Contract Amendment for BadgerCare Plus Services

____

(HMO)

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 for the period of September 1, 2010 through December 31, 2013 as follows:

1. Article I – Definitions

Amend "Assessment" to read:

Assessment: An encounter where an appropriately qualified health care professional evaluates a member's special health care needs using evaluation, examination or diagnostic tools, review of past medical history, records such as laboratory reports, patient interview, to adequately address the member's health care and/or cultural needs in a multi-disciplinary treatment plan, plan of care or approach to delivery of care. The evaluation must include an encounter of care, either face-to face or a telephonic contact. Comprehensive physical examination is not required, unless it is necessary to fully assess the member's health care needs. For the purposes of an assessment, qualified health care professional may include non-physician providers such as a psychologist for a member with an identified mental health care need, or advanced practice nurse, physician assistant, registered nurse or social worker, where physician intervention is not required.

Add as a new definition "Coordination of Benefits (COB)":

Coordination of Benefits: Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

Amend "Department" to read:

Department: The Wisconsin Department of Health Services.

Amend "Grievance" to read:

Grievance: An expression by a member or authorized representative of dissatisfaction or a complaint about any matter other than an action. The term is also used to refer to the overall system of complaints, grievances and appeals handled by the HMO. Possible grievance subjects include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The member or authorized representative may file a grievance either orally, or in writing and must follow an oral filing with a written, signed grievance (unless the member requests expedited resolution) (42 CFR 438.402(b)(3)(ii)).

Amend "Potential Member" to read:

Potential Member: A BadgerCare Plus member who is subject to mandatory managed care enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific HMO.

Add as a new definition "Serious Emotional Disturbance, Severe Emotional Disturbance, Severely Emotionally Disturbed and SED":

Serious Emotional Disturbance, Severe Emotional Disturbance, Severely Emotionally Disturbed and SED: A persistent mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders affecting an individual under 21 who meets specific criteria for symptoms or functional impairment, and receiving services from multiple systems.

Add as a new definition "Third Party Liability (TPL)":

Third Party Liability (TPL): The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims (see Addendum IV, B for additional definitions pertaining to TPL).

2. **Article II – Delegations of Authority**

Amend the third bullet to read:

The HMO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once per contract period.

3. **Article III, C.4.a.2) – Affirmative Action Plan**

Amend 2) to read:

The HMO must file its AA plan every 3 years and includes all programs. The plan must be submitted to:

Bureau of Intergovernmental & Contract Management (BIRCM)
Department of Health Services
Division of Enterprise Services
1 West Wilson Street, Room 618
P.O. Box 7850
Madison, WI 53707

Compliance with the requirements of the AA Plan will be monitored by the DHS Office of Affirmative Action and Civil Rights Compliance.

4. **Article III, C.4.b.(1) – Civil Rights Compliance (CRC) Plan**

Amend the first sentence to read:

The HMO receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of 2010-2013 regardless of the number of employees and the amount of funding received.

5. **Article III, D – Payment Requirements/Procedures**

   Delete the last sentence of the first paragraph.

6. **Article III, D.9 – Hospitalization at the Time of Enrollment or Disenrollment**

   Amend the last paragraph to read:

   In these two exceptions, the HMO's liability shall not exceed the period for which it is capitated. When calculating the HMO liability for the member, the HMO should take the total stay allowed divided by the total number of days hospitalized to determine a daily rate. The daily rate would then be multiplied by the number of days the member was enrolled in the HMO.

7. **Article III, E.1.a – Provision of Contract Services**

   Delete all of a.

8. **Article III, E.5.d – Ambulance Services**

   Amend the second sentence of "d" to read:

   Failure will constitute the HMO agreement to pay the appealed claim to the extent FFS Medicaid would pay.

9. **Article III, E.6**

   Amend to read:

   6. Non Emergency Medical Transportation (NEMT)

      BadgerCare Plus – Standard/Benchmark Plans (excluding BadgerCare Plus CORE)

      The HMO must provide or arrange for non emergency medical transportation, including HealthCheck screenings, as specified below and in accordance with the BadgerCare Plus transportation guidelines included in the Medicaid Enrollment Handbook, online at http://emhandbooks.wi.gov/bcplus/policyfiles/5_Coverage/38_Covered_Services/38.3.htm.

      Non emergency medical transportation includes, but is not limited to, taxi, van, or bus as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus covered services and including those Medicaid services not covered by the HMO such as chiropractic and family planning services. Non emergency medical transportation also includes coverage of meals and lodging in accordance with the Medicaid Enrollment Handbook.

      HMOs will be required to submit non emergency medical transportation reports according to the format in Addendum IV, J to receive reimbursement. SE RFP HMOS will not be reimbursed for administration for non emergency medical transportation.

10. **Article III, E.10 – Fertility Drugs**

    Remove #10.

11. Article III, F. 13 – Memoranda of Understanding (MOU)/Contract Requirement and Relations with other Human Service Agencies

Amend the third paragraph to read:

MOUs must be signed every three years as part of certification. If no changes have occurred, then both the county and the HMO must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Benefits Management upon request. HMOs must conduct outreach to agencies that do not have a MOU with the health plan, at a minimum, every two years. The HMO must submit evidence that it attempted to obtain a MOU or contract in good faith.

12. Article III, G – Provider Appeals

Amend the first paragraph of #4 to read:

The HMO must perform ongoing monitoring of provider appeals, and perform provider outreach and education on trends to prevent future denials/partial payments, thus reducing future provider appeals.

13. Article III, H.5.d – HMO Referrals to Out-of-Network Providers for Services

Amend to read:

The HMO must provide adequate and timely coverage of services provided out of network, when the required medical service is not available within the HMO network. The HMO must coordinate with out-of-network providers with respect to payment and ensure that cost to the member is no greater than it would be if the services were furnished within the network [42 CFR. §. 438.206(b) (v) (5) and S.S.A. 1932(b)(2)(D)].

Emergency services provided out of network must also not have a cost to the member greater than if the emergency services were provided in-network. The HMO must reimburse for emergency services provided to members in Canada or Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. Non-emergency services in Canada or Mexico may be covered by the HMO per the HMO's prior authorization policies, provided the financial institution receiving payment is located within the United States.

14. Article III, H.5 – Access to Selected BadgerCare Plus Providers and/or Covered Services

Add as a new g:

g. Access to Tribal Health Providers

For Native American members enrolled in the HMO, the HMO must ensure access to an Indian Health Care Provider or Service (Indian Tribe, Tribal Organization, or Urban Indian Organization, or I/T/U), when available. If such a provider agrees to serve in the network as a PCP and has capacity, the member must be allowed to select that provider as her or his PCP. If no such provider is contracted, the HMO must allow the member to see the provider

out of network. The Department encourages HMOs to contract with any Indian Health Care Providers or Services within the HMO's service area.

The HMO must pay all Indian Health Care Providers or I/T/Us, whether participating in the network o not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Native American members.

Native American members are exempt from payment of fees, co-payments, or premiums for services provided by an I/T/U organization or provider, or through referral by an I/T/U.

Native American members can be identified through the following:

- ForwardHealth medical status code
- Letter from Indian Health Services identifying the individual as a tribal member
- Tribal enrollment/membership card
- Written verification or a document issued by the Tribe indicating tribal affiliation
- Certificate of degree of Indian blood issued by the Bureau of Indian Affairs
- A Tribal census document, or
- A medical record card or similar documentation that is issued by an Indian health care provider that specifies an individual as an Indian.

15. Article III, H.6 – Network Adequacy Requirements

Amend the first sentence of the last paragraph to read:

The HMO must notify the Department of any geographical service area reductions 120 days before the intended decertification date unless DHS agrees to a shorter time period based on extraordinary circumstances beyond the control of the HMO.

16. Article III, I.1.a.6 – Advocate Requirements

Amend to read:

Participate in working with DHCAA Managed Care staff assigned to the HMO on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.

17. Article III, I.1.b – Staff Requirements and Authority of the BadgerCare Plus HMO Advocate

Amend the first paragraph to read:

At a minimum, the HMO must have one HMO Advocate for every 10,000 members. Alternative staffing plans will be considered and must be submitted to the Department for approval. The advocate(s) must be located in the organizational structure so that they have the authority to perform the functions and duties listed in Section 1, a, 1)-12) above.

18. Article III, I.5.g – Coordination and Continuation of Care

Amend g. to read:

Share with other HMOs (which may include Medicare or commercial plans, or for members transitioning to a new Medicaid HMO) serving the member, results of its identification and assessment of any member with special health care needs so that those activities need not be duplicated.

19. Article III, I.6 – Conversion Privileges

Delete all of 6.

20. Article III, I.7.a-Member Handbook, Education and Outreach for Newly Enrolled Members

Amend the first paragraph of a. to read:

Within 10 days of initial enrollment notification to the HMO, provide a member handbook written at a sixth grade reading comprehension level and which at a minimum will include information about:

Amend the last paragraph of a. to read:

HMOs can opt not to mail member handbooks to members who are being re-enrolled in the same health plan, unless a handbook is specifically requested by the member. The HMO shall notify all members annually that the member handbook is available online and can be mailed hardcopy upon request.

Notification about the availability of member handbooks and provider directories must be mailed to each case head, but HMOs may choose to mail to each individual member. HMOs must post their current BadgerCare Plus member handbooks and provider directories on their website.

21. Article III, L.3.e – Allowable Member Communication and Outreach Practices

Amend e. to read:

Offer gifts (valued $5-$25) to current members as incentives for a quality improvement strategy. Gifts given in a raffle may be valued up to $100 (only a few members in the HMO may receive gifts of this value). The Department will review any other incentives the HMO may want to implement on an individual basis.

22. Article III, L.4.d

Delete d:

~~Advertising of non-mandated services (e.g. waiving co-pays).~~

23. Article IV, B.1 – Monitoring and Evaluation

Amend the last two sentences of 1. to read:

The Department will report HEDIS results for MY 2012 and MY 2013 including HMO-audited HEDIS results, in CY 2013 and CY 2014 respectively. For clinical services where no HEDIS measure exists, the Department will use the existing MEDDIC-MS measures as applicable.

24. Article IV, J – Performance Improvement Priority Areas and Projects

Amend the last two sentences of the second paragraph to read:

Complete data for all reported services must be provided. The Department and the HMO will collaborate in the area of service and clinical care improvements by the development and sharing of "best practices" and use of performance measures.

25. Article IV, J.5

Amend the second sentence to read:

The preliminary summary must address Steps 1 through 6 (per list of PIP steps, included as point 12) and must be submitted to DHS in template format via email to the health plan's Contract Monitor.

26. Article V, A – Enrollment Determination

Amend to read:

Identify BadgerCare Plus Standard and Benchmark Plan members who are eligible for enrollment in the HMO as the result of eligibility under the eligibility status codes listed in the cart at the following website:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/reportsData.htm.spage

27. Article V, M – Member Health Status and Primary Language Report

Delete M.

28. Article VI, A – Capitation Rates

Amend the first bullet to read:

The Department's enhanced funding policies include ventilator dependent members. The HMO cannot submit a request for enhanced funding under more than one of the two funding policies for the same member for the same date(s) of service.

Delete the third bullet:

~~CDPS adjuster will be 100% in 2011 for BadgerCare Plus – Standard and Benchmark Plan members.~~

Amend the first paragraph of the third bullet to read:

For deliveries meeting the requirements for a kick payment, health plans should submit the information consistent with Addendum IV, L and should submit the associated encounter data as well. Periodically, the Department will validate the kick payment reporting to ensure accuracy.

Delete the last two bullets:

~~The Department will reimburse HMOs outside the capitation rate for reporting of ICD -9-CM V85.5 series diagnosis codes, and Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. Reimbursement will be consistent with the FFS implementation timeline and FFS policies as described in the ForwardHealth Provider Updates. The Department will develop the necessary forms that must be submitted for reimbursement. All services must be reflected in accepted encounter data. The HMO shall perform provider outreach and education regarding SBIRT services, and reporting of V85.5 series diagnosis codes.~~

~~"Dental: The HMO will audit or otherwise determine if any dental…"~~

29. Article VI, E – Payment Schedule

Delete the "Capitation payments for Newborns" Section

30. Article VI, H – Neonatal Intensive Care Unit (NICU) Risk-Sharing Payment(s)

Delete all of H. Neonatal Intensive Care Unit (NICU) Risk-Sharing Payment(s)

31. Article VI, I.2 – Payment(s) for Ventilator Dependent Members

Amend the first sentence of 2. to read:

HMO's medical costs are not to exceed 150% of the aggregate total Medicaid fee-for-service costs of providing BadgerCare Plus covered services to BadgerCare Plus HMO members who meet the ventilator dependent criteria.

32. Article VII, D – Computer Data Reporting System

Add as a new 11:
In 2012 the Department will be migrating to an 837 5010 transaction for encounter reporting from the existing proprietary encounter format. All encounter submissions after the designated conversion date will be required to be in the new 837 5010 transaction format.

33. Article VII, K – Contract Specified Reports and Due Dates

Amend the Reports and Due Dates chart to read:

2010 - 2013 REPORTS AND DUE DATES

Type of Report	Frequency	Report Period	Reporting Unit	Report Format	Location in Contract
Encounter Data File	Monthly, on 10th	Previous Month	Fiscal Agent	Electronic Media	Art. VII, E
HMO Provider and Facility Network	First business day of every month, or for significant changes	Next month	DHS	Electronic Media	Art. III, H Art. VII, I
Annual Performance Report	June 1	Annual	BBM	Electronic Media	Art. IV, M

Formal/Informal Grievance Experience Summary Report	Quarterly (within 30 days of end of quarter)	Previous Quarter	BBM	Hardcopy or Password protected e-mail	Art. IX Add. IV, H Art. VII, E
Attestation Form	Quarterly	Previous Quarter	BBM	Electronic Media	Add. III, C Add. IV, I
Non Emergency Medical Transportation Data	Quarterly	Previous Quarter	BFM – Rate Section	CD-Rom, Secure e-mail or FTP server	Art. III, E Add. IV, J
Ventilator Dependent Report	Quarterly (within 30 days of the end of the quarter)	Previous Quarter	BFM	CD-Rom & Hardcopy	Art. VI, I Add. IV, A
Coordination of Benefits Report	Quarterly (within 45 days of end of quarter)	Previous Quarter	BBM	Electronic Media	Art. VI, F Art. VII, E
Neonatal ICU Patient Care Data (2011 Final Report)	April 1, 2013		BFM	Hardcopy	Art. VI, H Add. IV, C
Initial Performance Improvement Project Topic Selection Summary	First business day of December	Annual	BBM & EQRO	Electronic Media	Art. IV, A Art. IV, J
Individual Hospital Access Payment Data	Monthly, at the time of access payment (Within 15 calendar days of receiving payment from DHS)	Previous month	Any hospital the HMO made payments to	As determined by hospital contract	Art. VI, J Add. IV, K
Summary Hospital Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Art. VI, J Add. IV, K
Individual Ambulatory Surgical Center Access Payment Data	Monthly, at the time of access payment (Within 15 calendar days	Previous month	Any ASC the HMO made payments to	As determined by ASC contract	Art. VI, K Add. IV, L

	of receiving payment from DHS)				
Summary Ambulatory Surgical Center Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Art. VI, K Add. IV, L
Individual Critical Access Hospital (CAH) Payment Data	Monthly, at the time of access payment (Within 15 calendar days of receiving payment from DHS)	Previous month	Any CAH the HMO made payments to	As determined by CAH contract	Art. VI, K Add. IV, K
Summary Critical Access Hospital Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Art. VI, K Add. IV, K
Newborn Report	Monthly	Previous Month	Fiscal Agent	Password-protected E-mail or Fax	Add. IV, F
Affirmative Action (AA) Plan	Every 3 years		AA/CRC Office	As specified on VendorNet	Art. III, C
Civil Rights Compliance Letter of Assurance and Plan	As specified by website listed in (Art. III, C.4.b)	Contract period	AA/CRC Office or filed until request	As specified on DHS website	Art. III, C
Member PCP assignment	First business day of every month	Next month	BBM	Electronic Media	Art. III, I
PCP data sharing plan	September 15, 2010	Term of contract	BBM	Hardcopy	Art. III, I
ED Utilization Management Plan	September 15, 2010	Term of contract	BBM	Hardcopy	Art. IV, M
Medical home pilot implementation plan	September 15, 2010	Term of contract	BBM	Hardcopy	Art. III, R
Medical home semi-annual evaluation	December 1 and June 1 (as part of Annual Performance	Annually	BBM	Hardcopy	Art. III, R

	Report)				
Medical Loss Ratio (MLR) report	July 15	Annually	BFM	Electronic media	Art. VII, J
Maternity Kick Payment Newborn Report	Monthly	Monthly	Fiscal Agent	Electronic Media	Add. IV, N

34. Article VIII, C – Enrollment and Disenrollment Practices

Add as new after the last paragraph:

Newborn Enrollment

If the mother is enrolled in a BadgerCare Plus HMO at the time of birth, the newborn will be enrolled in the same HMO as the mother back to the infant's date of birth.

If the mother is not enrolled in a BadgerCare Plus HMO on the date of birth, then the newborn will be enrolled following the normal ADD methodology for HMO enrollment if applicable. The newborn will be enrolled the next available enrollment month.

Infants weighing less than 1200 grams will be exempt from enrollment if the data submitted to HP by the HMO or the provider supports the infant's low birth weight. If an infant weighs less than 1200 grams, the HMO or provider should check the box on the BadgerCare Plus Newborn Report.

35. Article VIII, F.2.h

Amend the second bullet to read:

Must be seeking care from a provider (physician or hospital) who is either not affiliated with the HMO to which they were assigned or is affiliated but the HMO is closed to new enrollment.

36. Article IX, A.7 - Procedures

Amend the first sentence of #7 to read:

Respond to grievances and appeals in writing within 10 business days of receipt, except in emergency or urgent (expedited grievance) situations.

37. Article IX, B – Grievance and Appeal Process

Amend the first bullet to read:

Standard resolution: within 90 days of the date the member filed the appeal with the HMO if the member filed initially with the HMO (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.

38. Article IX, C – Notifications to Members

Amend the first sentence to read:

When the HMO, its gatekeepers, or its 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 except as provided below.

39. Article X, C.3 – Review and Approval of Subcontracts

Amend the second sentence of #3 to read:

Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Contract.

40. Article XI, D.4 – Withholding of Capitation Payments and Orders to Provide Services

Amend the first two sentences of #4 to read:

The term "erred encounter record" means an encounter record that has failed an edit when a correction is expected by the Department, unless the record remains listed as an "erred encounter record" but is priced for inclusion in the HMO encounter data. This does not apply to records for out-of-state emergency services that are not moved from the erred table due to the inability to match to the provider file.

Amend the first sentence of C. to read:

If it is found that an HMO submitted inaccurate encounter data that was used in the development of the CY11 and CY12 rates, the Department may assess damages associated with the reporting error.

41. Article XII, B – Unilateral Termination

Add as a new #4:

4. This contract may be terminated by the HMO due to dissatisfaction with the final 2012 rates. The HMO must notify the Department within 30 days of notice of the 2012 final rates if the HMO intends to terminate its contract with DHS. In the event of termination under this paragraph, the Contract will terminate without termination costs to either party and, for the purposes of section C., will be considered a termination under paragraph 1. To assure the smooth transition of members, termination of the Contract will be effective no less than 90 days, and no more than 120 days, after HMO notification to DHS of the intent to terminate the Contract. During this period, the HMO will be paid the CY2011 rates.

42. Add. II – Standard Member Handbook Language

Amend the first sentence of the first paragraph in the "Pregnant Women and Deliveries" section to read:

If you become pregnant, please let [HMO NAME] and your county human services department know right away.

Amend the "When You May Be Billed For Services" section to read:

It is very important to follow the rules when you get medical care so you are not billed for services. You must receive your care from [HMO NAME] providers and hospitals unless you have our approval. The only exception is for severe emergencies.
If you travel outside of Wisconsin and need emergency services, health care providers can treat you and send claims to [HMO NAME]. You may have co-payments for emergency services provided outside Wisconsin, but the charges for Medicaid covered services will be no more than charges for services in the network.

[HMO NAME] does not cover any service, including emergency services, provided outside of the United States, Canada and Mexico. If you need emergency services while in Canada or Mexico, [HMO NAME] will cover the service only if the doctor or hospital's bank is in the United States. Other services may be covered with HMO approval, if the provider has a United States bank. Please call [HMO] if you receive any emergency services outside the United States.

Amend the first sentence of the "Services Covered by [HMO NAME]" section to read:

The HMO is responsible to provide all medically necessary covered services under BadgerCare Plus Standard and Benchmark Plans (a summary of covered services and co-payment amounts are referenced in Addendum V).

Amend the "Mental Health and Substance Abuse Services" header to read:

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (language may be different based on which plan you are talking about in the handbook – see the summary of covered services and co-payments referenced in Addendum V.)

Amend the "Family Planning Services" header to read:

FAMILY PLANNING SERVICES (language may be different based on which plan you are talking about in the handbook – see the summary of covered services and co-payments referenced in Addendum V.)

Amend the "Dental Services" header to read:

DENTAL SERVICES (The following language applies to BadgerCare Plus Standard Plan members. The Benchmark Plan has a limited dental benefit for certain populations. See a summary of covered services and co-payments referenced in Addendum V.)

Amend #2 of the "Chiropractic Services" section to read:

You may get chiropractic services from any chiropractor who will accept your ForwardHealth ID card if you are a BadgerCare Plus Standard or Benchmark member. Your chiropractic services are provided by the State, not [HMO NAME].

Amend the "Transportation" section to read:

Non emergency medical transportation by bus, taxi, special medical vehicle (SMV) or other common carrier transportation is arranged by [HMO NAME]. Call our Customer Service Department at 1-800-xxx-xxxx if you need a ride.

[HMO NAME] covers transportation by special medical vehicle (SMV) for those in wheelchairs. We may also cover this service for others if your doctor asks for it. Call our Customer Service Department at 1-800-xxx-xxxx if you need this service.

Delete the "Health Insurance After Your Eligibility Ends" Section

~~HEALTH INSURANCE AFTER YOUR ELIGIBILITY ENDS~~

~~You have the right to purchase a private health insurance policy from [HMO NAME] when your eligibility ends. Call our Customer Service Department at [1-800-xxx-xxxx]. If you decide to purchase a policy from us, you have 30 days after the date you eligibility ends to apply.~~

Add as a new second paragraph to "Living Will or Power of Attorney for Health Care" section:

You have a right to file a grievance with the Department of Health Services, Division of Quality Assurance if your advance directive, living will or power of attorney wishes are not followed. You may request help in filing a grievance.

43. Add. IV, B – Coordination of Benefits Quarterly Report Form and Instructions for Completing the Form

Delete the first paragraph:

~~Note: In addition to the total dollar amount(s) billed and paid for all members the HMO must report the total dollar amount(s) billed and paid for each individual member.~~

Add as new after the second paragraph:

THIRD PARTY LIABILITY

Third Party Liability (TPL) – The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims.

Coordination of Benefits (COB) – Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

- In Medicaid, there are two primary functions related to detecting TPL obligations:
    1. Cost-avoidance – Determining the presence of TPL obligations before the claim is paid.
    2. Pay-and-chase – Identifying TPL obligations after the claim is paid

- The following definitions apply to TPL:
    - **Coinsurance** – A portion or percentage of the cost for a specific service or item for which the individual is responsible when the service or item is delivered.
    - **Cost Avoidance** – A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists, the Medicaid

agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).

- **Deductible** – A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.
- **Estate** – Property (real or personal) in which one has a right or interest at time of death.
- **Health Insurer** – Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)
- **Insurer** – Any private insurer or public insurer.
- **Post Payment Recovery (Pay and Chase)** – A method used where Medicaid pays the member's medical bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.
- **Third Party** – Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan. Medicaid is generally the payer of last resort. Examples of a third party are employment-related health insurance, medical child support from non-custodial parents, and Medicare. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to take reasonable measures to determine the legal liability of third party payers.

Revise A. and B. of the HMO Report on Coordination of Benefits to read:

A. Cost Avoidance – The amount reported should be the amount paid by TPL up to the Fee for Service allowed amount for "Dates of Payment" in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus program should not be reported.

Amount Cost Avoided:________________

B. Recoveries (Post-Pay Billing/Pay and Chase) – The amount reported should be the amount paid by TPL up to the Fee for Service allowed amount for "Dates of Recovery" in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus program should not be reported.

Subrogation/Workers' Compensation Amount:__________________
(e.g., a recovery associated with physical injury)

Other Recoveries Amount:__________________
(e.g., All other Third Party Liability (TPL) not specifically noted above.)

44. Add. IV, D – HMO Newborn Report (BadgerCare Plus Only)

Amend entire section to read:

This report should be completed for infants born to mothers who are BadgerCare Plus eligible and enrolled in the HMO at the time of birth of the infant.

The requirements for the Newborn Report can be found at:
https://www.forwardhealth.wi.gov/kw/pdf/2011-26.pdf

45. Add. IV, G – Attestation Form

Amend to read:

ATTESTATION

I, ____________________________, have reviewed the following data:
(Name and Title)

- ☐ Encounter Data for (quarter)________(year) 20___.
- ☐ Vent Report for (quarter)______________for (year) 20___.
- ☐ HMO Network Submission (submitted monthly) for (quarter) _________(year) 20__.
- ☐ Maternity Kick Payment Newborn Report for (quarter) _________(year) 20__.
- ☐ Non Emergency Medical Transportation Data for (quarter) _________(year) 20__.
- ☐ Other _____________________ (Specify Report)

46. Add. IV , H – Common Carrier Detail Report

Amend to read:

H. Non Emergency Medical Transportation Detail Report

The detail report must be provided either on disk CD ROM in an excel file format, sent via secure e-mail or via the FTP server to the transportation analyst in the Bureau of Fiscal Management (BFM). The reports must include all of the following data elements.

The table below sets forth the data elements required for the non emergency medical transportation detail report to be submitted by HMO's in Regions 5 and 6. To receive reimbursement in Region 5 HMOs must include the "Member County of Residence" field on the submitted data.

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	**Department of Health Services**
Official Signature	Official Signature
Printed Name	Printed Name Brett Davis
Title CEO	Title Medicaid Director Division of Health Care Access and Accountability
Date	Date