Contract Amendment for WrapAround Milwaukee BadgerCare Plus Services

The agreement entered into for the period of July 1, 2013 through June 30, 2015 between the State of Wisconsin acting by or through the Department of Health Services, herein after referred to as the "Department" and Milwaukee County – Wraparound Milwaukee ("County") is hereby amended.

1. Article I, I. – Definitions

Add as new definitions:

"Cold Call Marketing" – Any unsolicited personal contact by the County, with the purpose of marketing.

"Marketing" – Any communication, from the County to a Medicaid member who is not enrolled, that can reasonably be interpreted as intended to influence that member to enroll in the County's program.

"Marketing Materials" – Materials that are produced in any medium, by or on behalf of the County, that can reasonably be interpreted as intended to market to potential members.

"Special Health Care Needs Assessment"- The assessment performed by the County's appropriately qualified health care professionals to determine a member's special health care needs and to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.

2. Article IV, A – Provision of Contract Services

Add as new #9 and #10:

9. Wraparound Milwaukee, for members aged 18 years and older, must maintain written policies and procedures related to advance directives. Written information provided must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change. An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. Wraparound Milwaukee must:

    a. Provide written information at the time of enrollment to all adults receiving medical care through the Wraparound Milwaukee regarding:

        1) The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and

        2) The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, available assistance for the

member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements, and

3) Wraparound Milwaukee's written policies respecting the implementation of such rights.

b. Document in the individual's medical record whether or not the individual has executed an advance directive.

c. Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

d. Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

e. Provide education for staff and the community on issues concerning advance directives.

10. The County must have written policies regarding member rights, including free exercise of rights without adverse action by the County or the providers. The County must notify members of their rights in the member handbook upon enrollment and annually. The County must comply with applicable federal and state laws regarding enrollee rights, and must ensure its staff and providers consider those rights when providing services.

3. Article IV, R – Non-Discrimination

Amend to add a new fourth paragraph:

Wraparound Milwaukee will not prohibit or otherwise restrict a healthcare professional from advising or advocating on behalf of a member who is his or her patient:

- For the members' health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- For any information the member needs in order to decide among all relevant treatment options.
- For the risks, benefits, and consequences of treatment or non-treatment.
- For the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about further treatment decisions.

4. Article IV, V.2 – Member Handbook

Add a new section m.:

m. Enrollment and Disenrollment Rights

1) Provide notice of the member's enrollment within a reasonable timeframe.

2) Notify all members of their disenrollment rights, and their ability to request information on such rights, at a minimum, annually.

3) Notify all members, at the time of enrollment, of the member's right to change providers or disenroll for cause.

4) Notify all members of their right to request and obtain names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member service area, including identification of providers not accepting new members, at least once per year. Furnish to all members notice of this information within a reasonable time frame after notice of enrollment.

5) Give each member written notice of any change to their disenrollment rights at least 30 days before the intended effective date of the change.

6) Furnish to each member the disenrollment rights within a reasonable time frame following notice of the member's enrollment.

7) Provide the procedures for obtaining benefits including authorization requirements.

8) Provide the extent to which, and how, members may obtain benefits from out of network providers.

5. Article IV, Z – Utilization Management

Add a new #6 and #7 under Z.4.c:

6. The County must submit documentation to the State that it offers an appropriate range of behavioral health services that is adequate for the anticipated number of members in the service area.

7. The County must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

Add a new d. under Z.4:

d. Out of network providers must coordinate with the County with respect to payment. The County must ensure that cost to the member is no greater than it would be if the services were furnished within the network.

Amend Z.5 to read:

Service:
Wraparound Milwaukee may elect to provide behavioral health benefits to eligible members through the use of Certified Peer Specialist providers. Peer Specialists are under

the direct supervision of a Wraparound Medicaid certified clinician. Peer Specialists must be able to participate in multidisciplinary team meetings regarding a participating individual's care. This benefit will be targeted to members age 14 –21 years old with SED or co-occurring SED and substance abuse related disorders. This service will not duplicate any peer specialist services the member may be receiving.

Provider Qualification:
Wraparound Milwaukee will use peer specialists certified and trained by the State Division of Mental Health and Substance Abuse Services (DMHSAS). This certification includes a requirement that the Peer Specialist be supervised by a qualified mental health professional. In addition to being certified by DMHSAS, the peer specialist must have a minimum of a high school diploma or GED, must be 18 years of age or older, and have the ability to communicate effectively with peers.

Reimbursement
Peer specialist services will be billed under their supervising clinician's NPI, using HCPCS code H0038 – Self-help/peer services. Up to 16 units may be billed per week. A unit is 15 minutes.

Travel time to and from the member visits may not be billed separately; this time is considered covered within the direct time reimbursement.

Add a new section 9 and move current #9 - #11 to #10 - #12:

9. Notice of Adverse Action
   The notice of adverse action must explain:

   - The action the County or its contractor has taken or intends to take.
   - The reasons for the action.
   - The member or the provider's right to file an appeal.
   - The member's right to request a State Fair Hearing.
   - Procedures for exercising member rights to appeal or grieve.
   - Circumstances under which expedited resolution is available and how to request it.
   - The member's rights to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services.
   - Written material must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs.
   - All members and potential members must be informed that information is available in alternative formats and how to access those formats.

6. Article IV, DD – Use of Providers Certified by BadgerCare Plus Program

Add a new third paragraph that reads:

Federal Financial Participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

7. Article IV, GG – Coordination and Continuation of Care

Add as new #13 - #16:

13. Provide names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member service area, including identification of providers that are not accepting new members. Include any restrictions on the member freedom of choice among network providers. Provide information on the amount, duration, and scope of benefits available under the contract.

14. Provide the procedures for obtaining benefits including authorization requirements.

15. Provide the extent to which, and how, members may obtain benefits from out of network providers.

16. The County must submit documentation to the Department assuring adequate capacity and services to provide Contract required services upon request and as follows, but no less frequently than:

    - At the time the contract is entered.
    - At any time there has been a significant change in the County's operations or provider network that would affect adequate capacity and services, including changes in services, benefits, geographic service area, or payments, or
    - Enrollment of a new population into the County program, with Department approval.

8. Article X, D – Modification

Amend the second paragraph to read:

If the Department exercises its right to renew this Contract, the Department will recalculate the capitation rate for succeeding calendar years. The County will have 30 days to accept the new capitation rate in writing or to initiate termination of the Contract. If the Department changes the reporting requirements during the contract period, the County will have 180 days to comply with such changes or to initiate termination of the Contract.

9. Article XI, E – Trading Partner requirements under HIPAA

Add as new section d. at Article XI, E.7:

d. All information, records, and data collected in connection with this Contract shall be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., HFS 108.01, Wis. Adm. Code, 42 CFR 431 Subpart F and 45 CFR 160, 162, and any other confidentiality law to the extent that these requirements apply.

Milwaukee County - Wraparound Milwaukee	**Department of Health Services**
Official Signature	Official Signature
Printed Name	Printed Name Kevin Moore, Medicaid Director
Title	Title Medicaid Director Division of Health Care Access and Accountability
Date	Date