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# Contract Amendment for Foster Care Medical Home Services

This agreement entered into for the period of January 1, 2018 through December 31, 2019 between the State of Wisconsin acting by or through the Department of Health Services, hereinafter referred to as the "Department" and Children's Hospital and Health System, a Prepaid Inpatient Health Plan with a certificate of authority to do business in Wisconsin for the Foster Care Medical Home Program hereinafter referred to as the "PIHP", is hereby amended as follows:

1. **Article II, B.**
   **Amend to read as follows:**

   Disenrollment requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. If the Department fails to make a disenrollment determination within 30 days of receipt of all necessary information, the disenrollment is considered approved. The PIHP must direct all members with disenrollment requests to the Department's Enrollment Specialist for assistance and/or for choice counseling.

2. **Article III**
   **Add as new:**
   A. FCMH Health Care Management Model Pilot

   The PIHP may develop a pilot to test alternative staffing models to meet the FCMH care management requirements detailed in Article III A-F. The Department must review and approve the pilot prior to implementation.

   1. The following conditions of approval for the pilot health care management structure apply:

      a. The PIHP must align any change in staffing approach with the level of need of the children and to optimally meet the care management requirements detailed in Article III A-F.

      b. Pilot approval will be granted for a one calendar year period and may be extended per Department discretion.

      c. The Department reserves the right to suspend and/or end a pilot at any point during the contract year and, may take action with less than a 30-day notice if the Department determines that it would be in the best interest of the children enrolled in the pilot or of the Department.

      d. Any material changes to the approved pilot health care management structure during the contract year must be submitted in writing to the Department for approval prior to implementation.

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e. Approval is limited to the structure of the PIHP health care management team. The PIHP must continue to comply with all existing FCMH health care management activities as defined in Article III A-F.

2. Monitoring and evaluation of the pilot health care management structure

The PIHP is required to regularly monitor and evaluate the pilot health care management structure to determine the impact of the pilot on the delivery of care management services. The PIHP must report findings to the Department during the approved period of the pilot. Required activities may include monitoring and evaluation of: program operations; cost; utilization; quality measures defined in Addendum VII; and other agreed upon outcomes. The PIHP must participate in regularly scheduled status calls and deliver written monitoring and evaluation reports at an agreed upon schedule.

**3. Article VI, A., 3**
**Amend to read as follows:**

Member communication materials should be designed to provide the members with clear and concise information about the PIHP's program, the PIHP's network, and the FCMH program. All member communication materials must be written at a sixth-grade comprehension level and in a font size no smaller than 12 point. Written member communication materials critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices must be made available in at least the top three non-English languages spoken by members and potential members by service area. The PIHP serving members in at least one county in a service area must make its written materials critical to obtaining services available in at least the top three non-English languages for that service area. The Department will determine on an annual basis the non-English languages spoken by members and potential members by service area. All communication materials must contain taglines in at least the top three non-English languages spoken by members and potential members in the applicable service area, as well as large print, explaining that written translation or oral interpretation of the document is available to the member free of charge. All written communication materials must also include a large print tagline with information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. The PIHP must also arrange for translation into any other language and/or dialect appropriate for its members.

**Non-English Language**
The top three non-English languages for service area are:

| **Service Area** | | | |
|---|---|---|---|
| Rate Region 5 | Spanish | Chinese | Russian |
| Rate Region 6 | Spanish | Burmese | Hmong |

**4. Article IV, D, 2**
**Amend to read as follows:**

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Within 10 days of final enrollment notification to the PIHP, as outlined in Article II, PIHP shall provide a hardcopy member handbook (see Addendum I) to each new member or member's out-of-home care provider and legal guardian or parent according to the specification outlined in Article VI, D.

5. **Addendum I**
   **Amend to read as follows:**

INTERPRETER SERVICES

English – For help to translate or understand this, please call 1-800-xxx-xxxx (TTY).
Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-xxx-xxxx (TTY).
Russian – Если вам не всё понятно в этом документе, позвоните по телефону 1-800-xxx-xxxx (TTY).
Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-xxx-xxxx (TTY).

Interpreter services are provided free of charge to you.

[Note to PIHP: The Member Handbook must contain taglines in at least the top three non-English languages spoken by members in the service area, as well as large print, explaining that written translation or oral interpretation of the document is available to the member free of charge. The non-English tagline is provided in a fillable Word Document and is available for download at: https://www.dhs.wisconsin.gov/publications/p02057.docx]

[Note to PIHP: The Member Handbook must also include a large print tagline with information on how to request auxiliary aids and services, including the provision of the materials in alternative formats.]

[Name of PIHP]:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  o Qualified sign language interpreters
  o Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  o Qualified interpreters
  o Information written in other languages

If you need these services, contact [Name of entity or of contact at PIHP] at 1-xxx-xxx-xxxx.

6. **Addendum I**
   **Add as new:**

Fraud and Abuse
If you suspect fraud or abuse of the Medicaid program, you may report it. Please go to www.reportfraud.wisconsin.gov.

7. **Article V, I**
   **Amend to read:**

   I. Online Provider Directory
   The PIHP must post a provider directory on their website for members, network providers, and the Department to access. C4K must update the provider directory no later than 30 days after receiving updated provider information. The file must be updated at least monthly with hard copies available upon request from a member. The file must be in a machine readable file. The file must include the following information:
   - Provider full name and phone number
   - Provider gender
   - Clinic or facility address
   - Clinic or facility website (if available)
   - Accommodations for members with disabilities
   - Specialty
   - Languages spoken, and
   - If they are accepting new patients.

8. **Article XIV, B, 5, c**
   **Amend to read:**

   Notify Members of Provider Terminations

   The PIHP must send written notification to impacted members within 15 days after receipt or issuance of a notice of termination of a contracted primary care provider, or provider the member sees on a regular basis. The Department must approve all notifications before they are sent to members.

9. **Article VI, 4**
   **Add new language to read:**

   h. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.
   i. stating in PIHP materials that the PIHP is endorsed by the Centers for Medicare and Medicaid Services, the Federal or State government, or similar entity.

10. **Article I**
    **Add new language to read:**

    **Provider Network:** A list of physicians, hospitals, urgent care centers, and other health care providers that an HMO has contracted with to provide medical care to its members. These providers are “network providers”, “in-network providers” or “participating providers”. A provider that has not contracted with the plan is called an “out-of-network provider” or “non-participating provider”.

11. **Article XVI A, 3, b, 3**
    **Amend to read:**
    Total access payments paid for contract year

o Inpatient Hospital – Total access payments paid for claims with an admit date during the contract year being certified.
o Outpatient Hospital – Total access payments for claims with a from date of service during the contract year being certified.

**12. Remove Article XVI A, 3, b, 4 – Access Payment Costs.**

**13. Article XV, C, 3**
**Amend to read:**

3. Payment of PIHP Referrals to Non-Affiliated Providers

For PIHP approved referrals to non-affiliated providers, the PIHP must either establish payment arrangements in advance, or the PIHP is liable for payment only to the extent that Medicaid pays, including Medicare deductibles, or would pay, its FFS providers for services excluding Hospital Access Payments, and Hospital P4P Withhold. Refer to Article VIII for policy on Provider Appeals.

**14. Article X, B, 10**
**Amend to read:**

The PIHP must disseminate the practice guidelines to providers and, upon request, to members and potential members.

**15. Article X, E, 4, b, 2**
**Amend to read:**

Within 72 hours if the provider indicates, or the PIHP determines, that following the ordinary time frame could jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

**16. Article XI, A**
**Amend to read:**

A. Compliance with Applicable Law
In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations that are in effect when the Contract is signed, or that come into effect during the term of the Contract. This includes, but is not limited to Title XIX of the Social Security Act, Title XXI, SCHIP, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The American with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and Title 42 of the CFR.

**17. Article II, B, 5**
**Add as new:**

4. Change in Member Circumstance

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When a member's change is circumstance has been identified and verified by the PIHP, the PIHP must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. Changes in circumstance include:

a. Change in the enrollee's residence when the enrollee is no longer in the PIHP's service area.
b. The death of an enrollee.

**18. Article XII, D,**
**Amend to read:**

The PIHP is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. PIHP staff will participate with the Department in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA and MSIS/TMSIS requirements applicable to the PIHP. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual PIHP meetings with the Department to address changes in requirements, local applications or databases. The PIHP must cooperate with the Department on data submission protocol and testing. The Department or its designees reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract and anytime thereafter. Per 42 CFR 438.602(e), the Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

Data Management and Maintenance: The PIHP must have a system that is capable of providing information on utilization, processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, grievance and appeals, and meeting reporting requirements. The required formats and timelines are specified in Article XII, Section J. The PIHP must:

a. Participate in PIHP encounter technical workgroup meetings scheduled by the Department.

b. Capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contact. The original claim submitted by the provider must be stored and retrievable upon request by either the Department or CMS.

c. Have a database which is a complete and accurate representation of all services the PIHP provided during the Contract period.

d. Be responsible for monitoring the integrity of the database, and facilitating its appropriate use for such required reports as encounter data and targeted performance improvement studies.

e. Be responsible for maintaining unique identifiers assigned by the Department or its designee such as the identification number assigned to each submitted encounter. The PIHP must maintain all national code sets and Department specific fields as defined in ForwardHealth and the HMO Encounter User Guide.

f. Be responsible for updating and testing new versions of national codes sets and/or state specific code set.

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g. Submit at least 90% of adjudicated clean claims as encounters within 90 days, 99% within 150 days, and 100% within 240 days. The only exception is when the claim is suspended due to a dispute with the provider. If a PIHP paid encounter is denied within the Department's Medicaid Management Information System (MMIS), the PIHP has 90 days to resolve the encounter to priced status within the system.

h. Not alter encounters with dates of service older than two years of the current year. For example, if the current calendar year is 2015, the PIHP must not alter encounters with a date of service of 2012 or older.

i. Comply with section 6504(a) of the Affordable Care Act, including operating systems that allow the Department to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meet the requirements of section 1903(r)(1)(F) of the Act.

j. Verify the accuracy and timeliness of data reported by providers, including data from network providers the PIHP is compensating on the basis of capitation payments.

k. Screen the data received from providers for completeness, logic, and consistency.

l. Ensure that it is the sole entity to make payments to network providers for covered services, except in specific instances.

**19. Article XII – REPORTS AND DATA**
**Add as new Section N:**

N. Financial Report

The PIHP must submit its audited financial reports on an annual basis, starting with the PIHP's 2019 fiscal year. The audit must be conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards. The PIHP should include a Medicaid supplemental schedule along with the annual audited financial report. The Medicaid supplemental schedule will specifically segregate the financial results for the Foster Care Medical Home program contract from other lines of business for the required audit period and be reported on a GAAP basis. The audited Medicaid supplemental schedule will be provided to the Department in the form of a "Statement of Operations and Changes in Net Assets" exclusive to the PIHP's Foster Care Medical Home contract. The statement must separately identify revenue and expenses covered by this Medicaid contract, other Medicaid contracts, and other non-Medicaid lines of business as applicable for the financial report.

The following example is a minimum requirement for the "Statement of Operations and Changes in Net Assets". The PIHP may provide an expanded statement with additional account categories at its discretion.

PIHP
Statement of Operations and Changes in Net Assets

For the Year Ended December 31, 20xx

| | Foster Care Medical Home Medicaid Contract | All Other Medicaid Contracts | Other Non-Medicaid | Total |
|---|---|---|---|---|
| REVENUE | | | | |
| Premium revenue | | | | |
| Other revenue | | | | |
| Total Revenue | | | | |
| EXPENSES | | | | |
| Medical expenses | | | | |
| Claims adjustment expenses | | | | |
| General administrative expenses | | | | |
| Total Expenses | | | | |
| NET INCOME/(LOSS) | | | | |

The PHIP will also submit its financial data for the Foster Care Medical Home Medicaid Contract on an annual basis on a Financial Template in order to restate medical expenses for paid claims and revenue for enrollment retroactively. The payment period will align with the encounters reported for the final reconciliation and will include a reconciliation of the Foster Care Medical Home Medicaid Contract reported on the audited Medicaid supplemental schedule. The PIHP shall report financial data that exclusively includes allowable services under this contract for eligible members. The Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

**20. Article XVI, Section A – Reimbursement Method**
**Amend Part 3(b.2) to read:**

Service Costs - The reconciliation amounts will be calculated by comparing the amounts paid to providers against the services reported in the encounter system re-priced at the Medicaid fee-for-service paid amount. Encounters submitted and repriced in the encounter system by the end of the thirteenth (i.e. January 31st) month after the calendar year will be included in the final reconciliation. The Department will send all service year encounters in the MMIS to the PIHP by the middle of the 14th month (i.e. February 15th). The final reconciliation amount will include a missing data adjustment up to two percent of total allowable costs to account for missing encounters, as well as encounters that were submitted but not accepted by the Medicaid Management Information System.

This adjustment will be developed based on a comparison of the total PIHP paid amounts in the encounter data and the total member service costs reported in the PIHP's audited financial data. The total member service costs reported in the PIHP's audited financial data will be divided by the total PIHP paid amounts in the encounter data. A factor of one (1) will be subtracted from this percentage. This final percentage will be multiplied by the total repriced paid amounts in the encounter data to determine the missing data adjustment dollar amount.

The missing data adjustment will not exceed the lesser of either two percent of total allowable costs or the missing data adjustment dollar amount derived from dividing the total member service costs reported in the PIHP's audited financial data by the total PIHP paid amounts in the encounter data, subtracting one (1) and multiplying by the total repriced paid amounts in the encounter data.

Example of Missing Data Adjustment Calculation:

| | a | b | c<br>(a/b) - 1 | d | e<br>c * d | f<br>2% * a | g<br>Lesser of e or f |
|---|---|---|---|---|---|---|---|
| | Total allowable member service costs reported in the PIHP's audited financial data | Total PIHP paid amounts in the encounter data | Missing data adjustment formula | Total repriced paid amounts in the encounter data | Missing data adjustment amount | Two percent of total allowable costs | Lesser of missing data adjustment or two percent of total allowable costs |
| Example 1 | $1,000,000 | $950,000 | 5.263% | $930,000 | $48,947.37 | $20,000 | $20,000 |
| Example 2 | $1,000,000 | $990,000 | 1.010% | $970,000 | $9,797.98 | $20,000 | $9,797.98 |

The resulting total service costs for allowable services provided to eligible enrollees will be compared to the non-risk prepayment rates, less the administrative component, paid to the PIHP for the same period of time. If, in aggregate, the amount spent as reported in this manner is greater than the amount paid in non-risk prepayment rates by the Department, an additional payment will be made to the contracting provider. If, instead, the amount reported is less than the Department provided in non-risk prepayments, a recoupment will be processed. The PIHP will submit the Financial Template and signed encounter attestation by the end of the fifteenth month (i.e. March 31st). The corrected amount calculated will be provided, or recouped by the Department, by the end of, the seventeenth month (May 31st) after the end of the calendar year period in question.

21. **Addendum VIII – Rates**

**Add the following Rate Exhibit for CY 2019 rates.**

**Exhibit 4**
**Wisconsin Department of Health Services**
**CY 2019 Care4Kids Non-Risk Prepayment Rate Development**
**CY 2019 Non-Risk Prepayment Rates**

| | | Milwaukee Adjustment | | | Southeastern Adjustment | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Regional Variation | 1.085 | 1.085 | 1.085 | 0.844 | 0.844 | 0.844 | | | |
| | | CY 2019 Milwaukee PMPMs | | | CY 2019 Southeastern PMPMs | | | CY 2019 PMPMs | | |
| | Age Group | Title IV-E | Non Title IV-E | Total | Title IV-E | Non Title IV-E | Total | Title IV-E | Non Title IV-E | Total |
| CY 2019 PMPM | Age 0 | $480.49 | $1,192.78 | $839.82 | $373.84 | $928.03 | $653.42 | $443.01 | $1,099.75 | $774.32 |
| | Ages 1-5 | 303.99 | 464.18 | 383.66 | 236.52 | 361.15 | 298.51 | 280.28 | 427.98 | 353.74 |
| | Ages 6-14 | 404.17 | 441.04 | 427.39 | 314.46 | 343.15 | 332.53 | 372.65 | 406.64 | 394.06 |
| | Ages 15-20 F | 369.28 | 502.23 | 471.66 | 287.32 | 390.76 | 366.97 | 340.48 | 463.06 | 434.87 |
| | Ages 15-20 M | 237.10 | 355.38 | 331.40 | 184.48 | 276.50 | 257.84 | 218.61 | 327.66 | 305.55 |
| **CY 2019 PMPM Total** | | **$355.38** | **$497.31** | **$438.54** | **$276.50** | **$386.93** | **$341.21** | **$327.66** | **$458.52** | **$404.34** |
| PMPM Non-Service Costs | Age 0 | $72.02 | $72.02 | $72.02 | $72.02 | $72.02 | $72.02 | $72.02 | $72.02 | $72.02 |
| | Ages 1-5 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 |
| | Ages 6-14 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 |
| | Ages 15-20 F | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 |
| | Ages 15-20 M | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 | 72.02 |
| **PMPM Non-Service Costs Total** | | **$72.02** | **$72.02** | **$72.02** | **$72.02** | **$72.02** | **$72.02** | **$72.02** | **$72.02** | **$72.02** |
| Access Payments Add-On | Age 0 | $104.03 | $104.03 | $104.03 | $104.03 | $104.03 | $104.03 | $104.03 | $104.03 | $104.03 |
| | Ages 1-5 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 |
| | Ages 6-14 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 |
| | Ages 15-20 F | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 |
| | Ages 15-20 M | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 | 104.03 |
| **Access Payments Add-On Total** | | **$104.03** | **$104.03** | **$104.03** | **$104.03** | **$104.03** | **$104.03** | **$104.03** | **$104.03** | **$104.03** |
| Non-Risk Prepayment Rates | Age 0 | $656.54 | $1,368.83 | $1,015.87 | $549.89 | $1,104.08 | $829.47 | $619.06 | $1,275.80 | $950.37 |
| | Ages 1-5 | 480.04 | 640.23 | 559.71 | 412.57 | 537.20 | 474.56 | 456.33 | 604.03 | 529.79 |
| | Ages 6-14 | 580.22 | 617.09 | 603.44 | 490.51 | 519.20 | 508.58 | 548.70 | 582.69 | 570.11 |
| | Ages 15-20 F | 545.33 | 678.28 | 647.71 | 463.37 | 566.81 | 543.02 | 516.53 | 639.11 | 610.92 |
| | Ages 15-20 M | 413.15 | 531.43 | 507.45 | 360.53 | 452.55 | 433.89 | 394.66 | 503.71 | 481.60 |
| **Non-Risk Prepayment Rates Total** | | **$531.43** | **$673.36** | **$614.59** | **$452.55** | **$562.98** | **$517.26** | **$503.71** | **$634.57** | **$580.39** |

All terms and conditions of the January 1, 2018 through December 31, 2019 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect.

| **PIHP Name**<br><br>**Care4Kids** | **Department of Health Services** |
|---|---|
| Official Signature<br>DocuSigned by: Robert Duncan<br>3D62E652925447E... | Official Signature<br>DocuSigned by: Julie A. Willems Van Dijk<br>C778AE357914413... |
| Printed Name<br><br>Robert Duncan | Printed Name<br><br>Julie A. Willems Van Dijk |
| Title<br><br>President - CCHP | Title<br><br>Deputy Secretary |
| Date<br><br>2/27/2020 | Date<br><br>3/5/2020 |