member’s care.
- The identification of individuals involved in the member’s support network, including the member’s authorized representative.
- An initial comprehensive assessment of each member’s strengths and needs, the development of a care plan, annual reassessments, and ongoing care coordination, monitoring, referral, and follow-up.

### **Care Coordination, Monitoring, and Follow-up**

Care coordination will involve the ongoing management of a member’s medical and community care needs. The designated care coordinator will be responsible for the overall coordination of care. All care coordination, monitoring, and follow-up activities should be documented in the member’s record.

The responsibilities of the care coordinator will include, but will not be limited to, the following:

- Ensuring that the member has a current, written, individualized plan of care (POC) that includes all aspects of the member’s care. The care plan must be patient centered and must:
  - ✓ Be multidisciplinary and be based on a comprehensive assessment of the member’s health care needs, including personal support and personal care needs.
  - ✓ Identify everyone involved in the development of the care plan.
  - ✓ Specifically identify the member’s primary health care provider, the team lead, and the care coordinator.
  - ✓ Identify the member’s care and treatment goals.
  - ✓ Indicate the frequency and methods of member contacts. The health home provider should consider the member’s health status, interventions, and care and treatment goals in determining the frequency of contacts. (Refer to the Frequency of Member Contacts section of this *Update* for the requirements regarding the frequency of member contacts.)
  - ✓ Indicate the frequency and methods of communication among the health care professionals on the team.
  - ✓ Address coordination of treatment approaches among the multidisciplinary team, including how differences in treatment directions to the member will be resolved.
  - ✓ Address team access and updates to the care plan, including timeliness and accuracy of updates.

- Ensuring that the member has an identified primary care physician.
- Ensuring that the member's primary care physician is an integral part of the core team.
- Ensuring that the member, legal guardian, or other designated support person is actively involved in the development of the treatment plan and ongoing care.
- Identifying all services the member is receiving, including pertinent psychosocial services. To the extent appropriate, this should include coordinating with the member's family and other community-based service providers to ensure that identified non-medical needs are addressed (e.g., housing, transportation, and nutrition).
- Ensuring that health care is coordinated across all medical subspecialties, home care providers, hospitals, and other health care facilities.
- Ensuring that eligible members receive depression and substance abuse screenings and intervention (i.e., Screening, Brief Intervention, and Referral to Treatment [SBIRT]). These screenings must be carried out using an evidence-based screening tool administered by staff with the appropriate education and training.
- Ensuring timely follow-up regarding care concerns, including missed appointments, health care referrals, hospital discharges, emergency room visits, and lack of treatment adherence.
- Obtaining ongoing feedback from each member regarding his or her satisfaction with the assistance and support received from the health home. (Refer to the Member Satisfaction Surveys subsection of this *Update* for information about the specific feedback to be obtained.)
- Ensuring that members have timely access to their primary health care provider and to other participants of the core team.
- Ensuring that members have 24-hour access seven days a week to the health home provider and are informed of how to access care and support. Health home providers may designate a staff person or an on-call

provider, or they may identify other means of ensuring timely access.

- Verifying that members are aware of clinic hours and referral sources.
- Verifying members' contact information and preferred methods of contact.

### ***Health Promotion and Self-Care***

Health promotion and self-care will involve assisting members in better understanding their disease and participating in directing the care and treatment they receive. A member's care plan should include health promotion and self-care activities. The responsibilities of health home providers for health promotion and self-care will include, but will not be limited to, the following:

- Risk assessments and referral to counseling, as appropriate (e.g., for smoking, diet, mental health, or drug use).
- Monitoring of medication adherence and referral to counseling, as appropriate.
- Ongoing HIV disease and self-management education.
- Chronic disease management education, as appropriate.
- Active promotion of member self-management through education, motivational interviewing, modeling, mentoring, and monitoring (both in clinic and home settings, as appropriate). Self-management should also be promoted through access and/or referral to support groups and through family/caregiver engagement in care. Members should be adequately trained and encouraged to gradually take over many of the activities performed by the medical home team in terms of care coordination.
- Human Immunodeficiency Virus risk reduction education and counseling, and continuous active referral to the Wisconsin HIV Partner Services (PS) program. For more information about the PS program, including a link to a listing of PS providers, health home providers may refer to the following Web site: [www.dhs.wisconsin.gov/aids-biv/resources/overviews/AIDS\\_HIVPartnerServices.htm](http://www.dhs.wisconsin.gov/aids-biv/resources/overviews/AIDS_HIVPartnerServices.htm).
- Education about proper nutrition and referral to a nutritionist or dietitian, if appropriate.

- Ongoing education on stress management.
- Active involvement in providing risk-reduction counseling, promoting self-care activities, and addressing self-esteem issues.
- Tracking of member progress towards self-management over time.
- Ongoing mental health services, as needed.

### ***Comprehensive Transitional Care***

Comprehensive transitional care will involve the establishment of an automatic referral arrangement between local institutional care providers and the health home provider to ensure that health home members who are admitted to the institution or are seen in the emergency room are immediately referred to the health home.

The automatic referral arrangement should include the establishment of policies and procedures to ensure that there is systematic and timely sharing of information related to the member's institutional or emergency room care.

To the extent possible, the referral arrangement between the health home provider and institutional care provider should include an agreement for immediate direct contact between the institution and a health home representative. (Direct contact between the institutional provider and the health home provider will improve communication and coordination across these settings, which in turn should improve the member's transition back to community care.)

The responsibilities of health home providers for comprehensive transitional care will include, but will not be limited to, the following:

- Responding to referrals by contacting the institution or member within 24 hours and collaborating with the following individuals:
  - ✓ The member's primary care physician.
  - ✓ The institutional discharge planner.
  - ✓ The pharmacist.
  - ✓ The home care team.
  - ✓ The member.

- Reviewing the discharge summary with the member and assisting him or her in following through on written orders.
- Ensuring that the member has a comprehensive transitional care plan that addresses the following:
  - ✓ An immediate appointment with the member's primary health care provider.
  - ✓ Education on self-care.
  - ✓ Adherence to medication schedules.
  - ✓ Identification of symptoms to monitor.
  - ✓ A plan to address unnecessary or inappropriate use of emergency rooms, including education to help the member understand the difference between the need for urgent care and the need for emergency care.
  - ✓ Scheduled home visits and contacts with the member and caregivers.
- Making face-to-face or telephone contact with the member (or the member's authorized representative) within 24 hours of an emergency room visit or a hospital or nursing home discharge.
- Updating the member's comprehensive care plan to reflect the transitional care and follow-up. This includes documenting all transitional care activities.

### ***Member and Family Support (Including Authorized Representatives)***

Member and family support services will involve advocating on the member's behalf. Member and family support services will include imparting information in a manner that is simple, clear, straightforward, and culturally appropriate. The member's record should include documentation of these activities.

The responsibilities of health home providers for member and family support services will include, but will not be limited to, the following:

- Mobilizing services and support for the member.
- Periodically observing and monitoring the delivery of services and support to the member.
- Providing timely supportive contacts with the member or authorized representative to ensure that the member

is receiving the services specified in the care plan. Supportive contacts include contacts made to ensure that there are no new gaps or barriers to receiving the services specified in the care plan.

- Assisting the member in communicating effectively with his or her health care and community services providers.
- Following up with the member or authorized representative to ensure that identified health care services are adequately meeting the member's needs. These contacts should be made within two weeks of receipt of the identified service.
- Checking with the member or authorized representative regarding the member's participation in and satisfaction with identified community and home care services.
- Adjusting the care plan as needed to reflect new information based on direct observation or on feedback from the member (or authorized representative) or his or her family support.

### ***Referral to Community and Social Support Services***

Health home providers will be required to ensure that members have access to the community and social support services identified in the care plan by identifying and, if necessary, establishing meaningful working relationships with critical community resources. These resources will include, but will not be limited to, the following:

- Housing assistance/rent subsidy programs.
- Personal care services.
- Transportation services.
- Meal programs/food pantry.
- Legal services.
- Faith-based services.
- Health-related support groups.
- Child care assistance/day care programs.
- Interpreter services.
- Budgeting/financial workshops.
- Violence intervention programs.
- Anger management.
- Grief counseling.
- Fitness activities.

Health home providers will be required to make referrals to community and social support services, as appropriate (to the extent possible, referrals must be in written form).

Referrals must include any steps necessary to ensure that the member is able to access the service to which he or she is referred. For example:

- Assisting the member in identifying free or low-cost options for needed services.
- Informing the member if there is a charge for the service.
- Assisting the member in making transportation arrangements.
- Asking if the member needs a reminder call.
- Working directly with the referral agency, if appropriate.

The care coordinator will be required to follow up on all referrals to determine the outcome and to identify instances in which additional referrals or follow-up are needed.

Follow-up on referrals must occur no later than two weeks after the referral is given. All referrals, outcomes, and actions taken (including additional referrals and follow-up) should be documented in the member's record.

### **Frequency of Member Contacts**

Health home providers will be required to meet the following minimum requirements for frequency of member contacts:

- Review the care plan at least once every six months.
- Make a face-to-face contact with the member at least once every three months.
- Make at least one contact with the member, or with a collateral, at least monthly. A collateral is anyone involved in the member's care or in mobilizing services and support on the member's behalf. Collaterals could include health care providers, community advocates, social service providers, family members, or friends.

The member's record should include documentation that these contacts were made or provide rationale for contacts that are less frequent. The health home provider will be required to make at least five attempts, using different

means of communication, before indicating that a member is “loss to follow-up.”

Health home providers will be required to notify the member prior to reducing or terminating contacts. A decision to reduce or terminate health home services should be mutually agreed upon by the provider and the member. Providers may be required to report on members lost to follow-up and members who refuse continued care.

## **Reimbursement**

### ***Initial Assessment, Care Plan Development, and Annual Reassessments***

Health home providers will receive a flat fee for each eligible member for the initial comprehensive assessment of needs, development of the integrated care plan, and annual reassessments. The initial assessment, care plan development, and annual reassessments will be reimbursable only for members who meet the eligibility criteria and who agree to participate in the health home. Members agree to participate by actively engaging in the initial assessment, care plan development, and annual reassessments.

Reimbursement for the initial assessment, care plan development, and annual reassessments will be on a fee-for-service basis and will be limited to the lesser of the amount billed or the established maximum fee. The reimbursement will be the same regardless of the amount of time involved or the number of individuals participating.

ForwardHealth will recoup the reimbursement provided for the initial assessment, care plan development, and annual reassessments if the provider’s documentation does not support the member’s eligibility for health home services, or if the assessments or care plan are not multidisciplinary, as required for this benefit.

### ***Ongoing Care Management***

Health home providers will be reimbursed one care management fee per eligible member per month. A participant of the member’s core team must engage in at

least one care management activity during the month for which the provider is billing. This fee is reimbursable only for eligible health home members who have gone through the assessment and care plan development process and who have an assigned care coordinator. All care management activities must be identified in the member’s care plan. Care management activities do not include the direct provision of services.

Reimbursement for all care management services will be on a fee-for-service basis and will be limited to the lesser of the amount billed or the established maximum fee. The reimbursement will be the same regardless of the frequency or intensity of care management activities provided within the month. The monthly care management fee will include activities related to medication therapy management.

Care management services will be billed following the last DOS in the billable month, which means the last day on which there was care management activity in the month.

ForwardHealth will recoup the monthly care management fee for months in which there is no documentation of at least one care management activity involving a participant of the core team.

### ***Procedure Codes***

Health home providers will be required to use the following Healthcare Common Procedure Coding System (HCPCS) procedure codes when submitting professional claims for reimbursement under the new care coordination benefit for members diagnosed with HIV infection or AIDS:

- S0280 (Medical home program, comprehensive care coordination and planning, initial plan). This code must be used when billing for activities related to the initial assessment, care plan development, and comprehensive annual reassessments. The maximum reimbursement fee will be \$359.37.
- S0281 (Medical home program, comprehensive care coordination and planning, maintenance of plan). This code must be used when billing for activities related to

ongoing care coordination. The maximum reimbursement fee will be \$102.95.

To receive reimbursement, providers will be required to bill for services on a professional claim — an 837 Health Care Claim: Professional transaction or a 1500 Health Insurance Claim Form. Refer to the Attachment of this *Update* for a sample completed 1500 Health Insurance Claim Form for services rendered under the new care coordination benefit for members diagnosed with HIV infection or AIDS. Refer to the Case Management, Targeted service area of the Online Handbook for 1500 Health Insurance Claim Form completion instructions for case management services.

### **Copayment**

Health home services are not subject to copayment; however, members will still be responsible for applicable cost sharing for other Medicaid and BadgerCare Plus services they receive.

### **Billing the Usual and Customary Charge**

Health home providers will be required to bill their usual and customary charge for services provided under the new care coordination benefit for members diagnosed with HIV infection or AIDS. Reimbursement will be the lesser of the usual and customary charge or the Medicaid maximum established fee for the service.

### **Diagnosis Codes**

Claims submitted for reimbursement under the new care coordination benefit must include a primary diagnosis code related to HIV infection.

All diagnosis codes indicated on claims must be the most specific and appropriate *International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM)* diagnosis code. Providers are responsible for keeping current with diagnosis code changes. Etiology and manifestation codes may not be used as a primary diagnosis.

The required use of valid diagnosis codes includes the use of the most specific diagnosis code. Valid, most specific

diagnosis codes may have up to five digits. Claims submitted with three- or four-digit codes where four- and five-digit codes are available may be denied.

### **Dates of Service**

Health home providers should adhere to the following guidelines when determining the DOS to indicate on the professional claim:

- For activities related to the initial assessment, care plan development, and annual reassessments (indicated by HCPCS procedure code S0280), if the service was performed on more than one DOS, indicate the last DOS on the claim form.
- For activities related to ongoing care coordination (indicated by HCPCS procedure code S0281), if the service was performed on more than one DOS within the month, indicate the last date the service was performed in each month as the DOS on the claim form.

### **Place of Service Codes**

Providers should use a valid two-digit place of service (POS) code to indicate the setting in which services were provided. If services occurred in multiple settings, providers should indicate POS code 99 (Other Place of Service) on the claim.

*Note:* The actual POS must be indicated when documenting health home activities.

### **Limitations**

The following services are *not* covered under the health home benefit:

- Direct services. Health home services do not include direct health care (medical, dental, behavioral) provided to members. Members receive these services separately on a fee-for-service basis. Providers should separately bill for direct services according to the Medicaid or BadgerCare Plus requirements for the service (if covered by Medicaid or BadgerCare Plus).
- Travel time or other overhead costs incurred as part of coordinating care for the member.

- Translation services or any other social or supportive services, including transportation services.

Ongoing care management will be limited to one claim per member per month. Reimbursement for comprehensive assessments will be limited to one claim every 365 days. Case management and medication therapy management will not be separately reimbursed.

## **Program Evaluation and Data Reporting**

Federal laws governing the provision of health home services include a requirement that states must report to the Centers for Medicare and Medicaid Services on the “nature, extent, and use of the health home model of service delivery.” In particular, states will be required to report on the following:

- Hospital admission rates.
- Chronic disease management.
- Coordination of care.
- The state’s assessment of program implementation.
- Processes and lessons learned.
- Assessment of quality improvements and clinical outcomes.
- Estimates of cost savings.

To comply with the evaluation and data reporting requirements, ForwardHealth may require that health home providers collect and report certain information to ForwardHealth. Providers may be required to include members with one or more paid claims in their reporting. To the extent possible, ForwardHealth will use its own paid claims data for reporting and will only rely on providers for data not available through the claims system or through public health surveillance data. Providers will be required to respond to data requests as a condition of continued participation as a designated health home for members with HIV or AIDS.

## **Member Satisfaction Surveys**

Health home providers will be required to conduct annual member satisfaction surveys. The purpose of the surveys will be to obtain feedback from each member regarding his

or her satisfaction with the assistance and support received from the health home. The areas to be assessed will include, but will not be limited to, the following:

- Timeliness of and access to care.
- The level of the member’s involvement in the POC.
- The level and method of communication from the member’s core team (i.e., whether or not the member was able to get needed information).
- The team’s recognition and consideration of the member’s life circumstances (e.g., home environment, level of strength or frailty, personal support, ability to manage own care).
- The information the member received related to health promotion and self-care.

Providers may be required to periodically share the survey and the survey results with the Wisconsin DHS. Health home providers will be required to document any action taken to improve services or the approach to care based on feedback received from members.

## **Quality Measures**

Under federal health home laws, states are required to identify and report on certain quality indicators for services provided to members enrolled in the health home. ForwardHealth will identify quality indicators to address clinical outcome, experience of care, and quality of care for each of the covered health home service areas below:

- Comprehensive care management.
- Care coordination and health promotion.
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up care.
- Member and family support, which includes authorized representatives.
- Referral to community and social support services.
- Use of health information technology to link services, as feasible and appropriate.

To the extent possible, ForwardHealth will use its own paid claims data for the quality measures. Providers may be required to submit additional outcome data from the member’s medical record. Depending on the final measures,

the additional data could include members with at least one paid claim. Providers will be required to respond to data requests as a condition of continued health home participation.

### **Program Monitoring, Review, and Audit Activities**

The DHS will conduct regular site visits for the purposes of program monitoring, review, and audit. The DHS may use information obtained from site visits to respond to federal reporting requirements, particularly in regard to “processes and lessons learned” and the “assessment of program implementation.”

### **Information Regarding Managed Care Organizations**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. Members interested in this benefit who are enrolled in an HMO will need to disenroll from the HMO in order to participate in this benefit.

Providers should refer members to the HMO enrollment specialist at (800) 291-2002 for assistance in making an informed decision about their options for receiving Medicaid or BadgerCare Plus services.

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/](http://www.forwardhealth.wi.gov/).

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