Contract Amendment for BadgerCare Plus and SSI Medicaid Services

The agreement entered into for the period of January 1, 2016 through December 31, 2017 between the State of Wisconsin acting by or through the Department of Health Services, hereinafter referred to as the "Department" and _______________________________________, an insurer with a certificate of authority to do business in Wisconsin for the BadgerCare Plus and/or Medicaid SSI Managed Care Program hereinafter referred to as the "HMO", is hereby amended as follows:

Effective January 1, 2016

1. **Article I – Definitions**
   Add a new definition after "Service Area":

   Service Authorization: A member's request for the provision of a service.

2. **Article II, Section B - Disenrollment**
   Amend the first paragraph to read:

   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 or exemption determination within 30 days of receipt of all necessary information, the disenrollment or exemption is considered approved. The HMO must direct all members with disenrollment requests to the Department's Enrollment Specialist.

   Amend Part 1 to read:

   1. Voluntary Disenrollment

      Voluntary disenrollment requests from HMO enrollment must come from the member, the member's family, or legal guardian. Below are listed the different types of voluntary disenrollments.

      a. BadgerCare Plus

         All BadgerCare Plus members shall have the right to disenroll from the HMO pursuant to 42 CFR 438.56 unless otherwise limited by a State Plan Amendment or a Section 1115(a) waiver of federal laws. A voluntary disenrollment shall be effective no later than the first day of the second month following the month in which the member requests termination. Wisconsin currently has a State Plan Amendment and an 1115(a) waiver which allows the Department to "lock-in" members to the HMO for a period of 12 months in mandatory HMO service areas, unless disenrollment is allowed for just cause. Voluntary exemptions and disenrollments from the HMO are allowed for a variety of reasons.

      b. Medicaid SSI

         All mandatory Medicaid SSI or SSI-related Medicaid members have the right to disenroll from the HMO after completing a 60 day trial period. A voluntary disenrollment for the

mandatory Medicaid SSI population shall be effective no earlier than the first day of the third month following enrollment. If the member, legal guardian or authorized representative does not elect disenrollment during the first four months of enrollment, the member will be locked-in to the HMO for the remainder of the 12 month enrollment period. The member is required to complete only one 60 day trial period. If there is a disenrollment and subsequent re-enrollment, the member is not required to complete another trial period.

All voluntary Medicaid SSI members shall have the right to disenroll from the HMO within the first 90 days of enrollment. Such voluntary Medicaid SSI disenrollment shall be effective no earlier than the first day of the month following the request to disenroll. If the member, legal guardian or authorized representative does not elect disenrollment during the first three months of enrollment, the member will be locked-in to the HMO for the remainder of the 12-month enrollment period.

c. Members may also request disenrollment upon automatic reenrollment under 42 CFR 438.56(c) if the temporary loss of BadgerCare Plus and/or Medicaid SSI enrollment has caused the member to miss the annual enrollment period.

d. A member may also request disenrollment if an HMO 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.

e. A member may request HMO disenrollment if the member needs related services (e.g., a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

f. A member may request HMO disenrollment for other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

3. Article II, Section C – Exemptions
Amend the third paragraph to read:

Exemption requests from HMO enrollment must come from the member, the member's family, or legal guardian. Below are listed the exemption criteria that the Department uses to grant exemptions. The exemption chart (Subsection 6 of this article) indicates whether the exemption is applicable to BadgerCare Plus or SSI HMO. Even if a member meets the exemption criteria, the Department may, in its sole discretion, deny an exemption. Members who are denied an exemption may request a State Fair Hearing to appeal the denial.

4. Article IV, Section F – Provider Moral or Religious Objection
Amend the first bullet to read:

- To the Department and Enrollment Specialist so the Department can notify members of the HMO's non-coverage of service;

5. Article V, Section C – Written Standards for Accessibility of Care
Add a new Part 3 to read:

The HMO may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

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

6. Article V, Section E, Part 6 – Second Medical Opinions
Amend to read:

The HMO must have written policies and procedures guaranteeing each member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand and for providing members the opportunity to have a second opinion from a qualified network provider subject to referral procedures approved by the Department. If an appropriately qualified provider is not available within the network, the HMO must authorize and reimburse for a second opinion outside the network at no charge to the member, excluding allowable copayments.

7. Article VI, Section D – Member Handbook, Education and Outreach for Newly Enrolled Members
Amend Part 1 to read:

1. The member handbook shall be written at a sixth-grade reading comprehension level and at a minimum will include information about:

   a. The telephone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care.
   b. Information on contract services offered by the HMO.
   c. Location of facilities.
   d. Hours of service.
   e. Informal and formal grievance procedures, including notification of the member's right to a fair hearing.
   f. Grievance and appeal procedures.
   g. HealthCheck.
   h. Family planning policies.
   i. Policies on the use of emergency and urgent care facilities.

j. Contracted providers' telephone numbers and whether the provider is accepting new "members". Additionally, include languages spoken by the provider.
k. Changing HMOs.
l. SSI Comprehensive assessments (for Medicaid SSI members only).
m. Counseling and referral services that are not covered under the contract because of moral or religious objections.

Amend Part 4(a) to read:

As needed, the HMO must provide periodic updates to the handbook and notify members of changes to the information listed above. The HMO must provide members at least a 30 day notice, in writing, of any significant changes to the handbook before the intended effective date of the change. Such changes must be approved by the Department prior to printing. The HMO must work with the Department to review these changes in accordance with the timeline established in Article VI, A.2.

8. Article VII – Member Rights and Responsibilities
Amend the first paragraph to read:

The HMO must have written policies guaranteeing each member's rights, and share those written policies with staff and affiliated providers to be considered when providing services to members. The HMO must comply with any applicable Federal and State laws, including those identified in 42 CFR 438.100, that pertain to member rights. The HMO must have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

9. Article VII, Section B – Advance Directives
Add as a new Part 6:

6. Provide staff training about HMO specific policies and procedures related to advance directives.

10. Article VIII – Appeals and Grievances
Amend VIII title to read:

VIII. Provider Appeals and Member Grievances

11. Article VIII, Section A – Provider Appeals
Amend the first sentence of the first paragraph of Section A to read:

Providers, who have attempted unsuccessfully to resolve payment disputes directly with the HMO through the HMO's established appeal process, may choose to pursue resolution directly with the Department through the provider appeal process.

Amend Section A, Part 1(a) to read:

1. HMO Responsibility

The HMO must inform providers and subcontractors, in writing at the time they enter into a contract, of the toll-free number for members to file oral grievances and appeals as well as the provider's and subcontractor's right to appeal a denied/reduced payment or payment recoupment after audit or Utilization Management review (42 CFR s. 438.414).

12. Article VIII, Section B – Member Grievances
Amend the first sentence of the first paragraph of Section B to read:

The member grievance process refers to the overall system that includes complaints, grievances, and appeals or expedited appeals as defined in Article I.

Amend Part 1(g) to read:

g. Respond to grievances and appeals in writing within 10 business days of receipt, except in emergency or urgent (expedited grievance) situations. This represents the first response. The HMO must resolve the grievance or appeal within two business days of receipt of a verbal or written expedited grievance, or sooner if possible. If the HMO denies a request for expedited resolution of an appeal, it must:

- Transfer the appeal to the timeframe for standard resolution; and
- Make reasonable efforts to give the member prompt oral notice of the delay; and
- Within 2 calendar days, give the member written notice of the reason for the decision to extend or deny the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

Amend Part 1(k) to read:

k. Maintain records of complaints and grievances that includes a short, dated summary of each problem, the response, and the resolution. The log must distinguish between BadgerCare Plus and Medicaid SSI members, if the HMO serves both populations. If the HMO does not have a separate log for BadgerCare Plus and/or Medicaid SSI and their commercial members, the log must distinguish between the programs. The HMO must submit quarterly reports to the Department of all complaints, grievances and appeals (Addendum IV, H). The analysis of the log will include the number of complaints, grievances and appeals divided into two categories, program administration and benefit denials. HMOs should report [in Addendum IV, F, 1 (a-c)] those members that grieved or appealed to the HMO's grievance appeal committee.

Amend Part 1(o) and Part 1(p) to read:

o. Distribute to its gatekeepers, providers, subcontractors, and Independent Practice Associations (IPAs) the information flyer on member grievance and appeal rights (the Ombuds Brochure), at the time the contract is entered. When a new brochure is available, the HMO must distribute copies to its gatekeepers, providers, subcontractors, and IPAs within three weeks of receipt of the new brochure.

p. Ensure that its gatekeepers, providers, subcontractors, and IPAs have written procedures for describing how members are informed of denied services. The HMO will make copies of the

gatekeepers', providers', subcontractors', and IPAs' grievance procedures available for review upon request by the Department.

Amend the fourth paragraph of Part 2 to read:

The HMO and its' contracted providers must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports a member's grievance.

Amend Part 3 to read:

3. Notifications to Members

   When the HMO, its gatekeepers, providers, subcontractors, or IPAs discontinue, terminate, suspend, limit, or reduce a service (including services authorized by the HMO the member was previously enrolled in or services received by the member on a FFS basis), the HMO must notify the affected member(s), and his/her provider when appropriate, in writing at least 10 days before the date of action. When the HMO, its gatekeepers, providers, subcontractors, or its IPAs deny coverage of a new service, the HMO must notify the member of the denial in writing.

Amend Part 3(o) to read:

o. Notifications to members of termination, suspension, or reduction of an ongoing benefit (including services authorized by the HMO the member was previously enrolled in or services received by the member on a FFS basis), must in addition to items a. through n. above, also include the following:

   - The fact that a benefit will continue during the appeal or DHA fair hearing process if the member requests that it continue within 10 days of notification or before the effective date of the action, whichever is later.
   - The circumstances under which a benefit will continue during the grievance and appeal process.
   - The fact that if the member continues to receive the disputed service, the member may be liable for the cost of care if the decision is adverse to the member.

   This notice requirement does not apply when the HMO, its gatekeeper, provider, subcontractor, or IPA triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

13. Article IX, Section B – Monitoring and Evaluation
Add as a new Part 3:

3. HMOs must mandate provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR s. 434.6(a)(12) and 42 CFR s. 447.26. HMOs must report all identified provider-preventable conditions through its encounter data.

Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

Other provider-preventable conditions for non-payment are identified as:

- Wrong surgical or other invasive procedure performed on a patient;
- Surgical or other invasive procedure performed on the wrong body part;
- Surgical or other invasive procedure performed on the wrong patient.

14. Article IX, Section F – Medical Records
Amend Part 1 to read:

1. The HMO must have written policies and procedures for participating provider medical records content and documentation that have been communicated to providers and a process for evaluating its providers' medical records based on the HMO's policies. These policies must address patient confidentiality, data organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The HMO must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must include information with respect to disclosure of member-identified medical record and/or enrollment information and specifically provide:

   a. That members may review and obtain copies of medical records information that pertains to them.

   b. That members have the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected.

   c. That policies above must be made available to members upon request.

Amend Part 8 to read:

8. Requests for completion of residual functional capacity evaluation forms and other impairment assessments, such as queries as to the presence of a listed impairment, must be provided within 10 business days of the request (at the discretion of the individual provider and subject to the provider's medical opinion of its appropriateness) and according to the other requirements listed above.

15. Article IX, I – Accreditation
Amend the first paragraph to read:

Per 42 CFR §. 438.350, the HMO is required to undergo annual, external independent reviews of quality outcomes, timeliness of and access to services covered under this contract. The External Quality Review Organization will be the entity conducting the review of the HMO and must conduct the activities defined in 42 CFR §. 438.358 annually using the protocols defined in 42 CFR §. 438.352.

16. Article X, Section B – Compliance with Applicable Law
Amend the first paragraph to read:

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 Americans with Disabilities Act, and Title 42 of the CFR.

17. Article X, Section C, Part 6 – Provision of Services to the HMO Members
Add as a new third paragraph:

The HMO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

18. Article XI, Section K, Part 2 – Fraud and Abuse Investigations
Amend the first paragraph to read:

The HMO agrees to cooperate with the Affordable Care Act (ACA) suspension of payment requirements, and with the Department on fraud and abuse investigations. The HMO is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments. In addition, the HMO agrees to report allegations of fraud and abuse (both provider and member) to the Department within 15 days of the suspected fraud or abuse coming to the attention of the HMO. Failure on the part of the HMO to cooperate or report fraud and/or abuse may result in any applicable sanctions under Article XIII, Section C.

19. Article XIII, Section C, Part 7 – Sanctions and Remedial Actions
Amend to read:

The Department may pursue all sanctions and remedial actions with the HMO that is taken with FFS providers including any civil 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 an HMO as provided in 42 CFR 438.706.

The Department will provide written notice of all intermediate sanction (other than required temporary management) that explains the basis and nature of the sanction and any due process protections the state elects to provide.

20. Article XIII, Section D – Termination and Modification of Contract
Add as a new first paragraph to Part 2:

Before the State terminates an HMO contract under 42 CFR §438.708, the State must provide the HMO a pre-termination hearing. The State will give the HMO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. After the hearing, the State will give the HMO written notice of the decision affirming or reversing the proposed termination of the contract and, for affirming the decision, the effective date of termination. For an affirming decision, give enrollees of the HMO notice of the termination and information, consistent with 42 CFR §438.10, on their options for received Medicaid services following the effective date of termination.

In addition, this Contract between the parties may be terminated by either party as follows:

21. Article XIV, Section A – Billing Members
Amend the third paragraph to read:

The HMO and its providers and subcontractors must not bill a BadgerCare Plus or Medicaid SSI member for medically necessary covered services provided to the member, for which the State does not pay the HMO; or the State or the HMO does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of HMO enrollment, except for allowable co-payments and premiums established by the Division of Health Care Access and Accountability (DHCAA) for covered services provided during the member's period of enrollment in BadgerCare Plus. In addition, the HMO must ensure that its Medicaid members are not held liable for payments for medically necessary covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the HMO covered the services directly.

22. Article XIV, Section D – Payment Requirements/Procedures
Add as a new Part 11:

11. The HMO is prohibited from making payment to a provider for provider-preventable conditions (42 CFR 438.6(f)(2)(i)).

    All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made must be reported by all providers to the HMO per 42 CFR 438.6(f)(2)(ii).

Refer to Article IX, B.3 for a comprehensive listing of provider-preventable conditions.

23. Article XV, Section A – Actuarial Basis
Add as a new second and third paragraph:

Payment shall not be made with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

Payment shall not be made with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; except for "in lieu of" services outlined in this contract.

24. Article XV, Section C – Capitation Rates
Add as a new fourth paragraph:

No payment shall be made to a network provider other than by the HMO for services covered under this contract, except when these payments are specifically required by the State in Title XIX of the Act, in 42 CFR chapter IV, or when the State makes direct payments to network providers for graduate medical education costs approved under the State plan.

25. Article XVI, Section B, Part 1 – Ownership or Controlling Interest in an HMO and Business Transactions
Amend d. to read:

d. Potential Sources of Disclosure Information

HMOs must disclose all ownership and controlling interest to the Department upon request or as federally required. The HMO may supply this information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

As directed by the CMS Regional Office (RO), the Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the HMO has not supplied this information, a contract with the HMO is not considered approved for this period of time and no FFP is available for the period of time preceding the disclosure.

A managed care entity may not knowingly have as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's a person who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulation or who has an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the state.

If the Department finds that the HMO has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

- Must notify the Secretary of noncompliance.
- May continue an existing agreement with the HMO unless the Secretary directs otherwise.
- May not renew or otherwise extend the duration of an existing agreement with the HMO unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

26. Addendum II – Standard Member Handbook Language for BadgerCare Plus and Medicaid SSI Amend the first paragraph of the "Appeals" section to read:

You have the right to appeal to the State of Wisconsin, Division of Hearings and Appeals (DHA), for a fair hearing if you believe your benefits are wrongly denied, limited, reduced, delayed, or stopped by [HMO Name]. An appeal must be made no more than 45 days after the member receives notice of action about the decision being appealed. You may need to pay for the cost of services if the hearing services if the hearing decision is not in your favor.

All terms and conditions of the January 1, 2016 through December 31, 2017 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 Michael Heifetz
Title	Title Medicaid Director