Contract Amendment for BadgerCare Plus Services

The agreement entered into for the period of September 1, 2010 through December 31, 2013 between the State of Wisconsin acting by or through the Department of Health Services, herein after referred to as the "Department" and _____, an insurer with a certificate of authority to do business in Wisconsin for the BadgerCare Plus Managed Care Program is hereby amended as follows:

1. Article I – Definitions

Amend the definition of Members with Special Needs to read:

Members with Special Needs: Term used in clinical diagnostic and functional development to describe individuals who require additional assistance for conditions that may be medical, mental, developmental, physical or psychosocial. This includes, but is not limited to, members enrolled in the high risk pregnant women medical home pilot, members who need intensive medical or behavioral case management, or Birth to 3 members.

2. Article V, P – Conflict of Interest

Add as a new section P:

P. The Department will maintain state employee conflict of interest safeguards at least equal to federal safeguards (41 USC 423, section 27).

3. Article III, C.5 – Organizational Responsibilities and Duties

Remove "and/or Medicaid SSI population" from the second sentence in the last paragraph.

4. Article III, E.1– Covered BadgerCare Plus Services

Amend the last paragraph to read:

In addition, the HMO is not required to provide counseling or referral service if the HMO objects the service on moral or religious grounds. If the HMO elects not to provide, reimburse for, or provide coverage of, counseling or referral service because of an objection on moral or religious grounds, it must provide information about the services it does not cover as follows:

a) To the Department and Enrollment Specialist;
b) With the HMO's certification application for a BadgerCare Plus contract;
c) Whenever the HMO adopts the policy during the term of the contract;
d) It must b consistent with the provisions of 42 CFR 438.10;
e) It must be provided to potential members before and during enrollment;
f) It must be provided to members within ninety (90) calendar days after adopting the policy with respect to any particular service; and
g) In a written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the HMO because of an objection on moral or religious grounds.

5. Article III, E.8.b – Covered BadgerCare Plus Services

Add as a new paragraph:

The HMO must promptly provide or pay for needed contract services for emergency medical conditions and post stabilization services, regardless of whether the provider that furnishes the service has a contract with the entity. The HMO may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or HMO of the member's screening and treatment within ten (10) calendar days of presentation for emergency services. The HMO in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining

when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the HMO as identified in 42 CFR 438.114(b) as responsible for coverage and payment. Nothing in this requirement mandates the HMO to reimburse for non-authorized post-stabilization services.

6. Article III, E.8.c.1– Covered BadgerCare Plus Services

Amend to read:

The HMO is financially responsible for:

a) Emergency and post-stabilization services obtained within or outside the HMO's network that are pre-approved by the HMO. The HMO is financially responsible for post-stabilization care services consistent with the provisions in 42 CFR 422.113(c).
b) Post-stabilization services obtained within or outside the HMO's network that are not pre-approved by the HMO, but administered to maintain, improve or resolve the member's stabilized condition if:
    - The HMO does not respond to a request for pre-approval of further post-stabilization care services within one (1) hour;
    - The HMO cannot be contacted; or,
    - The HMO and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the HMO must give the treating physician the opportunity to consult with the HMO care team or medical director. The treating physician may continue with care of the member until the HMO care team or medical director is reached or one of the following occurs:
        (1) A network physician assumes responsibility for the member's care at the treating hospital or through transfer;
        (2) The treating physician and HMO reach agreement; or,
        (3) The member is discharged.

7. Article III, E.8.c.3 – Covered BadgerCare Plus Services

Amend to read:

The HMO must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the HMO. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

8. Article III, P.3 - Selective Reporting Requirements

Amend the second paragraph to read:

The HMO shall fully comply with the physician incentive plan requirements specified in 42 CFR s. 417.479(d) through (g) and the requirements relating to subcontracts set forth in 42 CFR s. 417.479(i), as those provisions may be amended from time to time. HMO contracts must provide for compliance with the requirements set forth in 422.208 and 422.210. HMO disclosures of physician incentive plans to the Department shall be in a format to be determined by the Department.

Add as a new third paragraph:

If the physician/group is at substantial financial risk, the HMO must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

9. Article IV, B – Monitoring and Evaluation

Add as a new #7:

The State will arrange for an independent, external review of the quality of services delivered under each HMO's contract with the State. The review will be conducted for each HMO contractor on an annual basis. The entity which will provide the annual external quality reviews shall not be a part of the State government, HMOs, or an association of any HMOs.

10. Article VI, E – Payment Schedule

Amend the second to last paragraph to read:

The HMO or their providers must complete an HMO Newborn Report. The HMO or their providers will report all births to the Department's fiscal agent as soon as possible after the date of birth, but at least monthly. If the HMO delegates the newborn reporting responsibility to providers, HMOs must specify in their subcontracts that the providers are responsible for newborn reporting. Prompt HMO reporting of newborns will facilitate retroactive enrollment and capitation payments for newborns, since this newborn reporting will ensure the newborn's BadgerCare Plus eligibility and HMO enrollment.

11. Article VIII, D.2.a.3 – Involuntary Disenrollment

Amend to read:

Moral or Religious Objections

The plan does not, because of moral or religious objections, cover the service the member seeks. The HMO must notify the Department, at the time of certification, of any services that they would not provide due to moral or religious objections.

12. Article IX, B – Grievance and Appeals Process

Add as new to the end of the first paragraph:

HMOs must give notice on the date of action when the action is a denial of payment.

13. Article IX, B – Grievance and Appeals Process

Amend the second to last paragraph to read:

A member may request a State Fair Hearing. The parties to the State Fair Hearing will include the HMO as well as the member and his or her representative or the representative of a deceased member's estate. Decisions will be reached within the specified timeframes:

- Standard resolution: within 90 days of the date the member filed the appeal with the HMO if the member filed initially with the HMOs (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing.
- Expedited resolution (if the appeal was heard first through the HMO appeal process): within three (3) working days from Department receipt of a hearing request for a denial of a service that:
    - Meets the criteria for an expedited appeal process but was not resolved using the HMOs appeal timeframes, or
    - Was resolved wholly or partially adversely to the member using the HMO's expedited appeal timeframes.
- Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the HMO appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

14. Article IX, C – Notifications to Members

Add as new after the last bullet:

For a rural area resident with only one HMO, the HMO must notify the member of the member's ability to obtain services outside the network:

- From any other provider (in terms of training, experience, and specialization) not available within the network.
- From a provider not part of the network who is the main source of a service to the member - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.

The member may also receive services outside of the network for the following reasons:

- Because the only plan or provider available does not provide the service because of moral or religious objections.
- Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network.
- The State determines that other circumstances warrant out-of-network treatment.

15. Article XI, D – Withholding of Capitation Payments and Orders to Provide Services

Add as new after D.7:

8. Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

16. Article XI, G – Sanctions and Remedial Actions

Amend Article XI G to read:

The Department may pursue all sanctions and remedial actions with the HMO that is taken with FFS providers including civil monetary penalties in the following specified amounts:

- A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to members, potential members or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
- A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the State.
- A maximum of $15,000 for each recipient the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).
- A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The State must deduct from the penalty the amount of overcharge and return it to the affected member(s).
- Appointment of temporary management for a HMO as provided in 42 CFR 438.706.

17. Article III, R.1 – Medical Home Pilot for High-Risk Pregnant Women

Amend the second to last paragraph to read:

Each member must be enrolled within the first 20 weeks of her pregnancy (for year one), within the first 18 weeks of her pregnancy (for year two), within the first 16 weeks of her pregnancy (for year three), must have attended a minimum of 10 appointments with the OB-care provider, and must continue to be enrolled through 60 days post-partum for the member to count towards the requirement.

Add as a new third sentence in the second to last paragraph:

If a member enrolls in one calendar year and delivers in the next calendar year, the member will count toward the minimum for both the enrollment year and the delivery year as long as all other eligibility criteria are met. The HMO only will be paid once per delivery.

18. Article III, R.1.c.2 – Target Population

Add after the last bullet:

DHCAA will consider exceptions to enrollment to allow pregnant women with chronic conditions, e.g., HIV/AIDS, on an individual basis. Requests for approval must be submitted to the contract administrator via e-mail briefly explaining the woman's condition and the rationale for inclusion in the medical home.

19. Article III, R.3 – Care Coordinator

Add to the end of the first paragraph:

All care coordinators must be easily accessible by members participating in the medical home on a regular established schedule. At a minimum, the care coordinator must be on-site at each medical home one full-day per week. HMOs are permitted to hire one care coordinator to float among their sites as long as the HMO can demonstrate that the needs of the medical home population are being met.

20. Article XVIII. C. 5. is amended by adding the following:

The monthly capitation rates listed in the BadgerCare Plus Benchmark Plan Exhibit is increased by a composite $0.21 PMPM (see exhibit 13a-1) for each month in the period beginning with January 1, 2010 and continuing through December 31, 2010 to remove the mental health/substance abuse inpatient and outpatient service limit.

Capitation Rates with IP/OP Mental Health and Substance Abuse Cap - Benchmark Plan **Exhibit 13a-1**

Age Range	Gender	1	2	3	4	5	6	Statewide
Age 0	All	$ 0.74	$ 0.84	$ 0.66	$ 0.74	$ 0.77	$ 1.00	$ 0.77
Ages 1 - 5	All	0.16	0.16	0.13	0.15	0.18	0.21	0.16
Ages 6 - 14	All	0.14	0.13	0.11	0.12	0.14	0.13	0.13
Ages 15 - 20	Female	0.29	0.29	0.26	0.26	0.28	0.29	0.28
Ages 15 - 20	Male	0.17	0.17	0.16	0.19	0.20	0.18	0.18
Ages 21 - 34	Female	0.32	0.34	0.29	0.30	0.35	0.34	0.32
Ages 21 - 34	Male	0.19	0.20	0.20	0.22	0.24	0.22	0.20
Ages 35 -44	Female	0.40	0.49	0.42	0.41	0.49	0.47	0.42
Ages 35 -44	Male	0.29	0.39	0.25	0.33	0.36	0.36	0.30
Ages 45 & Over	Female	0.58	0.59	0.50	0.56	0.56	0.62	0.56
Ages 45 & Over	Male	0.40	0.63	0.41	0.34	0.48	0.63	0.42
All Ages		$ 0.22	$ 0.21	$ 0.20	$ 0.20	$ 0.22	$ 0.24	$ 0.21

The monthly capitation rates listed in the BadgerCare Plus Standard Plan Exhibit is increased by a composite $0.54 PMPM (see exhibit 8-1) for each month in the period beginning with July 1, 2010 and continuing through December 31, 2010 to remove the CAH 90% Cost Adjustment.

Add to the Capitation Rate for the CAH Reduction 90% Cost - Standard Plan **Exhibit 8-1**

Age Range	Gender	1	2	3	4	5	6	Statewide
Age 0	All	$ 4.98	$ 1.47	$ 2.38	$ 0.63	$ 0.02	$ 0.01	$ 1.21
Ages 1 - 5	All	1.06	0.27	0.50	0.13	0.00	0.00	0.25
Ages 6 - 14	All	0.92	0.23	0.40	0.11	0.00	0.00	0.22
Ages 15 - 20	Female	1.98	0.52	0.96	0.22	0.01	0.00	0.48
Ages 15 - 20	Male	1.13	0.31	0.60	0.16	0.00	0.00	0.31
Ages 21 - 34	Female	2.99	0.82	1.48	0.36	0.01	0.01	0.75
Ages 21 - 34	Male	1.82	0.49	1.01	0.26	0.01	0.00	0.67
Ages 35 -44	Female	3.79	1.19	2.11	0.49	0.02	0.01	1.12
Ages 35 -44	Male	2.75	0.95	1.30	0.40	0.01	0.01	1.01
Ages 45 & Over	Female	5.42	1.44	2.56	0.67	0.02	0.01	1.56
Ages 45 & Over	Male	3.71	1.52	2.10	0.40	0.01	0.01	1.45
All Ages		$ 2.10	$ 0.58	$ 1.03	$ 0.25	$ 0.01	$ 0.00	$ 0.54

The monthly capitation rates listed in the BadgerCare Plus Benchmark Plan Exhibit is increased by a composite $0.56 PMPM (see exhibit 13b-1) for each month in the period beginning with July 1, 2010 and continuing through December 31, 2010 to remove the CAH 90% Cost Adjustment.

Add to the Capitation Rate for the CAH Reduction 90% Cost - Benchmark Plan **Exhibit 13b-1**

Age Range	Gender	1	2	3	4	5	6	Statewide
Age 0	All	$ 3.95	$ 1.23	$ 1.89	$ 0.50	$ 0.01	$ 0.01	$ 1.48
Ages 1 - 5	All	0.84	0.23	0.39	0.10	0.00	0.00	0.32
Ages 6 - 14	All	0.73	0.19	0.32	0.09	0.00	0.00	0.28
Ages 15 - 20	Female	1.57	0.43	0.77	0.18	0.01	0.00	0.63
Ages 15 - 20	Male	0.90	0.26	0.47	0.13	0.00	0.00	0.37
Ages 21 - 34	Female	2.74	0.79	1.36	0.33	0.01	0.01	1.26
Ages 21 - 34	Male	1.67	0.48	0.93	0.24	0.01	0.00	0.95
Ages 35 -44	Female	3.48	1.15	1.93	0.45	0.01	0.01	1.99
Ages 35 -44	Male	2.53	0.92	1.19	0.36	0.01	0.01	1.53
Ages 45 & Over	Female	4.97	1.39	2.35	0.61	0.02	0.01	2.85
Ages 45 & Over	Male	3.41	1.47	1.93	0.37	0.01	0.01	2.05
All Ages		$ 1.38	$ 0.35	$ 0.66	$ 0.15	$ 0.00	$ 0.00	$ 0.56

The maternity kick payment rates listed in the BadgerCare Plus Maternity Kick Payment Exhibit is increased by a composite $38.65 PMPM (see attached exhibit 8-1) for the period beginning with July 1, 2010 and continuing through December 31, 2010 to remove the CAH 90% Cost Adjustment.

Add Maternity Kick Payment CAH 90% Adjustment **Exhibit 8-1**

	1	2	3	4	5	6	Statewide
Maternity Kick Payment Add	$ 176.13	$ 31.15	$ 80.17	$ 5.97	$ 0.01	$ 0.20	$ 38.65

21. Addendum VI – Performance Requirements

Amend Addendum VI, A, 1, b to read:

b. Performance for each calendar year will be measured using all encounter data for that calendar year submitted to the Department by July 15 of the following year.

For measurement year 2010, HMOs have the option to calculate their own Medicaid HEDIS quality scores for the BadgerCare Plus population (Standard and Benchmark Plans only). For measurement year 2011 and beyond, all BadgerCare Plus HMOs will be required to calculate their own HEDIS quality scores.

The Department will use data from the following sources: HEDIS quality scores submitted by the HMOs and approved by NCQA-certified auditor, DHS Encounter Data, Wisconsin Immunization Registry, and Wisconsin Childhood Lead Poisoning Prevention Program.

The quality scores submitted by the HMOs shall follow the requirements defined in the "Guidelines and Operational Plan for HMO Submission of Medicaid HEDIS Data" in order to be utilized by the Department.

The Department will use data submitted as of July 15 of each year to calculate the quality measures not calculated by the HMOs Any encounter data which is populated by the HMO conducting its own internal (and audited) chart reviews which complies with HEDIS-hybrid methodology and the requirements in the encounter data manual to supplement their administrative data for a given year will be accepted as long as data is submitted by July 15 of that year.

Amend Addendum VI, A, 2 to read:

2. Emergency Department utilization management

   a. The Department will hold back payment of up to .5% of the HMO's capitation rate annually for failure to meet both of the following criteria:

      1) The HMO must not exceed the statewide rate of Emergency Department (ED) visits per continuously enrolled member in the HMO. For CY 2011, the HMO's rate must be no greater than 0.59 visits per continuously enrolled member. The Department will use data submitted as of June 21, 2011 to calculate the statewide rate for the CY 2012 benchmark and data as of June 21, 2012 to calculate the statewide rate for the CY 2013 benchmark. The Department estimates that it will inform the HMO of their benchmark for the following year in July of 2012 and 2013.

      2) The HMO must not exceed the statewide percentage of continuously enrolled members with 3 or more ED visits and no primary care visit in that measurement year. For CY 2011, the HMO's percentage must be no greater than 3.40% of their continuously enrolled population. The Department will use data submitted as of June 21, 2011 to calculate the statewide percentage for the 2012 benchmark and data as of June 21, 2012 to calculate the statewide percentage for the CY 2013 benchmark. The Department estimates that it will inform the HMO of their benchmark for the following year in July of 2012 and 2013.

   The HMO must meet both of the above criteria each year in order to be eligible for release of the .5% payment. If an HMO declines in performance in either of these measures from the previous year—even if they exceed the threshold—the HMO will not be eligible for this released amount.

   b. Although the Department will determine the HMO's full capitation rate, .5% of that rate will not be paid out to the HMO annually unless the HMO meets the performance benchmarks as indicated in this section. The Department will issue the HMO a payment for any monies owed after the Department has completed calculating the HMO's performance for the previous year. The Department estimates this payment will be made during the third quarter following the year for which performance was calculated. For example, the Department estimates that it will issue an HMO payment by September 2012 for the HMO's performance in CY 2011.

Amend Addendum VI, B, 1, d to read:

A chart review will be conducted by the Department to determine whether the care provided meets the criteria for satisfactory care. Satisfactory care is defined as care that meets a minimum set of ACOG guidelines critical for high risk pregnant women, including, best practices from a literature review of care for high risk women.

All terms and conditions of the September 1, 2010 through December 31, 2013 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect.

HMO Name	**Department of Health Services**
Official Signature	Official Signature
Printed Name	Printed Name Jason Helgerson
Title	Title Medicaid Director Division of Health Care Access and Accountability
Date	Date