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MEMORANDUM

Date: March 31, 2009

To: Family Care Managed Care Organization Directors

From: Monica Deignan, Managed Care Section Chief *Monica Deignan*
Office of Family Care Expansion

Subject: Contract Interpretation Bulletin Attached

This communication is to notify MCOs that the attached Contract Interpretation Bulletin (CIB) is effective as of April 1, 2009. The purpose of this CIB is to clarify the policy of the Department of Health Services in relation to payment of nursing home providers when a Family Care MCO member is also enrolled in a hospice program and receiving hospice care in a nursing home.

Please read and maintain this CIB with your 2009 Family Care contract.

The Department's policy is that MCOs are responsible for the cost of nursing home care for their members. However, in the case of members who are receiving nursing home care and are also enrolled in hospice, the hospice organization has been billing Medicaid fee-for-service for the nursing home cost at 95% of the nursing home rate and then paying for the nursing home services provided to the MCO member. This CIB clarifies that when a member is receiving care in a nursing home while the member is also enrolled in hospice it is the responsibility of the MCO to:

- Reimburse the nursing home for the cost of the care provided by the nursing home, and
- Pay claims from the nursing home at 95% of the MCO's rate for that nursing home.

This is consistent with the rate paid by fee-for-service Medicaid to a hospice organization for the nursing home "room and board" rate when a Medicaid recipient is receiving care in a nursing home and is also enrolled in hospice.

The scope of the policy in this CIB is limited to claims and payments for "the nursing home room and board rate." This rate, for purposes of claims related to situations where hospice care is provided in a nursing home, is defined as 95% of the nursing home rate. Temporary respite services in a nursing home for up to five days are included in the hospice benefit and are not within the scope of this policy.

The change is retroactive for claims received on or after October 13, 2008. This may cause some administrative burden for each of the providers involved – MCOs, nursing homes and hospice organizations – to correct any payments that were made in error. However, adjusting claims in the manner described below is necessary to assure a clear and accurate audit trail for each of the organizations involved and for the Medicaid fee-for-service and Family Care programs.

- If a nursing home has not already received a payment for a claim submitted on or after October 13, 2008 that is for services it provided to a MCO member who was also enrolled in hospice care, we expect that the nursing home will submit a claim to the MCO for 95% of the MCO's rate, and the MCO will pay the nursing home claim at 95% of the MCO's rate.

This is how future claims should be handled also. Please see the "Procedure" section on page 2 of the attached CIB.

- If a hospice organization has already paid a nursing home the nursing home daily rate for a claim received on or after October 13, 2008, expecting to be able to claim 95% of that cost from fee-for-service Medicaid as in the past, we expect that:
 - The hospice organization will recoup the payment that it has made to the nursing home; and
 - The nursing home will resubmit a claim to the MCO for 95% of the MCO's rate, and the MCO will pay the nursing home claim at 95% of the MCO's rate.

If you have questions, you may contact Marge Pifer at Marjorie.Pifer@wisconsin.gov or 608-266-3416.

cc: Melanie G. Ramey, The Hope of Wisconsin
John Sauer, Wisconsin Association of Homes and Services for the Aging
Tom Moore, Wisconsin Health Care Association
Rita Hallett, DHCAA
Shelley Dietzman, EDS Provider Services

**Family Care Contract
Contract Interpretation Bulletin
for CY 2009 Contract**

CIB #2009-1

Payment of Nursing Home Providers When a Family Care Member Is Also
Enrolled in a Hospice Program and Receiving Hospice Care Services in a Nursing Home
(Applies to Family Care Only)
Effective Date: April 1, 2009
Retroactive to: October 13, 2008

Statutory basis

§46.284 (4) (d) Wisconsin Statutes
HFS 10.44 (2) (h) Wisconsin Administrative Code

Related contract sections

Article IV.B.1.

Statement of current policy regarding pre-transfer planning

The policy of the Department of Health Services is that the Family Care benefit package and rate includes nursing home services. While hospice services are carved out of the Family Care benefit, nursing home services are not hospice services. Therefore, when members in Family Care also enroll in a hospice program to receive end-of-life services and reside in a nursing home the MCO is responsible for paying for the nursing home services.

The MCO and the hospice agency should work together to coordinate services for the member. In general, the MCO is expected to continue to provide services in the Family Care benefit that are not end-of-life services provided by the hospice agency. MCOs should execute memoranda of understanding with hospice agencies in order to assure coordination of service delivery and appropriate claims and payment of nursing home costs.

Purpose of bulletin and background

The purpose of this bulletin is to clarify procedures for payment to nursing homes when a Family Care member is in hospice in a nursing home, regardless of whether it is Medicare or Medicaid hospice services.

An edit in the new Interchange System was put into place on October 13, 2008 that assures the current policy is followed. After that date, any claims submitted to Medicaid fee-for-service by hospice organizations for the cost of nursing home stays for Family Care members who were enrolled in hospice at the time of the nursing home stay will be denied. The MCO is responsible for paying the nursing home when a Family Care member is also enrolled in a hospice program and is receiving hospice services in a nursing home. (Note that some claims received on and after October 13, 2008 may be for dates of service prior to that date. MCOs are also responsible for paying those claims.)

Procedure

In many such situations, prior to enrolling in hospice, the MCO member will have been in the nursing home for some time, with the nursing home services authorized and paid for by the MCO at the RUGS-based methodology rate used by the MCO for that nursing home. There may also be situations in which a Family Care member who is living at home may enroll in hospice and at a later time the member, MCO and hospice collaboratively decide that the member should move to a nursing home. In all these situations, the MCO is responsible to pay for the nursing home services.

When a Family Care member is also enrolled in a hospice program and is receiving hospice services in a nursing home, it is the expectation of the Department that the MCO will reimburse the nursing home in a way that is similar to the way the nursing home would be reimbursed if the person were in fee-for-service Medicaid and receiving hospice services in a nursing home.

- In fee-for-service Medicaid, temporary respite services in a nursing home for up to five days are included in the hospice benefit and the nursing home is not reimbursed separately by Medicaid. Similarly, MCOs are not expected to reimburse the nursing home for temporary respite services in a nursing home of up to five days since that is included in the hospice benefit.
- In fee-for-service Medicaid, the hospice agency bills the Medicaid program for “the nursing home room and board rate,” which is defined as 95% of the average Medicaid nursing home rate, and the hospice agency then reimburses the nursing home. Similarly, for a member who is enrolled in hospice and receiving care in a nursing home, the rate the MCO should pay the nursing home is 95% of the RUGS-based methodology rate it has established for that nursing home.

These procedures are consistent with Medicaid fee-for-service payment policies, carry out the current policy expectation that the MCO is responsible for the cost of the nursing home stay, and are simple and easy to understand for nursing homes, hospice agencies and MCOs.

MCOs should instruct nursing homes to use the HIPAA code 0169 along with SPC codes 505.10 (nursing home) or 505.20 (ICF-MR) as follows when submitting claims for MCO members who are also enrolled in hospice.

- Residential Services - NH Hospice
Revenue Code 0169, SPC 505.10, Code Unit - Day, Effective Date 10/13/08
- Residential Services - ICF-MR Hospice
Revenue Code 0169, SPC 505.20, Code Unit - Day, Effective Date 10/13/08