November 5, 2024

Update on HCBS Minimum Fee Schedule for Member Specific Rates

Dear Residential / Supportive Visit Provider:

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

What this means for you

Member Specific Rates – Dedicated Staffing:

- **If your current total member specific rate with MCW for a member(s) is above** the new minimum fee schedule for the Tier level (where applicable) plus room and board, your reimbursement will remain the same for the time period indicated on the Single Case Agreement (SCA). MCW will provide a new SCA and updated authorization with an effective date of **October 1, 2024.**
    - The new SCA and authorization will be updated 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 new SCA via DocuSign, which will need to be reviewed and signed.**

- **If your current total member specific rate with MCW for a member(s) is below** the new minimum fee schedule Tier level (where applicable) 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. MCW will provide an updated authorization only as an SCA will no longer be necessary.

- Dedicated staffing is subject to the contract requirements as outlined in the Residential Exhibit.

Member Specific Rates – Non-Dedicated Staffing

- **If your current total member specific rate with MCW for a member(s) is above** the new minimum fee schedule for the Tier level (where applicable) plus room and board, the current reimbursement will continue, and a new Single Case Agreement (SCA) and authorization will be issued with an effective date of **October 1, 2024**. In accordance with MCW's standard procedures, the members' needs will be re-evaluated to determine the member's ongoing level of care. A new SCA will be issued accordingly. MCW aims to complete these assessments by December 1, 2024.
  - The new SCA and authorization will be updated 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 new SCA via DocuSign, which will need to be reviewed and signed.**

- **If your current total member specific rate with MCW for a member(s) is below** the new minimum fee schedule Tier level (where applicable) 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. MCW will provide an updated authorization only as an SCA will no longer be necessary.

- **If you are a 1-2 Bed Owner-Occupied Adult Family Home** a Single Case Agreement will continue to be required. The reimbursement you receive for each member will be calculated after MCW has completed member assessments. The MCW contracting department will send you an SCA with a specific rate for each member currently residing in the home.

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

How to bill at the new rate

- In order to bill appropriately, providers must first submit clean claims with the new required medical coding requirements as shared by DHS. ***(see Tables 1&2 below)***
- Providers should ensure that claims for dates of service October 1, 2024, and later include the Revenue Code*, Procedure Code**, the member Tier level modifier ***(see Tables 1 & 2 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. Please note that MCW has until **December 31, 2024**, to reprocess claims related to the minimum fee schedule changes.

MCW will not be able to provide an estimated timeline for reprocessing specific claims by phone or e-mail.

Thank you for being a valued MCW provider!

Questions?

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

Table 1: 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 2: 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.