wisconsin Medicaid update
department of health and family services

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POH 1660

For Wisconsin Medicaid-certified providers

Commonly asked questions about BadgerCare

BadgerCare, which begins in July 1999, extends Medicaid coverage to uninsured children and parents with incomes below 185% of the federal poverty level and who meet the other program requirements. A BadgerCare fact sheet is included in this Update. The following is a list of questions providers have about BadgerCare.

BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients. Most will use existing Medicaid HMOs.

What services are covered under BadgerCare?

BadgerCare recipients receive the same health benefits as Wisconsin Medicaid recipients. Most will use existing Medicaid HMOs.

For the remainder of 1999, only certain HMOs currently participating in the Medicaid HMO Program are participating in BadgerCare. Beginning in the year 2000, all HMOs who successfully complete HMO certification will be required to accept both Medicaid and BadgerCare recipients. At the right is a list of all the HMOs participating in Medicaid and an indication of their participation in BadgerCare during this year.

HMO network providers should contact their HMOs for questions concerning billing issues, referral processes, reimbursement, and subcontracting concerns.

Are Medicaid providers required to be separately certified for BadgerCare?

No. Providers who are certified for Medicaid are automatically certified for BadgerCare. If a provider is *not* certified for Medicaid but serves a BadgerCare recipient, he or she will *not* be

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All HMOs participating in Medicaid

HMO	Participating in BadgerCare?
Atrium Health Plan (AHP)	Yes
CompCare Health Services (CHS)	Yes
Coordinated Care Health Plan (CCR) (formerly Maxicare)	No
Dean Health Plan (DHP)	Yes
Family Health Plan	No
Group Health of South Central Wisconsin (GHC)	No
Group Health Cooperative - Eau Claire (GHE)	Yes
Greater LaCrosse Health Plan (GLX)	No
Humana/WHO (WHO)	Yes
Managed Health Services (MHS)	No
Mercy Health Plan (MHP)	No
Network Health Plan (NHP)	No
Physicians Plus (PPP)	No
PrimeCare Health Plan (PRC)	Yes
Security Health Plan (SHP)	Yes
Unity Health Plan (UHP)	Yes
United Health Plan (UNH)	Yes
Valley Health Plan (VHP)	Yes

Inside this Update:

Medicaid restricts billing recipients

The Health Care Financing Administration (HCFA) recently sent a letter to state Medicaid directors to alert them about an incident that occurred in another state. Following is an excerpt from their letter:

> In the past few months we [HCFA] have received reports of providers which have inappropriately required Medicaid patients to make cash payments for Medicaid covered services. There have been reports from States of incidents where an anesthesiologist would not provide an epidural to a Medicaid patient in childbirth unless she paid in advance, with her own funds, for the procedure. In one instance, the obstetrician had ordered the epidural in advance but when the woman was in active labor, she was refused this service for lack of pre-payment.

Although an incident such as this has not been reported in Wisconsin, HCFA has encouraged state Medicaid programs to inform Medicaid-certified providers about this situation. In response to this request, the Medicaid policies on billing managed care and fee-for-service recipients are outlined below.

Providers prohibited from billing recipients for Medicaid-covered services

Under federal and state laws, a Medicaid provider must *not* seek payment from a recipient, or other person on behalf of the recipient, for services that are *covered* under Wisconsin Medicaid[1] even if:

- The provider fails to meet Wisconsin Medicaid program requirements or fails to comply with program policy and is denied Medicaid reimbursement.
- There is a difference between the provider's normal charge for a service and the Medicaid reimbursement to the provider for that service.
- The provider fails to seek or fails to obtain necessary prior authorization to perform the services and is denied Medicaid reimbursement.

See the exception to this requirement under "Fee-for-service recipient copayments."

Under state and federal laws, if a provider knowingly requests payment from an eligible recipient, or from anyone else on behalf of the recipient, for Medicaid-covered services, except for any required Medicaid copayment amounts, that provider is subject to program sanctions including termination of Medicaid certification. In addition, the provider may also be fined not more than $25,000, or imprisoned not more than 5 years, or both (as of Dec. 31, 1999, the term will change to 7 years, 6 months) per s. 49.49(3m), Wis. Stats.

Under federal and state laws, a Medicaid provider must *not* seek payment from a recipient, or other person, for services that are *covered* under Wisconsin Medicaid...

Provider responsibilities for billing recipients for noncovered services

Wisconsin Medicaid will only reimburse providers for Medicaid-covered services or services for which prior authorization has been approved. If a recipient requests noncovered services or services for which prior authorization was denied, then he or she is responsible for payment *only* if the provider informs the recipient *prior* to performing the service that it is a noncovered service and, therefore, he or she will be responsible for payment. If the noncovered service is separate or distinct from a related covered service, such as anti-glare coating put onto eyeglasses that are covered, the recipient is only responsible for the noncovered service if he or she is informed prior to receiving that service.

If a recipient agrees to receive a noncovered service, the provider and recipient should make payment arrangements for that service.

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Fee-for-service recipient copayments

Providers who perform services for fee-for-service recipients that require recipient Medicaid copayment are required to make a reasonable attempt to collect that copayment from the recipient, unless the provider determines that the cost of collecting the copayment, coinsurance, or deductible exceeds the amount to be collected. Providers may not waive the recipient copayment requirement. Providers may not deny services to a recipient for failing to make a copayment.

Managed care providers must not charge recipients a copayment.

Recipient liability

If an individual who has already paid for services he or she has received is determined to be retroactively eligible for Wisconsin Medicaid, a Medicaid-certified provider may bill Wisconsin Medicaid within 180 days after the mailing of the backdated Wisconsin Medicaid identification card to the recipient, if the services provided were Medicaid covered. If a provider receives reimbursement from Wisconsin Medicaid for services rendered to a retroactively eligible recipient, then the provider is required to reimburse the recipient, minus the copayment amount. The provider is not required to reimburse the recipient more than the amount paid by Wisconsin Medicaid according to s.49.43 (3m), Wis. Stats.

For more information

Providers

HFS 104 and 106, Wis. Admin. Code, and Part A, the all-provider handbook, contain further information regarding provider rights and responsibilities, and recipient rights. If you have further questions, please contact Provider Services at (800) 947-9627 or (608) 221-9883.

Recipients

If a recipient has questions about recipient rights or responsibilities, please refer him or her to Recipient Services at (800) 362-3002.

[1] Please refer to HFS 107, Wis. Admin. Code, and to the appropriate service-specific handbook for a detailed discussion of services covered by Wisconsin Medicaid. ✦

Y2K-ready electronic billing software is available

Starting July 1, 1999, the Medicaid fiscal agent will have Year 2000 (Y2K)-ready electronic billing software available for providers.

Electronic claims software availability

Year 2000 (Y2K)-ready electronic billing software distributed by the Medicaid fiscal agent to submit fee-for-service claims to Medicaid is now available. This free software replaces the billing software currently distributed by the fiscal agent. In June, providers using the current billing software received a letter and software request form. Providers should complete and return the request form to the fiscal agent to receive the new version of the software called PACE or EZ-Link. PACE is used for services billed on the UB-92 claim form and EZ-Link is used for services billed on the HCFA 1500 claim form. Please contact the fiscal agent's Electronic Media Claims (EMC) Department at (608) 221-4746 if you:

- Did not receive the June letter and request form.

- Are not currently using the electronic claims software and wish to use PACE or EZ-Link.
- Have questions.

Providers should install and use the new software as soon as possible so they can ensure there are no problems with claim submissions prior to the year 2000.

Claims submission process

Proservices is the software vendor that developed the PACE and EZ-Link software. In addition, Proservices also acts as a claims clearinghouse for electronic billing claims. Providers who use the new electronic billing software will transmit their claims to the fiscal agent via Proservices. Proservices will then transfer the claims to the fiscal agent.

System requirements

PACE and EZ-Link software are Windows-based products. A summary of the system requirements needed to use the Y2K-ready software, which was included in the May 1999 *Medicaid Update*, is as follows:

Hardware requirements

- 166 MHz Pentium level CPU*.
- 32 MB RAM*.
- Local hard drive.
- Mouse or trackball.
- Printer.
- CD-ROM (recommended).

*Please note that system performance may be affected by the hardware you use. If you will be processing a large volume of claims, a 233 MHz Pentium level CPU with 64 MB of RAM may be a more appropriate platform configuration.

Hard drive requirements

- 100 MB of available hard drive space.

Suggested guidelines for hard drive storage

Number of claims processed per month	Length of storage for data on hard drive	Minimum amount of disk space
500	4 months	40 MB
1000	4 months	80 MB
2000	4 months	160 MB
3000	4 months	240 MB

Note: The software application requires 6.5 MB of hard drive space.

Software requirements

- Windows 95, Windows 98, or Windows NT 4.X workstation.

Communications requirements

- 14.4K or higher Windows-ready modem.✦

Providers should install and use the new software as soon as possible so they can ensure there are no problems with claim submissions prior to the year 2000.

What's new on the Medicaid web site

The Wisconsin Medicaid web site includes provider and recipient publications, Medicaid contacts and statistics, and eligibility and benefit information. The following is a list of what has recently been added to the Medicaid web site.

You may visit the Medicaid web site at ***www.dhfs.state.wi.us/medicaid.***

- BadgerCare summary. Gives overall summary of BadgerCare program that extends Medicaid coverage to low-income families and children who meet the requirements.
- May and June 1999 *Medicaid Updates*.
- Medicaid Outreach information. Explains how Wisconsin has developed a plan to help potentially eligible families apply for Medicaid benefits and to promote maxi-

mum participation in Medicaid as major changes occur in the welfare system.

- Publications listed by provider type. Choose your provider type to access a list of Medicaid Updates that have been issued since 1995.
- Some downloadable commonly used appendices from Part A, the all-provider handbook. Appendices include forms such as the Provider Change of Address or Status Form and Instructions, Fee Schedule and Related Information Order Form, Paperless Claims Request Form, and Adjustment Request Form and Instructions.

Keep in mind that if you do not have a computer with Internet access, many schools and libraries have access. ✦

BadgerCare questions

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reimbursed for those services. HMO network providers should contact their HMO for specific questions regarding contracting issues.

Will I be able to distinguish between BadgerCare and Medicaid recipients?

No. BadgerCare and Medicaid recipients' ID cards are identical. It is not necessary for providers to identify Medicaid versus BadgerCare recipients because the benefits, claims submission, and reimbursement are the same.

Providers should submit claims for a BadgerCare recipient in the same way they do for any Medicaid recipient.

How do I submit claims for BadgerCare?

Providers should submit claims for a BadgerCare recipient in the same way they do for any Medicaid recipient. Refer to your Medicaid service-specific handbook or your HMO for more information on submitting claims.

What reimbursement will I receive for providing services to BadgerCare recipients?

Reimbursement is identical for services provided to BadgerCare and Medicaid recipients. All applicable copayments are still in effect for fee-for-service recipients. HMO network providers should contact their HMO for specific reimbursement policies.

Will I notice an increase in the number of Medicaid and BadgerCare recipients in my facility?

Providers may see an increase in the number of Medicaid and BadgerCare recipients they see. It may depend on the services you offer or your geographic area.

Where should I refer potential recipients regarding eligibility and income requirements for BadgerCare?

Providers should refer potential Medicaid or BadgerCare recipients to their county social or human services department, tribal agency, Wisconsin Works (W-2) agency, or Medicaid outstation. If recipients have questions about Medicaid or BadgerCare coverage, they may also call Recipient Services at (800) 362-3002 (recipient use only). In addition, recipients may refer to the Department of Health and Family Services' (DHFS) web site at *www.dhfs.state.wi.us* for more information about BadgerCare.

Who can I contact if I have more questions?

Providers who have questions about BadgerCare may call Provider Services at (800) 947-9627 or (608) 221-9883. In addition, providers may refer to the DHFS' web site at *www.dhfs.state.wi.us* for more information about BadgerCare, including how to order promotional materials.

Where can I get BadgerCare brochures/ posters for my clinic?

The DHFS will have copies of brochures and posters available to providers and county agencies in July 1999. ✦

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, 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 *www.dhfs.state.wi.us/medicaid.*

BadgerCare Program Summary

Eligibility

BadgerCare ensures access to health care for all uninsured children and parents with incomes up to 185% of the federal poverty level (FPL). Once enrolled, families may remain in BadgerCare until family income exceeds 200% of the FPL. No asset test is required.

BadgerCare fills gaps between Medicaid and private health insurance without supplanting or "crowding out" private insurance. BadgerCare extends health care coverage to low-income families with children through a Medicaid expansion under Titles XIX and XXI.

As allowed under federal law, if BadgerCare enrollment is projected to exceed budgeted enrollment levels, a new enrollment threshold will be established for new applicants. An expedited review and approval process will be specified for modifications to the income threshold in the federal waiver. In addition, the State will provide a minimum of 30 days public notice prior to any change in the income threshold.

If the enrollment threshold changes, families already in BadgerCare will remain enrolled if they continue to meet eligibility criteria in effect on the date they were enrolled. However, all families in BadgerCare will be required to report significant changes that may affect eligibility within 10 days and to undergo a redetermination for BadgerCare every 12 months.

In addition, the State's current Medicaid entitlement will be maintained.

Premiums

Families with income above 150% of the FPL pay a monthly premium of no more than 3% of family income. No family with income at or below 150% of the FPL pays a premium.

Family Size	150% FPL Annual	Monthly Premium	185% FPL Annual	Monthly Premium	200% FPL Annual	Monthly Premium
2	$16,590	$30	$20,461	$45	$22,120	$45
3	$20,820	$45	$25,678	$60	$27,760	$60
4	$25,050	$60	$30,895	$75	$33,400	$75

BadgerCare premiums are collected either through wage withholding, electronic funds transfer (EFT) from a family's savings or checking account, or direct pay by check or money order. Families who fail to pay the required premium are subject to a restrictive re-enrollment period of not more than six months, with exceptions provided for good cause. During restrictive re-enrollment periods, families cannot be eligible for BadgerCare.

Additional Children and Families Covered

BadgerCare is budgeted to cover an additional 67,535 uninsured, low-income Wisconsin residents, including 24,787 children and 42,748 parents. (In addition, it is anticipated that an additional 7,300 children will be identified as eligible for Medicaid.)

Crowd-Out of Private Insurance

BadgerCare has several policies related to eligibility and purchasing which prevent crowd-out of private insurance:

- Eligibility Crowd-Out Policies
  - ✓ BadgerCare requires that applicants are currently not covered or have not been covered by private health insurance for the three-calendar month period prior to application.
  - ✓ Families with current access, or access in the 18-month period prior to enrollment, to employer-provided health insurance where the employer pays at least 80% of the cost of family coverage are not eligible for BadgerCare.

- Insurance Purchasing Decisions to Prevent Crowd-Out

  The State buys employer-sponsored health insurance for families according to the following requirements:

  - ✓ The employer pays between 60% and 80% of premiums.
  - ✓ The family was not covered by an employer-sponsored plan in the previous six months.
  - ✓ It is cost-effective to buy an employer plan, including wraparound (BadgerCare fee-for-service) coverage up to BadgerCare benefit levels.

Health Care Benefits/Delivery System

BadgerCare benefits are identical to the comprehensive package of benefits and services covered by Wisconsin Medicaid. The existing Wisconsin Medicaid HMO managed care system, including provisions for quality assurance, for improved health outcomes, and for grievances, is used for BadgerCare.

Funding

The total amount of funding budgeted for BadgerCare at full implementation is $97.6 million — $61.7 million in federal, $34.2 million in state, and $1.7 million in premium revenue.

BadgerCare will expand Medicaid coverage for families with income up to 185% of the FPL through an 1115(a) waiver using a combination of funding under Title XIX (for parents) and Title XXI (for children). Health care costs of children and families who qualify for employer-sponsored coverage through Wisconsin's Title XXI allocation are funded at an enhanced federal match rate, with premiums used to offset total Title XXI costs. Parents' health care costs and their premiums are funded through Title XIX at the regular match rate, with premiums used as a portion of the match for Title XIX funds.

Expansion Timetable

- "OBRA Children" (children 15-18 up to 100% of the FPL): April 1999.
- BadgerCare: July 1999.

For More Information Contact:

- Applicants/Recipients: BadgerCare Hotline at (800) 362-3002
- Providers: Provider Services at (800) 947-9627 or (608) 221-9883

July 1999