October 24, 2024

Update on HCBS Minimum Fee Schedule for Residential Provider Agreements

Dear Residential Provider:

The Wisconsin Department for Health Services (DHS) recently set a minimum fee schedule for Residential, Supportive Home Care, and Supportive Home Care - SDS services that began October 1, 2024. My Choice Wisconsin (MCW) is writing to notify you of changes that you can expect to your Residential facility agreement.

Please note we are still working on member-specific rates with single case agreements. We will share those details in another communication as soon as possible.

What this means for you

If you are a 1-2 Bed Corporate Owned Adult Family Home:

- **The MCW members in your home will be assigned to a Tier level** (T1, T2, T3) aligned with their needs, as captured in the Long-Term Care Functional Screen ***(see Table 1 below).***
- **If your current total contracted rate with MCW for a member(s) is above** the new minimum fee schedule for the Tier level plus room and board, your reimbursement will remain the same.
- **If your current total contracted rate with MCW for a member(s) is below** the new minimum fee schedule Tier level plus room and board, your reimbursement will be updated with an effective date of **October 1, 2024,** to the new minimum fee schedule rate for each members' Tier level plus room and board.

If you are a 1-2 Bed Owner-Occupied Adult Family Home

- **You will be reimbursed at $6.38 per 15 minutes for the total hours of direct care and active supervision a member requires per day,** as documented in the member-centered plan.
  - For MCW to identify the number of hours per day your member(s) requires for direct care and active supervision, the member's Care Manager will conduct member assessments beginning October 1, 2024, through November 1, 2024.
- As a result of this new requirement, **the reimbursement you receive for each member will be calculated after we have completed our assessments.** The MCW contracting department will send you a specific rate for each member currently residing in the home.

If you are a 3-4 Bed Corporate Owned or Owner-Occupied Adult Family Home

- **The MCW members in your home will be assigned to a Tier level** (T1, T2, T3) aligned with their needs, as captured in the Long-Term Care Functional Screen ***(see Table 1 below).***
- **If your current total contracted rate with MCW for a member(s) is above** the new minimum fee schedule Tier level plus room and board, your reimbursement will remain the same.
- **If your current total contracted rate with MCW for a member(s) is below** the new minimum fee schedule Tier level plus room and board, your reimbursement will be updated with an effective date of **October 1, 2024,** to the new minimum fee schedule rate for each members Tier level plus room and board.

If you are a Community Based Residential Facility (CBRF) 5-8 bed or 9+ bed

- **The MCW members in your home will be assigned to a Tier level** (T1, T2, T3) aligned with their needs, as captured in the Long-Term Care Functional Screen ***(see Table 1 below).***
- **If your current total contracted rate with MCW for a member(s) is above** the new minimum fee schedule Tier level plus room and board your reimbursement will remain the same.
- **If your current total contracted rate with MCW for a member(s) is below** the new minimum fee schedule Tier level plus room and board, your reimbursement will be updated with an effective date of **October 1, 2024,** to the new minimum fee schedule rate for each members Tier level plus room and board.

If you are a Residential Care Apartment Complex (RCAC)

- **MCW members residing in an RCAC do not have a DHS fee schedule rate assigned based on a member Tier level.** The RCAC fee schedule reimbursement dictated by DHS is the same rate for all members.
- **If your current total contracted rate with MCW for a member(s) is above** the new minimum fee schedule plus room and board, your reimbursement will remain the same.
- **If your current total contracted rate with MCW for a current member(s) is below** the new minimum fee schedule plus room and board your reimbursement will be updated with an effective date of **October 1, 2024,** to the new minimum fee schedule rate plus room and board.

Room and Board

- Prior to October 1, 2024, MCW reimbursed Residential providers for a standard room and board rate based on facility type, county, and the member's room status of private or shared – plus the 2023 U.S. Department of Housing and Urban Development (HUD) room and board rate.
- Starting October 1, 2024, through January 31, 2025, MCW will reimburse Residential providers by the new DHS fee schedule rate plus the 2023 HUD room and board rate. This rate may change each year. We will post any updates to the HUD rate on our website by February 1 of each year.
- Providers will receive a notification annually when the new room and board rates have been updated in MIDAS.

Authorizations

- Within the next few months, we will update member authorizations to reflect the new code structure and member Tier level information (where applicable) to comply with the new DHS and Managed Care Organization (MCO) contract requirements.
- Providers will receive a notice in MIDAS when new authorization(s) are available.
    - Providers seeking to verify a member's tier level can obtain the Long-Term Care Functional Screen tier result page from MCW by contacting: DLFAMCPrivacyOfficer@mychoicewi.org or sending a fax to (608) 245-3107.

Claims Submission and Reimbursement Guidelines

- To ensure compliance with DHS requirements and facilitate accurate claims processing, providers must submit clean claims with the new required medical coding requirements as shared by DHS. ***(see Table 2 below)***
- Claims for dates of service October 1, 2024 and later should include the Revenue Code*, Procedure Code**, the member Tier level modifier ***(see Tables 2 & 3 below)***, and the additional appropriate modifiers as indicated on the member authorization.
- Claims should only be submitted monthly for services rendered, per your contract with MCW. Claims should not be submitted for October dates of service until November 1, 2024. Submitting claims monthly will help ensure your reimbursement is accurate per the new fee schedule requirements and reduce underpayments to you.
- Any clean claims submitted below the DHS minimum fee schedule for October 1, 2024, dates of service or beyond will be automatically reprocessed at the new minimum fee rate. No additional action is required by you, the provider, for your claims to be reprocessed.
- MCW and DHS will not be able to provide an estimated timeline for reprocessing specific claims by phone or e-mail. Please note that MCW has until December 31, 2024, to reprocess claims related to the minimum fee schedule changes.

Thank you for being a valued MCW provider!

Questions?

- Visit our dedicated webpage at mychoicewi.org/hcbs.
- Please feel free to contact us via email at hcbsminimumfeeschedule@molinahealthcare.com.

Table 1: Member Acuity Tiers Criteria

Tier 1	Tier 2	Tier 3
Wandering = 0 Does not wander	Wandering = 1 Daytime wandering but sleeps nights	Wandering = 2 Wanders at night or day and night
Self-Injurious Behaviors = 0 No injurious behaviors demonstrated	Self-Injurious Behaviors = 2 Self-injurious behaviors require interventions 2-6 times per week or 1-2 times per day	Self-Injurious Behaviors = 3 Self-injurious behaviors require intensive one-on-one interventions more than twice each day
Self-Injurious Behaviors = 1 Some self-injurious behaviors require interventions weekly or less		
Offensive or Violent Behavior to Others=0 No offensive or violent behaviors demonstrated	Offensive or Violent Behavior to Others = 2 Offensive or violent behaviors that require interventions 2-6 times per week or 1-2 times per day	Offensive or Violent Behavior to Others = 3 Offensive or violent behaviors that require intensive one-on-one interventions more than twice each day
Offensive or Violent Behavior to Others = 1 Some offensive or violent behaviors that require interventions weekly or less		
	Dressing = 2 Help (supervision, cueing, hands-on assistance) needed- helper MUST be present	Uses Mechanical Lift (not a lift chair) selected for Transferring ADL.
	Toileting = 2 Help (supervision, cueing, hands-on assistance) needed- helper MUST be present	Tracheostomy Care selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day
	Transferring = 2 Help (supervision, cueing, hands-on assistance) needed- helper MUST be present	Tube Feedings selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day
	Ostomy – Related Skilled Services selection is any of the following: Independent, 1-3x/Month, Weekly, 2-6/Week, 1-2/Day, 3-4/Day, or 5+/Day	Positioning in Bed or Wheel Chair every 2-3 hours selection is any of the following: 3-4/Day, or 5+/Day

Table 2: Revenue Codes

*Revenue Code	National Definition	Notes	Required Procedure Code**	Required Modifiers
0240	All Inclusive Ancillary General Classification	Use for 1-2 Bed AFH.	T2031 (Assisted Living; Waiver, Per Diem)	-U1, U2, or U3 as the first modifier. -U5 or U6 as the second modifier. -U7 as the third modifier. -U4 as the fourth modifier if applicable.
0241	All Inclusive Ancillary Basic	Use for 3-4 Bed AFH.	T2031 (Assisted Living; Waiver, Per Diem)	-U1, U2, or U3 as the first modifier. -U5 or U6 as the second modifier. -U8 as the third modifier. -U4 as the fourth modifier if applicable.
0242	All Inclusive Ancillary Comprehensive	Use for a CBRF with 8 beds or fewer.	T2033 (Residential Care, Not Otherwise Specified, Waiver; Per Diem)	-U1, U2, or U3 as the first modifier. -U7 as the second modifier. -U4 as the third modifier if applicable.
0243	All Inclusive Ancillary Specialty	Use for a CBRF with more than 8 beds.	T2033 (Residential Care, Not Otherwise Specified, Waiver; Per Diem)	-U1, U2, or U3 as the first modifier. -U8 as the second modifier. -U4 as the third modifier if applicable.
0670	Outpatient Special Residence Charges General Classification	Use for a RCAC.	T2033 (Residential Care, Not Otherwise Specified, Waiver; Per Diem)	-U9 as the first modifier. -U4 as the second modifier if applicable.

Table 3: Modifiers for Residential Care

Modifier	Notes for Modifier Usage
U1	Use to indicate that the member meets the criteria for Level of Need (Acuity) Tier 1, based on elements from the member's Long-Term Care Functional Screen.
U2	Use to indicate that the member meets the criteria for Level of Need (Acuity) Tier 2, based on elements from the member's Long-Term Care Functional Screen.
U3	Use to indicate that the member meets the criteria for Level of Need (Acuity) Tier 3, based on elements from the member's Long-Term Care Functional Screen.
U4	Use to indicate the member received 24-hour 1-on-1 (or greater) care.
U5	Use to indicate that the Adult Family Home is owner-occupied.
U6	Use to indicate that the Adult Family Home is corporate owned.
U7	For AFH, use to indicate 1-2 bed Adult Family Home. For CBRF, use for Community Based Residential Facilities with 5-8 beds.
U8	For AFH, use to indicate 3-4 bed Adult Family Home. For CBRF, use for Community Based Residential Facilities with 9 or more beds.
U9	For RCAC, use to indicate Residential Care Apartment Complex.