



PROGRAM OF ALL-INCLUSIVE CARE FOR THE  
ELDERLY (PACE) CONTRACT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAID SERVICES

and

PO

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## PREAMBLE

The Wisconsin Department of Health Services (the Department) contracts with the PACE Organization(PO) to deliver the Program of All-Inclusive Care for the Elderly (PACE) as defined in this contract, the PACE program agreement, and 42 CFR Part 460. PACE provides supports and services in the individual benefit package through a managed care service delivery model to enrollees in need of long-term care.

It is the intent of the Department that the PACE program is a truly integrated model for the delivery of all aspects of the members' services.

**PACE** is a capitated integrated Medicaid and Medicare managed care program that conforms to some service delivery methods prescribed in federal regulations. All members enrolled in PACE have a Wisconsin Medicaid nursing home-certifiable level of care, which is required as a condition of eligibility. As a fully integrated program, all supports and services – whether Medicare or Medicaid benefits – are delivered through the PACE model design identified in this contract.

This contract, the PACE program agreement, 42 C.F.R. Part 460, and the PACE Organization's Enrollment Agreement and Member Handbook define the philosophy and basic methods for the PACE program.. It is the Department's expectation under this contract that benefits will be fully integrated and will afford options that foster opportunities for interaction and integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community while supporting each member's individual outcomes and recognizing each member's preferences. The Department further expects that each member will have the opportunity to make informed choices about where he or she will live, how he or she will make or maintain connections to the community and whether he or she will seek competitive employment.

All services and supports within the program benefits are delivered through the PACE program model of care including:

- Integration and support for Medicaid or Medicare eligibility determination and enrollment procedures
- Maintenance of a network of providers with capacity to provide program benefits to members;
- Member-centered outcome-based care planning;
- Member-centered interdisciplinary care management;
- Member-centered service authorization and delivery;
- Support of member rights;
- Responsiveness to grievances and appeals;
- Quality management; and
- Cost effective and efficient contracting and service utilization.



Any PACE organization that delivers the PACE benefit under this contract must first be certified by the Department. The Department pays the PACE organization a fixed monthly capitation payment for each Medicaid eligible member. The PACE organization provides to each member the long-term care and health care services and supports identified in this contract that are appropriate to that individual member's outcomes and needs.

As part of the Department's quality management strategy, this contract describes desired outcomes, how the Department will determine that member-identified outcomes have been supported, and the standards of operation the Department expects to be met by PACE organization contractors.

This contract is entered into between the State of Wisconsin represented by its Division of Medicaid Services, of the Department of Health Services, whose principal business address is One West Wilson Street, P.O. Box 309, Madison, Wisconsin, 53707-0309, and <<name of PO>>, PACE organization, whose principal business address is <<address>>.

An electronic version of this contract can be accessed at:  
<https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm>.



## I. Definitions

Refer to Addendum VI, Service Definitions, for service definitions.

1. **Abuse:** as defined by Wis. Stats. s. 46.90(1)(a), means any of the following:
  - a) Physical abuse: intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.
  - b) Emotional abuse: language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.
  - c) Sexual abuse: a violation of criminal assault law, Wis. Stats. §§ 940.225 (1), (2), (3), or (3m).
  - d) Treatment without consent: the administration of medication to an individual who has not provided informed consent, or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.
  - e) Unreasonable confinement or restraint: the intentional and unreasonable confinement of an individual in a locked room, involuntary separation of an individual from his/her living area, use on an individual of physical restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement and restraint.
2. **Activities of Daily Living or ADLs:** bathing, dressing, eating, mobility, transferring from one surface to another such as bed to chair and using the toilet.
3. **Acute Care:** treatment, including all supplies and services, for an abrupt onset as in reference to a disease. Acute connotes an illness that is of short duration, rapidly progressive, and in need of urgent care.
4. **Adult at Risk:** as defined in Wis. Stat. § 55.01(1e), means any adult, age 55 and older for PACE, who has a physical or mental condition that substantially impairs his/her ability to care for his/her needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation.
5. **Adult Protective Services or APS:** as defined by Wis. Stat. § 55.01(6r), includes any of the following: (a) outreach, (b) identification of individuals in need of services, (c) counseling and referral for services, (d) coordination of services for individuals, (e) tracking and follow-up, (f) social services, (g) case management, (h) legal counseling or



- referral, (i) guardianship referral, (j) diagnostic evaluation, and (k) any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, financial exploitation, neglect, or self-neglect or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person.
6. **Advance Directive:** 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.
  7. **Adverse Action Date:** by law, individuals must be given at least ten (10) calendar days advance notice before any adverse action (i.e., reduction or termination) can take effect relative to their Medicaid eligibility and benefits. The “Adverse Action Date” is the day during a given month by which an adverse action must be taken so as to assure that the member has the notice in hand at least ten (10) calendar days before the effective date of the adverse action. The effective date of most Medicaid benefit reductions or terminations is the first day of a given month. Therefore, the Adverse Action Date is generally mid-month in the month prior. In a thirty-one (31) day month, adverse action is on or around the 18th; in a thirty (30) day month, it's on or around the 17th.
  8. **Aging and Disability Resource Center (ADRC) or Aging Resource Center or Disability Resource Center or Resource Center:** an entity that meets the standards for operation and is under contract with the Wisconsin Department of Health Services to provide services under Wis. Stat. § 46.283(3), or, if under contract to provide a portion of the services specified under Wis. Stat. § 46.283(3), meets the standards for operation with respect to those services. For the purposes of this contract, entity will be referred to as Resource Center.
  9. **Assets:** any interest in real or personal property that can be used for support and maintenance. “Assets” includes motor vehicles, cash on hand, amounts in checking and savings accounts, certificates of deposit, money market accounts, marketable securities, other financial instruments and cash value of life insurance.
  10. **Assistance:** cueing, supervision or partial or complete hands-on assistance from another person.
  11. **Auxiliary Aids and Services:** includes qualified interpreters, screen readers, note takers, telephone headset amplifiers, telecommunications devices, qualified readers, audio recordings, large print or Braille materials, or other effective methods of making materials available to individuals with hearing or visual impairments.
  12. **Balanced Work Force:** an equitable representation of handicapped persons, minorities and women in each level (job category) of a work force which approximates the percentage of individuals with disabilities, minorities, and women available for jobs at



- each level from the relevant labor market from which the contractors/vendor recruits job applicants.
13. **Behavior Modifying Medication:** a psychotropic medication (i.e., prescription medication within the classification of antipsychotic, mood stabilizer, anti-anxiety, antidepressant, or stimulant and/or medication outside of these classifications utilizing off-label use as a means to regulate behaviors).
  14. **Benefit:** the package of services provided by the PACE organization under this contract to which a member has access if, within the benefit, a specific service is identified as a service necessary to support long term care outcomes. The PACE program benefits that may be contracted for under this contract are:
    - a) All Medicare-covered services and items;
    - b) The home and community-based waiver services defined in Addendum VIII.A;
    - c) All Medicaid State Plan Services identified in Addendum VIII.B; and
    - d) Any cost-effective health care services the PACE IDT determines necessary to improve and maintain the member's overall health status.
  15. **Business Day:** Monday through Friday, except days which the office of the Managed Care Organization is closed.
  16. **Care Management** (also known as Case Management or Service Coordination): individualized assessment and care planning, authorizing, arranging and coordinating services in the member-centered plan (MCP) and periodic reassessments and updates of the MCP. Care management also includes assistance in filing grievances and appeals, maintaining eligibility, accessing community resources and obtaining advocacy services.
  17. **Centers for Medicare and Medicaid Services (CMS):** the federal agency responsible for oversight and federal administration of Medicare and Medicaid programs.
  18. **Client Rights:** see Member Rights in this section.
  19. **Cold Call Marketing:** any unsolicited personal contact by the PACE organization, including its employees, agents, subcontractors, and providers, with a potential enrollee for the purpose of marketing as defined in Article I.
  20. **Community Supports:** supports and services that are not authorized or paid for by the PACE organization and that are readily available to the general population.
  21. **Complex Medication Regime:** the member takes eight (8) or more scheduled prescription medications for three (3) or more chronic conditions. Chronic conditions include, but are not limited to, dementia or other cognitive impairment (including intellectual and/or developmental disability), heart failure, diabetes, end-stage renal disease, dyslipidemia, respiratory disease, arthritis or other bone disease, and mental



health disorders such as schizophrenia, bipolar disorder, depression or other chronic and disabling mental health conditions. Medication classes of particular concern are: anticoagulants, antimicrobials, bronchodilators, cardiac medications, central nervous system (CNS) medications, and hormones.

22. **Comprehensive Assessment:** an initial and ongoing part of the member-centered planning process employed by the interdisciplinary team (IDT) to identify the member's outcomes and the services and supports needed to help support those outcomes. It includes an ongoing process of using the knowledge and expertise of the member and caregivers to collect information about:
- a) The member's needs, strengths and outcomes;
  - b) The member's resources, natural supports and community connections through significant others, family members and friends;
  - c) Any ongoing conditions of the member or other risk factors that require a course of treatment or regular care monitoring; and
  - d) The member's preferences for the way in which the services and supports identified in the member-centered planning process will be delivered or coordinated by IDT staff.
23. **Confidential Information:** all tangible and intangible information and materials accessed or disclosed in connection with this contract, transferred or maintained in any form or medium (and without regard to whether the information is owned by the Department or by a third party), that consist of:
- a) Personally Identifiable Information;
  - b) Individually Identifiable Health Information;
  - c) Non-public information related to the Department's employees, customers, technology (including databases, data processing, and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; and
  - d) Information designated as confidential in writing by the Department.
24. **Conflict of Interest:** a situation where a person or entity other than the member is involved in planning or delivery of services to the member, and has an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.
25. **Contract/this Contract/the Contract:** this contractual agreement between the Wisconsin Department of Health Services and the PACE organization.
26. **Cost Share:** the contribution toward the cost of services required under 42 C.F.R. § 435.726 as a condition of eligibility for Medicaid for some members who do not otherwise meet Medicaid categorical or medically needy income limits.



27. **County Agency:** a county department of aging, social services or human services, an aging and disability resource center, a long-term care district or a tribal agency that has been designated by the Department of Health Services to determine financial eligibility and cost sharing requirements.
28. **Crime:** conduct which is prohibited by state or federal law and punishable by fine or imprisonment or both. Conduct punishable only by forfeiture is not a crime.
29. **Days:** calendar days unless otherwise noted.
30. **Department:** the Wisconsin Department of Health Services (DHS) or its designee.
31. **Developmental Disability:** a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome. This also includes an intellectual disability diagnosed before age 18 and characterized by below-average general intellectual function and a lack of skills necessary for daily living, or another neurological condition closely related to such intellectual disability or requiring treatment similar to that required for such intellectual disability, that has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. “Developmental disability” does not include senility that is primarily caused by the process of aging or the infirmities of aging.
32. **DHS:** the Wisconsin Department of Health Services.
33. **Donation:** something of value voluntarily transferred by or on behalf of a member to the MCO without compensation.
  - a) Something of value means cash or some other existing identifiable items that has a fair market value of more than \$100.00.
  - b) Voluntarily transferred means any of the following:
    - i. The member or another person on behalf of the member transferring the item of value has the intention to voluntarily give it without compensation;
    - ii. The member or other person on behalf of the member transferring the gift is legally competent (in order to have intention);
    - iii. The MCO receiving the gift is an eligible recipient (e.g., some entities have prohibitions against employees accepting gifts);
    - iv. The item of value is an existing identifiable thing (e.g., a promise to give something in the future is not a gift); or
    - v. The item of value is actually transferred.
34. **Dual Eligible:** refers to an individual who meets the requirements to receive benefits from both the Federal Medicare Program and the Wisconsin Medicaid Program. “Dual eligibility” does not guarantee “dual coverage.”





35. **Elder Adult at Risk:** as defined in Wis. Stat. § 46.90(br), means any person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation.
36. **Emergency Medical Condition:** a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
- a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - b) Serious impairment to bodily functions; or
  - c) Serious dysfunction of any bodily organ or part.
37. **Emergency Services:** covered inpatient and outpatient services that are:
- a) Furnished by a provider that is qualified to furnish these services under Title 19 of the Social Security Act; and
  - b) Needed to evaluate or stabilize an emergency medical condition.
38. **Encounter Reporting:** the collection and reporting of encounter data to the Department of Health Services is submitted via the LTCare Information Exchange System (IES). Encounter data are detailed records of health care services or items that have been provided to PACE members. Encounter data are used for rate setting and program analysis.
39. **End Stage Renal Disease or ESRD:** the stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.
40. **Enrollee:** see Member in this section.
41. **Enrollment Agreement and Member Handbook:** a document describing the program benefits and policies that is approved by the Department and distributed to members. The handbook must meet all the handbook requirements identified in Article IX, Marketing and Member Materials. The member handbook is known in the Medicare program as the Enrollment Agreement and Member Handbook.
42. **Enrollment Consultant:** the individual who performs enrollment consulting activities to potential enrollees such as, answering questions and providing information in an unbiased manner on available delivery system options, including the option of enrolling in an MCO or PO and advising on what factors to consider when choosing among these options.





43. **Experimental Surgery and Procedures:** “experimental” means a service, procedure, item or treatment that is “not proven and effective” for the conditions for which it is intended to be used.
44. **Fair Hearing:** a de novo proceeding under Wis. Admin. Code § HA 3, before an impartial administrative law judge in which the petitioner or the petitioner’s representative presents the reasons why an action or inaction by the Department of Health Services, a county agency, a resource center or a PACE organization in the petitioner’s case should be corrected.
45. **Federally Qualified Health Center or FQHC:** defined in Section 4161 of the Omnibus Budget Reconciliation Act of 1990. The purpose of FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. FQHCs are providers such as community health centers, outpatient health programs funded by the Public or Indian Health Service, and programs serving migrants and the homeless.
46. **Financial Abuse:** a practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary program costs or any act that constitutes financial abuse under applicable Federal and State law. Financial abuse includes actions that may, directly or indirectly, result in: unnecessary costs to the PACE Organization, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Financial abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.
47. **Financial Eligibility and Cost-Sharing Screen:** a uniform screening tool prescribed by DHS that is used to determine financial eligibility and cost-sharing under Wis. Stat. §§ 46.286(1) (b) and (2) and Wis. Admin. Code §§ DHS 10.32 and 10.34.
48. **Financial Exploitation:** includes any of the following acts:
- a) Fraud, enticement or coercion;
  - b) Theft;
  - c) Misconduct by a fiscal agent;
  - d) Identity theft;
  - e) Unauthorized use of the identity of a company or agency;
  - f) Forgery; or
  - g) Unauthorized use of financial transaction cards including credit, debit, ATM and similar cards.
49. **Frail Elder:** an individual who is 65 years of age or older and has a physical disability or irreversible dementia that restricts the individual’s ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.



50. **Fraud:** any intentional deception made for personal gain or to damage another individual, group, or entity. It includes any act that constitutes fraud under applicable federal or state law. Fraud is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program (18 U.S.C. 1347).
51. **Functional Capacity:** the skill to perform activities in an acceptable manner.
52. **Gift:** something of value voluntarily transferred by one person or entity to another person or entity without compensation.
- a) Something of value means cash or some other existing identifiable thing that has a fair market value of more than \$100.00.
  - b) Voluntarily transferred means:
    - i. The person or entity transferring the thing of value has the intention to voluntarily give it without compensation; and
    - ii. The person transferring the gift is competent (in order to have intention); and
    - iii. The person or entity receiving the gift is an eligible recipient (e.g., some entities have prohibitions against employees accepting gifts); and
    - iv. The thing of value is an existing identifiable thing (e.g., a promise to give something in the future is not a gift); and
    - v. The thing of value is actually transferred.
53. **Group A:** persons age 18 and over who are financially eligible for full-benefit Medicaid on a basis separate from qualifying to receive home-and-community-based waiver services. Individuals between ages 18 and 54 are not eligible for PACE.
54. **Group B:** persons age 18 and over who are not in Group A, meet the non-financial requirements to receive home and community-based waiver services and have a gross monthly income no greater than a special income limit equal to 300% of the SSI federal benefit rate for an individual. Individuals between ages 18 and 54 are not eligible for PACE.
55. **Group B+:** persons age 18 or over not in Group A, meeting all requirements for Group B except for income, whose monthly income after subtracting the cost of institutional care is at or below the medically needy income limit. Individuals between ages 18 and 54 are not eligible for PACE.



56. **Harassment:** any unwanted offensive or threatening behavior, which is linked to one or more of the below characteristics when:
- a) Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or eligibility for services;
  - b) Submission to or rejection of such conduct by an individual is used as the basis for employment or service decisions affecting such individual; or
  - c) Such conduct has the purpose or effect of substantially interfering with an individual's work performance, or of creating an intimidating, hostile or offensive work or service delivery environment, which adversely affects an individual's opportunities.

Harassing behavior may include, but is not limited to, demeaning or stereotypical comments or slurs, ridicule, jokes, pranks, name calling, physical or verbal aggression, gestures, display or possession of sexually graphic materials, cartoons, physical contacts, explicit or implicit threats separate from supervisory expressions of intention to use the disciplinary process as a consequence of continued inappropriate behavior, malicious gossip or any other activity that contributes to an intimidating or hostile work environment.

Sexually harassing behavior is unwelcome behavior of a sexual nature toward males or females which may include, but, is not limited to, physical contact, sexual advances or solicitation of favors, comments or slurs, jokes, pranks, name calling, gestures, the display or possession of sexually graphic materials which are not necessary for business purposes, malicious gossip and verbal or physical behaviors which explicitly or implicitly have a sexual connotation.

Harassment is illegal when it is a form of discrimination based upon age, disability, association with a person with a disability, national origin, race, ancestry or ethnic background, color, record of arrest or conviction which is not job-related, religious belief or affiliation, sex or sexual orientation, marital status, military participation, political belief or affiliation, and use of a legal substance outside of work hours.

57. **Home:** a place of abode and lands used or operated in connection with the place of abode.
58. **Hospital:** has the meaning specified in Wis. Stat. § 50.33(2).
59. **Incident Management System:** a System which manages incidents occurring at the member and provider levels and includes the activities of incident discovery, report, response, investigation, remediation, and data collection and analysis in order to a) assure member health and safety; b) reduce member incident risk(s), and; c) enable development of strategies to prevent future incident occurrence(s).



60. **Income Maintenance Agency or IM Agency:** a subunit of a county, consortia, or tribal government responsible for administering IM Programs including Wisconsin Medicaid; formerly known as the Economic Support Agency.
61. **Indian:** an individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. 136.12. This means the individual:
- a) Is a member of a Federally recognized Indian tribe; or
  - b) Resides in an urban center and meets one or more of these four criteria:
    - i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
    - ii. Is an Eskimo or Aleut or other Alaska Native;
    - iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;
    - iv. Is determined to be an Indian under regulations issued by the Secretary; or
  - c) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
  - d) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
62. **Indian Health Care Provider (IHCP):** a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).
63. **Individual at Risk:** an elder adult at risk (age 60 and over) or an adult at risk (age 18-59).
64. **Individually Identifiable Health Information:** member demographic information, claims data, insurance information, diagnosis information, and any other information that relates to an individual's past, present or future physical or mental health or condition, provision of health care, or payment for health care that identifies the individual or could reasonably be expected to lead to the identification of the individual.
65. **Institution for Mental Disease:** a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.



66. **Instrumental Activities of Daily Living or IADLs:** management of medications and treatments, meal preparation and nutrition, money management, using the telephone, arranging and using transportation and the ability to function at a job site.
67. **Interdisciplinary Team or IDT:** the member and individuals identified by the PO to provide care management services to members.
68. **Interdisciplinary Team Staff:** individual employees assigned to an IDT that shall have specialized knowledge of the conditions of the target populations served by the PO, the full-range of long-term care resources and community alternatives.
69. **Interdisciplinary Team for County Elder Adults/Adults at Risk or I-Team:** a group of selected professionals from a variety of disciplines who meet regularly to discuss and provide consultation on specific cases of elder abuse, neglect or exploitation. An I-Team uses the varied backgrounds, training and philosophies of the different professions to explore the best service plan for the cases involved.
70. **Legal Decision Maker:** a member's or potential member's legal decision maker is a person who has the legal authority to make certain decisions on behalf of a member or potential member. A legal decision maker may be a guardian of the person or estate (or both) registered under Chapter 53 of the Wisconsin Statutes, a guardian of the person or estate (or both) appointed under Chapter 54 of the Wisconsin Statutes, a conservator appointed under Chapter 54 of the Wisconsin Statutes, a person designated power of attorney for health care under Chapter 155 of the Wisconsin Statutes or a person designated durable power of attorney under Chapter 244 of the Wisconsin Statutes. A legal decision maker may have legal authority to make certain kinds of decisions, but not other kinds of decisions. A member may have more than one legal decision maker authorized to make different kinds of decisions. In any provision of this Contract in which the term "legal decision maker" is used, it applies only to a person who possesses the legal authority relevant to that provision. A person designated by the member or potential member as an "authorized representative" under 42 C.F.R. § 435.923 for assisting with Medicaid application and renewal of eligibility is not a legal decision maker.
71. **Limited English Proficient (LEP):** potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.
72. **Long-Term Care Services:** the services identified in Addendum VIII, Benefit Package Service Definitions, section A and the following State Plan Services (Addendum VIII. B): AODA day treatment, AODA services, case management, community support program, DME/DMS, home health, mental health day treatment, mental health, nursing home, nursing, occupational therapy, personal care, physical therapy, speech and language pathology, and transportation.



73. **Long-Term Care Facility:** a nursing home, adult family home, community-based residential facility or residential care apartment complex.
74. **Long-Term Care Functional Screen or LTC FS:** a uniform screening tool prescribed by DHS that is used to determine functional eligibility under Wis. Stat. §§ 46.286(1) (a) and (1m) and Wis. Admin. Code §§ DHS 10.32 and 10.33.
75. **Managed Care Organization or MCO:** an entity that the Department has certified as having capacity for financial solvency and stability as defined in Article XVII, Fiscal Components/Provisions, and which has agreed under this contract to make the services in the benefit package defined in Article VII, Services, available to members for payment as defined in Article XVIII, Payment to the Managed Care Organization.
76. **Marketing/Outreach:** any communication, sponsorship of community events, or the production and dissemination of marketing/outreach materials from a PO, including its employees, agents, subcontractors, and providers, to an individual who is not enrolled in that entity that can reasonably be interpreted as intended to influence the individual to enroll in or not to enroll in that particular managed care organization's Medicaid product, or to disenroll from another PACE organization's or managed care organization's Medicaid product. Communications from a Qualified Health Plan to Medicaid beneficiaries are excluded from the definition of marketing, even if the issuer of the Qualified Health Plan is also an entity providing Medicaid managed care.
77. **Marketing/Outreach Materials:** materials in all mediums, including but not limited to, internet, brochures and leaflets, newspaper, magazine, radio, television, billboards, yellow pages, advertisements, other print media and presentation materials, used by or on behalf of the PO to communicate with individuals who are not members, and that can be reasonably interpreted as intended to influence the individuals to enroll or reenroll in the PO.
78. **Master Client Index or MCI:** this index is a way to identify the same person between different computer systems. Client Assistance for Reemployment and Economic Support (CARES), the LTC Functional Screen and the ForwardHealth interChange system all use MCI. The member ID used in the ForwardHealth interChange system is also that member's MCI.
79. **Medicaid:** the Wisconsin Medical Assistance program operated by the Wisconsin Department of Health Services under Title XIX of the Federal Social Security Act, Wis. Stats. ch. 49 and related state and federal rules and regulations. The term "Medicaid" will be used consistently in this contract. However, "Medicaid" is also known as "MA," "Medical Assistance," and "Wisconsin Medical Assistance Program" or "WMAP."
80. **Medicaid Deductible:** a way of attaining full-benefit Medicaid financial eligibility in which an applicant is given a six-month deductible period in which incurred medical and remedial costs can be used to lower excess income to medically needy limits. The applicant's deductible amount is equal to six times the difference between net monthly





income and the monthly medical needy limit. Once the applicant has met the deductible, the person becomes eligible for Medicaid for the remainder of the six-month period and may enroll in PACE without paying a PACE premium. A person can also pre-pay a deductible instead of incurring medical and remedial expenses.

81. **Medicaid Recipient:** any individual receiving benefits under Title XIX of the Social Security Act and the Medicaid State Plan as defined in Wis. Stats. ch. 49.
82. **Medical Equipment or Appliances:** are items that are primarily or customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.
83. **Medical Supplies:** are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness, or injury.
84. **Medically Necessary Services:** for the State plan services in Addendum VIII. B medically necessary has the meaning in Wis. Admin. Code DHS §101.03(96m): services (as defined under Wis. Stat. § 49.46 and Wis. Admin. Code § DHS 107) that are required to prevent, identify or treat a member's illness, injury or disability; and that meet the following standards:
  - a) Are consistent with the member's symptoms or with prevention, diagnoses or treatment of the member's illness, injury or disability;
  - b) Are provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
  - c) Are appropriate with regard to generally accepted standards of medical practice;
  - d) Are not medically contraindicated with regard to the member's diagnoses, symptoms, or other medically necessary services being provided to the member;
  - e) Are of proven medical value or usefulness and, consistent with Wis. Admin. Code § DHS 107.035 are not experimental in nature;
  - f) Are not duplicative with respect to other services being provided to the member;
  - g) Are not solely for the convenience of the member, the member's family or a provider;
  - h) With respect to prior authorization of a service and other prospective coverage determinations made by DHS, are cost-effective compared to an alternative medically necessary service which is reasonably accessible to the member; and
  - i) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.



For the home and community-based waiver services in Addendum VIII. A, medically necessary means that the service is reasonable, appropriate and cost-effectively addresses a member's assessed long-term care need or outcome related to any of the following purposes:

- a) The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;
- b) The ability to achieve age-appropriate growth and development;
- c) The ability to attain, maintain, or regain functional capacity; and
- d) The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

85. **Medication Review and Intervention:** a comparison of medications prescribed by health care providers and medications taken by the member.
86. **Member:** a person who is currently enrolled in a PACE organization.
87. **Member-Centered Plan or MCP:** a record that documents a process by which the member and the interdisciplinary team staff further identify, define and prioritize the member's outcomes initially identified in the comprehensive assessment. The MCP also identifies the services and supports, paid or unpaid, provided or arranged by the PO including the frequency and duration of each service (e.g., start and stop date), and the provider(s) that will furnish each service. The MCP identifies long-term care outcomes, personal experience outcomes, and any risks.
88. **Member Materials:** materials in all mediums to inform members of benefits, procedures, formularies and provider networks, including but not limited to, handbooks and brochures used by or on behalf of the PO to communicate with enrolled members.
89. **Member Rights:** the rights outlined in applicant information materials and the Member Handbook as approved by DHS consistent with Wis. Admin. Code § DHS 10.51 and 42 C.F.R. Part 460, Subpart G.
90. **Member's Home:** living quarters in which a member resides that is owned or leased by the member or member's family.
91. **Memorandum of Understanding or MOU:** an agreement detailing the actions of two parties under circumstances specified in the agreement.
92. **Natural Supports:** individuals who are available to provide unpaid, voluntary assistance to the member in lieu of 1915(c) waiver and/or State Plan home and community-based services (HCBS). They are typically individuals from the member's social network (family, friends, neighbors, etc.).





93. **Necessary Long-Term Care Services and Supports:** any service or support that is provided to assist a member to complete daily living activities, learn new skills, maintain a general sense of safety and well-being, or otherwise pursue a normal daily life rhythm, and that meets the following standards:
- a) Is consistent with the member’s comprehensive assessment and member-centered plan;
  - b) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
  - c) Is appropriate with regard to the Department’s and PO’s generally accepted standards of long-term care and support;
  - d) Is not duplicative with respect to other services being provided to the member;
  - e) With respect to prior authorization of a service and other prospective coverage determinations made by the PO, is cost-effective compared to an alternative necessary long-term care service which is reasonably accessible to the member; and,
  - f) Is the most appropriate supply or level of service that can safely and effectively be provided to the member.
94. **Neglect:** the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual’s physical or mental health. “Neglect” does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual’s previously executed declaration or do-not-resuscitate order under ch. 154, Wis. Stats., a power of attorney for health care under ch. 155, Wis. Stats., or as otherwise authorized by law. *See*, Wis. Stat. s.46.90(1)(f).
95. **Non-Nursing Home Level of Care:** a level of care in the Family Care program only, which is defined in s. 46.286(1)(a)2m, Wis. Stats.
96. **Nursing Home:** has the meaning specified in s. 50.01(3), Wis. Stats.
97. **Nursing Home Level of Care:** a level of care provided in a nursing facility and reimbursable under the Medicaid program.
98. **Office of the Commissioner of Insurance or OCI:** The OCI issues the HMO license, monitors the HMO’s solvency, and performs financial examinations of the HMO in accordance with prescribed insurance laws and regulations.



99. **Outcome:** a desirable situation, condition, or circumstance in a member's life that can be a result of the support provided by effective care management. Outcomes defined include:
- a) **Clinical outcome** is an identified need, condition or circumstance that relates to a member's individual physical, mental, or emotional health, safety, or well-being. Clinical outcomes are objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's preferences regarding the condition or circumstance. Clinical outcomes, along with functional outcomes, are referred to as "long term care" outcomes on the Member Care Plan (MCP).
  - b) **Functional outcome** is an identified need, condition or circumstance that results in limitations on the member's ability to perform certain functions, tasks, or activities and require additional support to help the member maintain or achieve their highest level of independence. This includes, but is not limited to, assistance with Activities of Daily Living and Instrumental Activities of Daily Living. The presence, absence, or degree of functional outcomes can be objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's preferences regarding the functional ability. Functional outcomes, along with clinical outcomes, are referred to as "long term care" outcomes in the member's MCP.
  - c) **Personal-experience outcome** is a desirable situation, condition, or circumstance that a member identifies as important to him/her. A personal experience outcome is measurable primarily by the member.
  - d) **Long term care outcome** is a situation, condition, or circumstance that a member, or IDT staff, identifies that maximizes a member's highest level of independence. This outcome is based on the members identified clinical and functional outcomes.

Throughout this contract the use of the term "outcomes" refers to both long term care outcomes (comprised of clinical and functional outcome identification) as well as personal experience outcomes, unless otherwise specified (e.g., health and safety outcomes, quality outcomes).

100. **PACE organization:** an entity that has in effect a PACE program agreement to operate a PACE program under 42 C.F.R Part 460.
101. **PACE or a Program of All-inclusive Care for the Elderly:** a capitated integrated Medicaid and Medicare managed care program, in accordance with 42 C.F.R. § 460.6, Definitions. All members enrolled in PACE have a Wisconsin Medicaid nursing home-certifiable level of care, which is required as a condition of eligibility. As a fully integrated program, all supports and services – whether Medicare or Medicaid benefits – are delivered through the PACE model design identified in this contract.
102. **Participant:** see Member in this section.



103. **Personally Identifiable Information:** an individual's last name and the individual's first name or first initial, in combination with and linked to any of the following elements, if the element is not publicly available information and is not encrypted, redacted, or altered in any manner that renders the element unreadable:
- a) The individual's Social Security number;
  - b) The individual's driver's license number or state identification number;
  - c) The individual's date of birth;
  - d) The number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account;
  - e) The individual's DNA profile; or
  - f) The individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.
104. **Physical Abuse:** the willful or reckless infliction of bodily harm. Bodily harm means physical pain or injury, illness, or any impairment of physical condition.
105. **Physical Disability:** a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, that results from injury, disease or congenital disorder and that significantly interferes with or significantly limits at least one major life activity of a person. In the context of physical disability, "major life activity" means self-care, performance of manual tasks unrelated to gainful employment, walking, receptive and expressive language, breathing, working, participating in educational programs, mobility other than walking and capacity for independent living.
106. **Post-Eligibility Treatment of Income:** see Cost Share in this section.
107. **Post Stabilization Services:** services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. They are not emergency services, which PACE organizations are obligated to cover. Rather, they are non-emergency services that the PACE organization should approve before they are provided outside the service area.
108. **Potential Enrollee or Potential Member:** a person who is or may be eligible to enroll in a PACE organization but is not yet a member.
109. **Primary Care:** health care provided by a medical professional with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment. Services are provided to the patient with a goal of providing a broad spectrum of care, both preventive and curative, over a period of time. Activities include coordinating all of the care the patient receives and, ideally, the provision of continuity



and integration of health care. Primary Care Providers include primary care physicians, community-based physicians, physician assistants, and nurse practitioners..

110. **Private Pay Individual:** a person who:
- a) Is a member of a PACE organization's target population; and
  - b) Meets the non-financial conditions for eligibility and enrollment; and
  - c) Either:
    - i. Does not qualify financially for Medicaid ; or
    - ii. Does qualify financially for Medicaid , but who is not entitled to receive the benefit immediately and is on a waiting list; and
  - d) Would like to pay the PACE premium for services and supports.
111. **Provider:** any individual or entity that has a provider agreement with the PACE organization or a subcontractor and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the Department's contract with a PACE organization.
112. **Provider Agreement:** a written agreement between a provider as defined under of this Article and the PACE organization or a subcontractor to provide services to the PACE organization's members.
113. **Provider Preventable Condition:** means a condition that meets either of the following criteria:
- a) Is a Healthcare Acquired Condition. A Healthcare Acquired Condition is a condition listed below occurring in any inpatient hospital setting:
    - i. Foreign object retained after surgery;
    - ii. Air embolism;
    - iii. Blood incompatibility;
    - iv. Stage III and IV pressure ulcers;
    - v. Falls and trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries;
    - vi. Catheter-associated urinary tract infection (UTI);
    - vii. Vascular catheter-associated infection;
    - viii. Manifestations of poor glycemic control including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity;
    - ix. Surgical site infection following coronary artery bypass graft (CABG)-  
Mediastinitis;



- x. Surgical site infection following bariatric surgery for obesity, including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery;
  - xi. Surgical site infection following certain orthopedic procedures including spine, neck, shoulder, and elbow;
  - xii. Surgical site infection following cardiac implantable electronic device (CIED);
  - xiii. Deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions; or
  - xiv. Latrogenic pneumothorax with venous catheterization.
- b) Is an Other Provider-Preventable Condition. An Other Provider-Preventable Condition is a condition occurring in any health care setting that meets the following criteria:
- i. Is identified in the State plan;
  - ii. Has been found by the State, based upon a review of the medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
  - iii. Has a negative consequence for the beneficiary;
  - iv. Is auditable; and
  - v. At a minimum includes:
    - 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.
114. **Readily accessible:** electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0AA and successor versions.
115. **Re-enrollee:** an individual who is disenrolled from PACE and then re-enrolled in the same PACE organization within 30 calendar days.
116. **Residential Care Apartment Complex or RCAC:** a place where 5 or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, including a stove, and individual bathroom, sleeping and



- living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services.  
“Residential care apartment complex” does not include a nursing home or a community-based residential facility, but may be physically part of a structure that is a nursing home or community-based residential facility.
117. **Resource Allocation Decision (RAD) Method:** the Department’s approved method of authorizing services.
118. **Resource Center:** see Aging and Disability Resource Center in this section.
119. **Restrictive Measure:** any type of restraint, isolation, seclusion, protective equipment, or medical restraint.
120. **Secretary:** means the secretary of the Wisconsin Department of Health Services.
121. **Self-neglect:** means a significant danger to an individual’s physical or mental health because the individual is responsible for his/her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care. *See*, Wis. Stat. s. 46.90(1)(g).
122. **Service Area:** the geographic area within which potential members must reside in order to enroll and remain enrolled in the PO under this contract. To be eligible to enroll in a PO, a potential member must be a resident of the county (or one of the counties) listed in Article XIX, PACE Specific Contract Terms.
123. **Services Necessary to Support Outcomes:** services necessary to support outcomes are identified in the member’s Member-Centered Plan and include both necessary long-term care services and medically necessary services. The PO can offer reasonable alternative services that meet a member’s needs and support desired outcomes at less expense. Reasonable alternatives are those which:
- a) Have been effective for persons with similar needs;
  - b) Would not have a negative impact on desired outcomes; and
  - c) Are likely to support the desired outcomes.
124. **Sexual Abuse:** sexual conduct in the first through fourth degrees as defined in Wis. Stat. § 940.225.
125. **Subcontract:** a written agreement between the PO and a subcontractor as defined under 126 of this Article to fulfill the administrative requirements of this contract.
126. **Subcontractor:** any individual or entity that has a contract with the PO that relates directly or indirectly to the performance of the PO’s obligations under its contract with the Department except for the provision of services to the PO’s members.



127. **Target Population:** any of the following groups that a managed care organization or PO has contracted with DHS to serve:
- a) Frail elderly.
  - b) Adults with a physical disability.
  - c) Adults with a developmental disability.
128. **Third Party Administrator or TPA:** a service business that provides health and other service claims processing services, as an independent agent under contract with the PO. In addition to the control, adjudication and payment of service claims, the services generally encompass some level of other claims processing related functions; enrollment, service plan and pricing maintenance, service provider data management, service-authorization management, reporting of encounter data, financial reporting, provider management and claims related customer service support and other services, depending on the scope of the contract.
129. **Urgent Care:** the care provided to a PACE participant who is out of the PACE service area, and who believes their illness or injury is too severe to postpone treatment until they return to the service area, but their life or function is not in severe jeopardy.
130. **Voluntary Contributions, Payments or Repayments:** member choice to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, reduce potential claim in an estate, or in gratitude for Medicaid services that were provided. The payment is made to the State Medicaid program. A member cannot pay more than the amount Medicaid has paid for that individual.
131. **Vulnerable/High Risk Member (VHRM):** a member who is dependent on a single caregiver, or two or more caregivers all of whom are related, to provide or arrange for the provision of nutrition, fluids or medical treatment that is necessary to sustain life and to whom at least one of the following applies:
- a) Is nonverbal and unable to communicate feelings or preferences; or
  - b) Is unable to make decisions independently; or
  - c) Is clinically complex, requiring a variety of skilled services or high utilization of medical equipment; or
  - d) Is medically frail.





## II. PACE Organization Governance and Consumer and Member Involvement

### A. PACE organization Governing Board

The PO shall have a governing board that provides input to the PO decision-making process. When a PO takes action that is not consistent with the input of the governing board, the PO Director shall provide the governing board with a written justification for the decision and the rationale for diverging from the governing board recommendation.

The PO governing board shall meet the following specifications:

1. *Separation from Eligibility/Enrollment*

Assurance of the PO's separation from the eligibility determination and enrollment counseling functions. The separation shall meet criteria established by the Department in accordance with Wis. Stat. § 46.285 and applicable federal guidelines.

2. *Long-Term Care District*

If the PO is operated by a long-term care district, as described in Wis. Stat. § 46.2895, the district shall meet the requirements for governance in Wis. Stat. § 46.2895.

3. *Separation from the Aging and Disability Resource Centers*

No member of the PO board may also be a member of a Resource Center board.

### B. PACE Member Advisory Committee

1. *Purpose*

The PO shall create and staff a Member Advisory Committee to advise the PO on its policies and operations, how it is meeting the needs of members and how operations and outcomes may be improved. The Committee shall in addition be a vehicle for members to participate in the PO's quality management program under Article XII.

2. *Frequency of Meetings*

The Member Advisory Committee shall meet at least once per year.

3. *Documentation*

The PO shall maintain documentation of the Committee's meetings and actions, such as attendance records, minutes, votes, recommendations and PO responses, to document the types and level of the Committee's participation in the Quality Management program and other aspects of PO oversight. It shall make this documentation available to the Department upon request.





### III. Eligibility

#### A. PACE Program Specific Eligibility Criteria

In addition to eligibility requirements in 42 C.F.R. § 460.150, certain program specific eligibility criteria may apply.

##### 1. *Medicare Election*

- a. Eligibility to enroll in PACE is not restricted to an individual who is either a Medicare beneficiary or a Medicaid beneficiary. A potential PACE enrollee is not required to be:
  - i. Entitled to Medicare Part A
  - ii. Enrolled under Medicare Part B, or
  - iii. Eligible for Medicaid.
- b. If a PACE member becomes Medicare-eligible after enrollment, the member will be disenrolled from PACE if he or she elects to obtain Medicare coverage other than from the PACE organization.

##### 2. *Deemed Eligibility*

The process described below shall be utilized if a current PACE member's functional screen results in a non-nursing home level of care and the PO requests DHS to deem the member eligible.

- a. The PO contacts the contract coordinator to request the ineligible member be deemed eligible.
- b. The contract coordinator reviews the records and information provided by the PO. The contract coordinator may request additional information if warranted.
- c. The contract coordinator decides whether to deem the member eligible based on the following standards:
  - i. The member would be reasonably expected to become eligible at nursing home level of care within 6 months in absence of continued coverage of service, AND
  - ii. The member's medical record and plan of care support deemed continued eligibility.
- d. If the contract coordinator decides the member does not meet the standards to be deemed eligible, the contract coordinator will inform the PO of this decision in writing.
- e. If the contract coordinator deems the member eligible, the contract coordinator shall inform the PO of this decision and contact the section chief overseeing the functional screen.



- f. The screen team works with the PO screen liaison to continue eligibility for the member.
- g. The member will be deemed functionally eligible for PACE as the functional screen will show a nursing home level of care.

**B. Eligibility Determination Process**

1. *Assisting Members to Maintain Medicaid Eligibility*

The PO is responsible for assisting members in their responsibility to maintain Medicaid eligibility. This may include:

- a. Reminding members of the required annual Medicaid recertification procedure and assisting them to get to any needed appointments;
- b. Assisting members to understand any applicable Medicaid income and asset limits and as appropriate and needed, supporting members to meet verification requirements;
- c. Assisting members to understand any deductible, cost share or patient liability obligation they may need to meet to maintain Medicaid eligibility;
- d. Assisting members to understand the implications of their functional level of care as it relates to the eligibility criteria for the program;
- e. If appropriate and needed, assisting members to obtain a representative payee or legal decision maker; and
- f. Referring members as needed to other available resources in the community that may assist members in obtaining or maintaining eligibility such as Elder and Disability Benefits Specialists and advocacy organizations.

2. *Providing Information that May Affect Eligibility*

Members have a responsibility to report certain changes in circumstances that may affect Medicaid eligibility to the income maintenance agency, within ten (10) calendar days of the change.

Notwithstanding the member's reporting obligations, if the PO has information about a change in member circumstances that may affect Medicaid eligibility, the PO is to provide that information to the income maintenance agency as soon as possible but in no event more than ten (10) calendar days from the date of discovery.

Members who receive SSI benefits are required to report certain changes to the Social Security Administration rather than the local IM agency. POs should assist members in meeting these reporting requirements since loss of SSI has a direct impact on Medicaid eligibility.



Reportable information includes:

- a. The member's functional eligibility as determined by the Long-Term Care Functional Screen using procedures specified by the Department;
- b. The average monthly amount of medical/remedial expenses the member pays for out-of-pocket;
- c. The housing costs the member pays for out-of-pocket, either in the member's own home or apartment or in a community-based residential care facility (see Section Dof this article);
- d. Non-payment of any required cost share (post eligibility treatment of income);
- e. The member has died;
- f. The member has been incarcerated;
- g. The admission of a member who is age 21 or over and under age 65 to an Institute for Mental Disease;
- h. The member has moved out of the county or service area;
- i. Any known changes in the member's income or assets;
- j. Any disqualifying Medicare coverage elections
- k. Changes in the member's marital status.

3. *Medicare Coverage Elections*

The MCO is responsible to assist members to understand any Medicare coverage choices, including Medicare Advantage plan election periods, in order to avoid unintended disenrollment.

**C. Medicaid Deductibles or Cost Share**

1. *Deductibles*

A member may attain full-benefit Medicaid financial eligibility through meeting a deductible (see Medicaid Eligibility Handbook Ch. 24.2, <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>). Such members are eligible in Group A without a cost share for the remainder of the deductible period.

The PACE organization shall explain to the member the circumstances under which the member may have to pay a deductible and assist the member with the financial eligibility re-determination by the income maintenance agency at the end of the deductible period.

2. *Cost Share or Patient Liability*

- a. Members may be required to pay a monthly cost share or patient liability in order to be eligible for Medicaid PACE.



- i. Cost share, also called post eligibility treatment of income, applies to members who live in their own home, an adult family home, a community-based residential facility or a residential care apartment complex.
  - ii. Patient liability applies to members who reside in a nursing home or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) for 30 or more consecutive days or are likely to reside there for 30 or more consecutive days.
- b. The income maintenance agency is responsible for determining the member's cost share or patient liability. Cost share is imposed on members in accordance with 42 C.F.R. § 435.726. Patient liability is imposed in accordance with 42 C.F.R. § 435.725. The Department will ensure that a member who has a cost share is not required to pay any amount in cost share which is in excess of the average capitation payment attributable to waiver services, as determined by the Department.
- c. The PO is responsible for collecting the members' monthly cost share or patient liability, subject to the following Department policies and procedures:
- i. The PO will send a bill to any member who has a cost share or patient liability in advance of or as early as possible during the month in which the cost share or patient liability is due.  
  
Members who were enrolled in IRIS as of the first day of the month in which they transition to PACE, generally pay the cost share amount for that month to their IRIS fiscal employer agent. If the PO capitation payment was offset by the cost share amount for that month, the PO will attempt to verify whether the member paid his or her cost share to an IRIS fiscal employer agent. If the PO has documentation to verify the member paid the cost share to the fiscal employer agent, the PO may request a capitation payment adjustment on an enrollment discrepancy report.
  - ii. Cost share and patient liability are not prorated for partial months.
  - iii. The system logic that determines a member's patient liability amount can offset either a capitation payment or a Nursing Home Fee-for-Service (NH FFS) claim, but not both. ForwardHealth automatically deducts the appropriate monthly patient liability amount from the first NH FFS claim or capitation payment received for the member. (See ForwardHealth Online Handbook topic #3188: <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx> ).



Generally, when members residing in a NH are enrolled into a PO and the enrollment includes past months, the NH FFS claim will be offset by the patient liability amount for the past month(s), and the subsequent capitation payment(s) for the past month(s) will not be offset by the patient liability amount. However, this depends on when the NH FFS claim is submitted and processed in the system, so the PO should monitor the 820 transaction to determine whether or not the patient liability amount was used to offset the capitation payment.

If the patient liability amount was used to offset the capitation payment, the PO should collect the liability amount.

The PO will attempt to collect the patient liability amount from the nursing home when the 820 Report (see Article XV.E) indicates that the capitation payment was offset by the patient liability amount but the member already paid the patient liability to the nursing home.

The PO will attempt to collect the patient liability amount from the member when the 820 Report indicates the capitation payment was offset by the patient liability amount, the paid FFS NH claim was not offset by the patient liability amount, and the member did not pay the patient liability to the nursing home.

The PO will transfer the patient liability amount to the nursing home when the 820 Report indicates that the capitation payment was not offset by the patient liability amount but the member already paid the patient liability amount to the PO.

- iv. If a member fails to pay the cost share or patient liability as billed by the due date, the PO will:
  - a) Contact the member to determine the reason for non-payment.
  - b) Determine whether the cost share or patient liability presents an undue hardship for which the PO is willing to waive some or the entire obligation.
  - c) Remind the member that non-payment may result in loss of Medicaid eligibility and disenrollment unless the member becomes a private pay PACE member.
  - d) Attempt to convince the member to make payment or negotiate a payment plan.



- e) Offer the member assistance with financial management services or refer the member for establishment of a representative payee or legal decision maker if needed.
- f) If all efforts to assist the member to meet the financial obligation are unsuccessful, refer the situation to the income maintenance agency for ongoing eligibility determination and the ADRC for options counseling.

3. *Monitoring Cost Share or Patient Liability*

The PO is responsible for the ongoing monitoring of the cost share or patient liability amounts of its members.

**D. Room and Board**

Members shall use their own income to pay for the cost of room and board. Any PO contribution to member room and board obligation from capitation revenue shall not be considered a countable expense in developing capitation rates. For each member who resides in community-based residential care as defined in Addendum VIII.A.16, the PO is responsible for all of the following tasks:

1. *Determining the Member's Room and Board Obligation*

The PO determines the member's of room and board obligation in the facility in which the member resides. The PO shall use one method for all its members. It shall select one of the three following methods:

a. *Actual Cost Methodology*

This method requires calculation of actual room and board costs for each community residential facility with which the PO contracts. Facility-specific costs are split between care and supervision on the one hand and room and board on the other. Total costs attributable to room and board are divided by the number of residents licensed or certified for the living arrangement to get a room and board rate.

i. *Costs attributable to Room and Board:*

- a) Rent, mortgage payments, title insurance, mortgage insurance
- b) Property and casualty insurance
- c) Building and grounds maintenance costs
- d) Residents' food
- e) Household supplies and equipment necessary for the room and board of the individual
- f) Furnishings used by the individual (does not include office furnishings)



- g) Utilities
  - h) Resident's telephone, cable television
  - i) Property taxes
  - j) Specific individual special dietary needs
- ii. Costs attributable to Care and Supervision. The following are allowable elements in residential provider rates for which FFP can be claimed:
- a) Staff Costs:
    - Salaries. In certain circumstances, a staff person's wages and benefits may need to be apportioned between room and board costs and care and supervision.
    - FICA
    - Staff health insurance
    - Worker's compensation
    - Unemployment compensation
    - Staff travel
    - Staff liability insurance
    - Staff development and education
  - b) Resident travel (includes depreciation on vehicle)
  - c) Administrative overhead-contractor's costs to do business, including:
    - Office supplies and furnishings
    - Percentage of administrative staff salaries
    - Office telephone
    - Recruitment
    - Audit fees
    - Operating fees/permits/licenses
    - Percentage of office space costs
    - Data processing fees
    - Legal fees
    - Agency liability insurance

A PO that uses this method is responsible for assuring that each residential care provider with which it contracts uses this method for identifying the portion of the facility rate attributable to room and board, for maintaining documentation or auditing providers to



verify the accuracy of these calculations and for updating this information annually.

b. SSI-E Methodology

SSI-E Payment Standard - SSI-E or the SSI Exceptional Expense Supplement represents the highest combined federal and state SSI payment amount in Wisconsin. Eligibility for the supplement is based on qualifying for SSI and either residing in community residential care or needing at least 40 hours a month of supportive services in one's personal home. The flat rate equals the SSI-E payment amount minus a personal needs allowance the PO may set at either \$80 or \$100 a month (must be the same for all members in community residential care in the service area). This flat rate method is used regardless of whether the member receives SSI or her/his income comes from other sources. Since the SSI-E amount changes annually, the PO must update this room and board flat rate annually.

c. HUD Fair Market Rent (FMR) Methodology

HUD Fair Market Rate (FMR) Method - This method uses HUD FMR rental amounts as a proxy for housing costs. HUD FMR rents are set at the 40% percentile of surveyed rental costs reflecting modest but reasonable housing, include utilities, vary by county and apartment size, and are updated yearly. A PO using this method use the prior year's efficiency rent for owner-occupied Adult Family Homes; the one bedroom rent for corporate-operated Adult Family Homes and Community Based Residential Facilities; and the two bedroom rent for Residential Care Apartment Complexes.

The board portion is set at a flat amount equal to the maximum Supplemental Nutrition Assistance Program (SNAP, called FoodShare in Wisconsin), allocation for one person plus a small amount for ancillary costs not included in the FMR or FoodShare figures. Figures are updated yearly.

2. *Determining the Member's Room and Board Obligation (Replaces D.1 effective 2/1/2021)*

The PO determines the member's room and board obligation in the facility in which the member resides, excluding members who reside in subsidized housing. POs must update member room and board obligations annually on February 1<sup>st</sup> or upon member request.

The member's room and board obligation is the lesser of:

- The prior calendar year's HUD FMR rental amounts, based on residential type by county, plus the prior calendar year's maximum Supplemental Nutrition Assistance Allocation for one person;





- HUD FMR amounts:  
<https://www.huduser.gov/portal/datasets/fmr.html>
- SNAP allocation:  
<https://www.dhs.wisconsin.gov/foodshare/fpl.htm>
- The member's available income for room and board.

Round HUD FMR, SNAP allocation, and member's available income down to the nearest dollar.

Use the prior calendar year's efficiency rent for owner-occupied Adult Family Homes, the one bedroom rent for corporate-operated Adult Family Homes and Community Based Residential Facilities, and the two-bedroom rent for Residential Care Apartment Complexes. Use the HUD FMR amount for the county where the member lives. For a member residing in a shared room, divide the HUD FMR by two and add the maximum SNAP allocation.

To calculate the amount of income the member has available for room and board, MCOs must use the following calculation:

Deduct from the member's gross monthly income:

- a. Discretionary income allowance of \$100 for basic living expenses;
- b. Health insurance premiums, defined in MEH 28.6.4.4;
- c. Spousal income allocation, defined in MEH 18.6;
- d. Income used for supporting others, defined in MEH 15.7.2.1;
- e. Expenses associated with establishing and maintaining a guardianship, defined in MEH 15.7.2.3;
- f. Court ordered fees and payments, defined in MEH 15.7.2.3;
- g. Garnishments;
- h. Deductions from unearned income, including IRS and SSA paybacks; and
- i. State and federal income taxes.

3. *Determining the Member's Available Income*

The PO determines the amount of available income the member has to pay for room and board, using procedures specified by the Department.

Room and board is not pro-rated for partial months.

4. *Implementing Contingencies if the Member Lacks Funds for Room and Board*

If the member lacks sufficient income available to pay room and board in the facility, the PO either:



- a. Develop an alternative plan of care to support the member's needs and outcomes; or
  - b. Contribute to the member's payment to the facility to make up the shortfall. Any PO contribution to a member's room and board obligation from capitation revenue shall not be considered a countable expense in developing PACE capitation rates.
5. *Collecting and Giving the Member's Room and Board Obligation to the Residential Facility*
- The PO shall collect the member's room and board obligation and give it to the residential facility on behalf of the member.
6. *Sharing Information with Income Maintenance*
- The PO shall inform the income maintenance agency of the room portion of the member's room and board obligation. The room portion is always the member's obligation minus the maximum SNAP allocation (which is the board portion). That information may be used by income maintenance to determine any allowable excess housing costs that may reduce the member's cost-share.

**E. Long-Term Care Functional Screen**

1. *Functional Screen Tool and Database*
- The tool used for determining level of care in PACE is the Long-Term Care Functional Screen (LTC-FS). Information about the LTC FS is found at: <https://www.dhs.wisconsin.gov/functionalscreen/index.htm>.
2. *Notification of Changes in Functional Eligibility Criteria*
- The Department will notify the PO of any changes in administrative code requirements related to functional eligibility, including, but not limited to, code changes that result in changes to the LTC FS algorithms or logic in determining functional eligibility for the programs.
3. *Reimbursement*
- If the trained screener administering the LTC FS is an employee, or under direct supervision, of the PO, no Medicaid administration reimbursement may be claimed for administration of the screen.
4. *Level of Care Re-Determinations*
- The PO shall develop procedures to assure that all members have a current and accurate level of care as determined by the LTC FS. Level of care re-determinations may only be completed by an individual trained and certified to administer the LTC FS.
- The responsibility to assure that all members have a current and accurate level of care shall include:



a. Post-Enrollment Re-Determination

The PO may re-determine level of care for a new member shortly after enrollment if the interdisciplinary team believes that different or additional information has come to light as a result of the initial comprehensive assessment.

The PO shall consult with the ADRC if the PO re-determines level of care for a newly enrolled member or when a newly enrolled member is found to be functionally ineligible or eligibility changes to a non-nursing home level of care within six (6) months of the submission of the most recent pre-enrollment screen. The PO shall review and compare the screens, attempt to resolve the differences, and contact the Department or its designee if differences cannot be resolved.

b. Annual Re-Determination

An annual re-determination of level of care shall be completed within 365 days of the most recent functional screen.

If the level of care re-determination is not completed in the designated timeframe, the PO is required to inform the income maintenance agency of the lack of functional eligibility determination according to change reporting requirements. (The member will lose Medicaid eligibility if the re-determination is not done timely.)

c. Change of Condition Re-Determination

A re-determination of level of care should be done whenever a member's situation or condition changes significantly.

d. Level of Care Determinations and Redeterminations for Private Pay Individuals

Private pay individuals must meet the functional eligibility conditions for eligibility (see Article I for definition of "Private Pay Individual"). The initial level of care determination for a private pay individual is performed by the resource center and the annual redetermination of level of care is performed by the PO.

5. *Accuracy of Information*

The PACE organization shall not knowingly misrepresent or knowingly falsify any information on the LTC FS. The PACE organization shall also verify the information it obtains from or about the individual with the individual's medical, educational, and other records as appropriate to ensure its accuracy.

6. *Long-Term Care Functional Screener Certification*

a. Education and Experience

Before being allowed to administer the functional screen on individuals, PO staff or PO contractors must satisfy the following standards:



- i. Be a representative of a PO with an official function in determining eligibility for a specific program area.
    - ii. Have a license to practice as a registered nurse in Wisconsin pursuant to Wis. Stat. § 441.06, or a Bachelor of Arts or Science degree or more advanced degree in a health or human services related field (e.g. social work, rehabilitation, psychology), and a minimum of one year of experience working with at least one of the target populations.
    - iii. Successfully complete the online screener certification training course(s) and become certified as a functional screener by the Department. Information on the online web class can be found at: <https://wss.ccdet.uwosh.edu/stc/dhsfunctionscreen> and
    - iv. Meet all other training requirements specified by the Department.
  - b. Certified Screener Documentation

Each PO shall maintain documentation of compliance with the requirements set forth in section (a) above and make this documentation available to the Department upon request.
7. *Administration of the Screening Program*
  - a. Listing of Screeners

Each PO shall maintain an accurate, complete, and up-to-date list of all the staff members and/or PO contractors who perform functional screens. POs shall submit to the Department requests to have a screener's security access deactivated as follows:

    - i. If the PO terminates the employment of a screener, the PO shall submit the deactivation request within one (1) business day of the screener's termination.
    - ii. When a screener leaves the PO and/or no longer has a need for access to the functional screen application, the agency shall submit the deactivation request within three (3) business days of the departure or reassignment of the screener.
  - b. Communications

Each PO that administers functional screens shall ensure that each screener is able to receive communications from the Department's functional screen listserv(s).
  - c. Mentoring

Each PO that employs newly certified screeners shall have a formal program for mentoring new screeners (that is providing them with close supervision, on-the-job training, and feedback) for at least six months.



This program shall be described in internal policy and procedures documents that are made available to new screeners and to the Department upon request. Each PO will include activities that allow new screeners to:

- i. Observe an experienced screener administering an actual screen;
- ii. Complete practice screens on a paper version of the LTC FS;
- iii. Be observed by an experienced screener while completing screens or to have his/her screens reviewed by an experienced screener; and
- iv. Have the opportunity for discussion and feedback as a result of those observations or reviews.

d. **Screen Liaison**

Each PO shall designate at least one staff member as “Screen Liaison” to work with the Department in respect to issues involving the screens done by the PO. This person must be a certified functional screener and, at Department determined intervals, successfully pass the required continuing skills testing. This person’s current contact information must be provided to the Department.

- i. Screeners shall be instructed to contact the Screen Liaison with questions when they need guidance or clarification on the screen instructions, and shall contact the Screen Liaison whenever a completed screen leads to an unexpected result in terms of eligibility or level of care;
- ii. The duties of the Screen Liaison are to:
  - a) Provide screeners with guidance when possible, or contact the Department’s Functional Screen Staff for resolution;
  - b) Consult with the Department or its designee on all screens that obtain an unexpected result or that are especially difficult to complete accurately;
  - c) Oversee new screener mentoring program as listed in 7.c.
  - d) Act as the contact person for all communications between the Department or its designee relating to functional screens and the screening program;
  - e) Ensure that all local screeners have received listserv communications and updates from the Department;
  - f) Act as the contact person other counties/agencies can contact when they need a screen transferred;
  - g) Act as the contact person for technical issues such as screen security and screener access;





iv. Identification of the methods that will be employed to improve screener competency given the findings of the monitoring.

b. Continuing Skills Testing

The PO shall require all of its certified screeners to participate in continuing-skills testing required by the Department. The Department requires each screener to pass a test of continuing knowledge and skills at least once every two years, in order to maintain their certification. The PO will:

- i. Provide for the participation of all certified screeners in any continuing-skills training that is required by the Department.
- ii. Administer continuing-skills testing required by the Department in accordance with instructions provided by the Department at the time of testing.
- iii. Cooperate with the Department in planning and carrying out remedial action if the results of the continuing-skills testing indicate performance of any individual screener or group of screeners is below performance standards set for the test result, including retesting if the Department believes retesting to be necessary.

c. Annual Review

At a minimum, annually review a sample of screens from each screener. This is to determine whether the screens were done in a complete, accurate, and timely manner and whether the results were reasonable in relation to the person's condition.

d. Remediation

Review and respond to all quality assurance issues detected by the Department or its designee. The PO shall correct errors in evaluating level of care within 10 days of notification by the Department or its designee.

e. Quality Improvement

Implement any improvement projects or correction plans required by the Department to ensure the accuracy and thoroughness of the screens completed by the agency.

f. Subcontracts

PO that subcontract with another entity or organization to conduct functional screens on behalf of the PO must adopt policies and procedures to ensure subcontractor screen quality.



#### IV. Enrollment and Disenrollment

##### A. Enrollment

The PACE organization shall use Department issued and CMS approved forms related to enrollment.

##### B. Disenrollment

###### 1. *Disenrollment Due to Loss of Eligibility*

In addition to the reasons outlined in the PACE Agreement, Appendix G, and 42 C.F.R. § 460.164,

- a. Members admitted to an IMD when the service is authorized by the PACE IDT should not be disenrolled.
- b. Members may make choices below, that result in the loss of eligibility. When a member makes one of the following choices, the PACE organization will complete the change routing form and send it to the income maintenance agency and the resource center. The income maintenance agency will end the waiver eligibility and the resource center will process the disenrollment:
  - i. Chooses a primary care provider who is not in the PACE organization provider network, or
  - ii. Chooses to enroll in any other Medicare or Medicaid prepayment plan or optional benefit, including hospice benefit.

###### 2. *Informing the Resource Center*

When the PO provides information to the income maintenance agency or another agency that may result in the member being disenrolled, the PO will also inform the resource center. The income maintenance agency will determine whether the person is ineligible. If the member is found ineligible for Medicaid, the disenrollment will occur automatically in ForwardHealth interChange. The PO must offer the member an opportunity to pay the PACE premium to remain in the PACE program. The member may elect to enroll in the PACE program with a premium or disenroll from the PACE program following the determination of Medicaid ineligibility.

##### C. Transition of Care

The PO shall comply with the Department's transition of care policy to ensure that members transitioning to the PO from FFS Medicaid or transitioning from one MCO or PO to another have continued access to services if the member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The Department's transition of care policy can be found at: <https://www.dhs.wisconsin.gov/publications/p02364.pdf>





## V. Care Management

Functions of the PO should support and enhance member-centered care. Designing member-centered plans that effectively and efficiently identify the personal experience outcomes and meet the needs and support the long term care outcomes of members and monitor the health, safety, and well-being of members are the primary functions of care management. Member-centered planning supports: 1) the success of each individual member in maintaining health, independence and quality of life; 2) the success of the PO in meeting the long-term care needs and supporting member outcomes while maintaining the financial health of the organization; and 3) the overall success of the Department's managed long-term care programs in providing eligible persons with access to and choices among high quality, cost-effective services.

### A. Member Participation

The PO is expected to ensure that the member, the member's legal decision maker and any other persons identified by the member will be included in the care management processes of assessment, member outcomes identification, member-centered plan development, and reassessment. This process must reflect cultural considerations of the individual and must be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual and for persons who are limited English proficient through the provision of language services at no cost to the member. The PO shall provide information, education and other reasonable support as requested and needed by members, other persons identified by the member or legal decision makers in order to make informed long-term care and health care service decisions.

1. Members shall receive clear explanations of:
  - a. His/her health conditions and functional limitations;
  - b. Available treatment options, supports and/or alternative courses of care;
  - c. The member's role as part of the interdisciplinary care team;
  - d. The full range of residential options, including in-home care, residential care and nursing home care when applicable;
  - e. The benefits, drawbacks and likelihood of success of each option;
  - f. Risks involved in specific member preferences;
  - g. The possible consequences of refusal to follow the recommended course of care; and
  - h. His/her available choices regarding the services and supports he/she receives and from whom.
2. The PO shall inform members of specific conditions that require follow-up, and if appropriate, provide training and education in self-care. If there are factors that



hinder full participation with recommended treatments or interventions, then these factors will be identified and explained in the member-centered planning process.

## **B. Interdisciplinary Team Composition**

The interdisciplinary team (IDT) is the vehicle for providing member-centered care management. The full IDT always includes the member and other people specified by the member, as well as IDT staff. Throughout this article the term “IDT staff” refers to the social worker, registered nurse and any other staff who are assigned or contracted by the PO to participate in the IDT and is meant to distinguish those staff from the full IDT.

1. The member receives care management through designated IDT staff, which at a minimum include the following:
  - a. Primary care provider,
  - b. Registered nurse,
  - c. Master’s level social worker,
  - d. Physical therapist,
  - e. Occupational therapist,
  - f. Recreational therapist or activity coordinator,
  - g. Dietitian,
  - h. PACE center manager,
  - i. Home care coordinator,
  - j. Personal care attendant or his or her representative,
  - k. Driver or his or her representative.
- l. The team may include additional persons with specialized expertise for assessment, consultation, ongoing coordination efforts and other assistance as needed.
2. The IDT staff shall have knowledge of community alternatives for the target populations served by the PO and the full range of long-term care resources. IDT staff shall also have specialized knowledge of the conditions and functional limitations of the target populations served by the PO, and of the individual members to whom they are assigned.
3. The PO shall establish a means that ensures ease of access and a reasonable level of responsiveness for each member to their IDT staff during regular business hours.

## **C. Assessment and Member-Centered Planning Process**

Member-centered planning is an ongoing process and the member-centered plan (MCP) is a dynamic document that must reflect significant changes experienced in members’



lives. Information is captured through the initial comprehensive assessment and changes are reflected through ongoing re-assessments.

Member-centered planning reflects understanding between the member and the IDT staff and will demonstrate changes that occur with the member's outcomes and health status. The member is always central to the member centered planning and comprehensive assessment process. The IDT staff will ensure that the member is at the center of the member centered planning process. The member will actively participate in the planning process, in particular, in the identification of personal outcomes and preferences. All aspects of the member centered planning and comprehensive assessment process involving the participation of the member must be timely and occur at times and locations consistent with the requirements of Article V. C and H. The member centered plan incorporates the following processes:

1. *Comprehensive Assessment*
  - a. Purpose
    - i. The purpose of the comprehensive assessment is to provide a unique description of the member to assist the IDT staff, the member, a service provider or other authorized party to have a clear understanding of the member, including their strengths, the natural and community supports available to the member, and the services and items necessary to support the member's individual long term care outcomes, needs and preferences.
    - ii. The comprehensive assessment is essential in order for IDT staff to comprehensively identify the member's personal experience outcomes (as defined in Addendum VI, page 261), long term care outcomes, strengths, needs for support, preferences, natural supports, and ongoing clinical or functional conditions that require long-term care, a course of treatment or regular care monitoring.
  - b. Procedures
    - i. The PO shall use an assessment protocol that includes a face-to-face interview in the member's current residence by the IDT social worker, PCP, and registered nurse every twelve (12) months (or every six (6) months for a vulnerable/high risk member) with the member and other people identified by the member as important in the member's life.
    - ii. As a part of the comprehensive assessment, the IDT staff shall review the functional screen, all available medical records of the member and any other available background information.
    - iii. The IDT staff shall encourage the active involvement of any other supports the member identifies at the initial contact to ensure the initial assessment as described in Section D.1.c. of this article is member-centered and strength-based. The IDT staff, member and



other supports shall jointly participate in completing an initial assessment.

- iv. The PO shall use a standard format developed or approved by the Department for documenting the information collected during the comprehensive assessment. The standard format will assist the IDT staff to gather sufficient information to identify the member's strengths and barriers in each area of functional need and natural supports available to the member. It will also assist the IDT staff to identify the associated clinical supports, including assessment of any ongoing conditions of the member that require long-term care, a course of treatment or regular care monitoring, needed to support the member's long term care outcomes.

The PO's standard assessment format will be designed to facilitate, for each member, comprehensive assessment by the IDT staff of the domains of personal experience outcomes and the member's values and preferences, including preferences in regard to services, caregivers, and daily routine.

- c. Documentation

The comprehensive assessment will include documentation by the IDT staff of all of the following:

- i. The registered nurse on the IDT is responsible to assure that a full nursing assessment is completed. This assessment identifies risks to the member's health and safety, including but not limited to risk assessments for falls, skin integrity, nutrition and pain as clinically indicated. The nursing assessment also includes an evaluation of a member's ability to set-up, administer, and monitor their own medication. This includes medication review and intervention.
- ii. A member of the IDT staff is responsible for reviewing and documenting in the comprehensive assessment the member's medications every six months or whenever there is a significant change in the member's health or functional status. When a complex medication regimen or behavior modifying medication or both are prescribed for a member, the IDT staff nurse or other appropriately licensed medical professional shall ensure the member is assessed and reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and understands the potential benefits and side effects of the medication and that all assessments results and follow-up have been completed and documented in the member record. If a complex medication regimen or behavior modifying medication or both are prescribed, the IDT staff nurse or other appropriately licensed medical professional shall ensure that the



- comprehensive assessment includes the rationale for use and a detailed description of the behaviors which indicate the need for administration of the complex medication regime or behavior modifying medication.
- iii. When there is a discrepancy between medications prescribed and medications being taken, the IDT staff is responsible, in accordance with state and professional standards, to assure that efforts are made to clarify and reinforce with the member the correct medication regimen.
  - iv. An exploration with the member of the member's understanding of self-directed supports and any desire to self-manage all or part of his/her care plan.
  - v. An exploration with the member of the member's preferences in regard to privacy, services, caregivers, and daily routine, including, if appropriate, an evaluation of the member's need and interest in acquiring skills to perform activities of daily living to increase his/her capacity to live independently in the most integrated setting.
  - vi. An assessment of mental health and alcohol and other drug abuse (AODA) issues, including risk assessments of mental health and AODA status as indicated.
  - vii. An assessment of the member's overall cognition and evaluation of risk of memory impairment.
  - viii. An assessment of the availability and stability of natural supports and community supports for any part of the member's life. This shall include an assessment of what it will take to sustain, maintain and/or enhance the member's existing supports and how the services the member receives from such supports can best be coordinated with the services provided by the PO.
  - ix. An exploration with the member of the member's preferences and opportunities for community integration including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.
  - x. An exploration with the member of the member's preferred living situation and a risk assessment for the stability of housing and finances to sustain housing as indicated.
  - xi. An exploration with the member of the member's preferences for educational and vocational activities, including supported employment in a community setting.



- xii. An assessment of the financial resources available to the member.
  - xiii. An assessment of the member's understanding of his/her rights, the member's preferences for executing advance directives and whether the member has a guardian, durable power of attorney or activated power of attorney for health care.
  - xiv. An assessment of vulnerability and risk factors for abuse and neglect in the member's personal life or finances including an assessment of the member's potential vulnerability/high risk per Article V.J.1.
- 2. IDT staff will work with the member to identify and document in the comprehensive assessment and MCP the long term care and personal experience outcomes.
  - 3. *Member-Centered Planning*
    - a. Purpose
      - i. Member-centered planning is a process through which the IDT identifies appropriate and adequate services and supports to be authorized, provided and/or coordinated by the PO.
      - ii. Member-centered planning results in a member-centered plan (MCP) which identifies the long term care and personal experience outcomes. The plan identifies all services and supports whether authorized and paid for by the PO, or provided by natural and/or community supports that are consistent with the information collected in the comprehensive assessment and are:
        - a) Sufficient to assure the member's health, safety and well-being;
        - b) Consistent with the nature and severity of the member's disability or frailty; and
        - c) Satisfactory to the member in supporting the member's long term care outcomes.
    - b. Procedures
      - i. Member-centered planning shall be based on the comprehensive assessment. IDT staff shall involve the member and other parties in accordance with the member's preference and the parties' ability to contribute to the development of the MCP.
      - ii. As requested by the member, the IDT staff shall encourage the active involvement of the member's natural and community supports in the member-centered planning process and in development of the MCP. For members with communicative or cognitive deficits, the IDT staff shall encourage family members,



friends and others who know the member and how the member communicates to assist in conveying the member's preferences in the member-centered planning process and in development of the MCP.

- iii. IDT staff shall provide assistance as requested or needed to members in exercising their choices about where to live, with whom to live, work, daily routine, and services, which may include involving experts in member outcomes planning for non-verbal people and people with cognitive deficits.
- iv. The member-centered planning process shall include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants. The IDT staff shall identify potential conflict of interest situations that affect the member's care and, either eliminate the conflict of interest or, when necessary, monitor and manage it to protect the interests of the member.
- v. The written member centered plan resulting from the member centered planning process shall be understandable to the member and the individuals important in supporting the member. At a minimum, this requires that the plan be written in plain language and in a manner that is accessible to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual and for persons who are limited English proficient through the provision of language services at no cost to the member.

c. Documentation

- i. The MCP shall document the member's long term care and personal experience outcomes. It must document the actions to be taken and the services needed to support the long term care outcomes. The MCP must document which IDT staff will monitor and evaluate these actions and services.
- ii. The MCP shall document areas of concern or risk that IDT staff have identified and which they have discussed with the member, but that the member has not agreed to as a priority at the present time.
- iii. The PO shall use a standard format for documenting the information collected during the assessment and member-centered planning process. The IDT staff shall use the PO's approved service authorization policies and procedures in order to produce an MCP that supports the member's outcomes and is cost-effective.





- iv. The MCP shall document at least the following:
  - a) The member's personal experience and long term care outcomes;
  - b) The member's strengths and preferences;
  - c) The frequency of face-to-face and other contacts, consistent with the minimums required by Article V.H, and an explanation of the rationale for that frequency. These figures and the supporting rationale shall be based upon the assessment of the complexity of the member's needs, preferences, risk factors including potential vulnerability/high risk, and any other factors relevant to setting the frequency of face to face visits;
  - d) The paid and unpaid supports, services, strategies and backup plans to mitigate risk and help the member work toward achieving his/her long term care outcomes, including those services, the purchase or control of which the individual elects to self-direct;
  - e) The natural and community supports that provide each service or support that is identified by the assessment and verification from the member/legal decision maker that natural supports included in the MCP are available and willing to provide assistance as identified in the MCP;
  - f) The home and community-based residential setting option chosen by the member and other options presented to the member unless the member declines to consider other options;
  - g) How the setting in which the member resides supports integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community;
  - h) For members residing in a provider-owned or controlled residential setting, the MCP must document that any modification of the standards listed under 42 C.F.R. § 441.301(4)(vi) A through D are supported by a specific assessed need and justified in the MCP. Specifically, this documentation must include: (1) the identification of a specific and individualized assessed need; (2) the positive interventions and supports used prior to any modifications to the MCP; (3) the less intrusive methods of meeting the need that have been tried but did not work; (4) a clear





description of the condition that is directly proportionate to the specific assessed need; (5) the regular collection and review of data to measure the ongoing effectiveness of the modification; (6) the established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; (7) the informed consent of the individual and (8) an assurance that interventions and supports will cause no harm to the individual.

- i) The plan for coordinating services received by the member;
- j) The plan to sustain, maintain and/or enhance the member's existing natural supports and community supports and for coordinating services the member receives from such supports;
- k) The specific period of time covered by the MCP;
- l) Any areas of concern that IDT staff see as a potential risk that have been discussed with the member, including instances when:
  - 1) The member refuses a specific service or services that IDT staff believes are needed and IDT staff have attempted to make the member aware of any risk associated with the refusal.
  - 2) The member engages in behavior that IDT staff view as a potential risk but the member does not want to work on that behavior at this time, and IDT staff have offered education about the potential negative consequences of not addressing the risk; and

d. Authorizing Services

IDT staff will prepare service authorizations in accordance with the PO's approved service authorization policies and procedures and Section K., Service Authorization, of this article.

e. Documenting Services Authorized by the PO

The IDT staff shall give the member, as part of the MCP, a listing of the services and items that will be authorized by the PO. The list shall include at a minimum:

- i. The name of each service or item to be furnished;
- ii. For each long-term care service, the units authorized;
- iii. The frequency and duration of each service including the start and stop date; and



- iv. For each service, the provider name.
- f. Cost of Services  
Upon the member's request, the IDT staff shall provide information on the current cost per unit for services authorized by the PO.
- g. Member-Centered Plan Signatures
  - i. Member or Legal Decision Maker Signature  
IDT staff shall review the MCP with the member and legal decision maker, if applicable, and obtain the signature of the member or the member's legal decision maker to indicate his/her agreement with the MCP. Signatures shall be obtained at the initial MCP development and when the MCP is updated due to change in the member's condition.  
If a member declines to sign the MCP, the IDT staff shall:
    - a) Document in the member record the request to the member to sign the MCP and the reason(s) for refusal; and
    - b) If the refusal to sign the MCP reflects the member's disagreement with the MCP, the IDT staff shall discuss the issues with the member and provide the member with information on how to file a grievance or appeal.If the member's record contains documented evidence, including casenotes or, when available, documentation from a mental health professional, that obtaining the member's signature on the MCP is detrimental to the member's clinical or functional well-being, the IDT staff shall:
    - a) Document in the member record the specific reason(s) why the IDT staff and/or mental health professional believe that the member's signature should not be obtained; and
    - b) At each subsequent MCP review, reevaluate the decision to not obtain the member's signature on the MCP or provide the member with a copy of the MCP.
  - ii. Provider Signatures
    - a) Essential Providers  
The IDT shall obtain the signatures of all essential waiver service providers. Providers of the following waiver services are essential service providers:
      - 1) Adult Day Care Services;
      - 2) Day Habilitation Services;



- 3) Daily Living Skills Training;
  - 4) Prevocational Services;
  - 5) Adult residential care (adult family homes, community-based residential facilities, residential care apartment complexes);
  - 6) Respite;
  - 7) Skilled nursing services RN/LPN;
  - 8) Supported employment (individual and small group employment support); and
  - 9) Supportive home care (excluding routine chore services).
- b) Non Essential Providers
- For non-essential providers, the PO must attach a copy of the provider's current signed provider agreement or service authorization to the MCP.
- iii. Methods and Frequency for Obtaining Essential Provider Signatures
- Acceptable methods to obtain essential provider signatures are: electronic, telephonic, secure email, mail, fax, electronic access through a case management system, and face-to-face.
- Signatures shall be obtained at the initial MCP development and annually. A signature must be obtained from a new essential provider when that provider is added to the MCP.
- h. Member-Centered Plan Distribution
- The PO shall distribute a copy of the MCP to the member or the member's legal decision maker and essential provider(s). For self-directing members, the PO shall provide enough copies of the MCP for members and/or their legal decision makers to give to the member's essential providers. Distribution of the MCP shall occur at the initial MCP development and annually.
- i. Electronic Signature
- If the member, the member's legal decision maker or a provider prefers to sign the MCP electronically and the PO offers this option, it is allowable when the following standards are met:
- i. The PO provides the member, the member's legal decision maker, or a provider with access to the documents to be electronically



- signed for through a secure website or email system which includes a secure log-in, user name, and unique password.
- ii. The documents to be electronically signed meet all applicable electronic media accessibility requirements under Article IX.B.3.
  - iii. The PO has a DHS approved electronic signature policy and procedure for staff that:
    - a) Satisfies all contract MCP signature timeframes; and
    - b) Includes a process to verify the date of the electronic signature.
  - iv. The PO uses a DHS approved electronic signature template that includes the following:
    - a) The member, member's legal decision maker or provider's full name; and
    - b) IDT staff signatures; and
    - c) A list of the documents to which the electronic signature of the member, member's legal decision maker or provider applies and a statement that the electronic signature is only valid for these documents; and
    - d) A date range during which the signed documents must be accessible to the member, member's legal decision maker or provider including a statement that the documents will be available to the member, member's legal decision maker or provider during this time period.
  - v. Distribution of, and access to, signed materials must meet contract requirements including all applicable HIPAA and confidentiality requirements.

#### **D. Timeframes**

##### *1. Initial Assessment and MCP Timeframes*

##### *a. Immediate Service Authorization*

Beginning on the date of enrollment, the PO is responsible for providing the member with needed PACE services. This includes responsibility to continue to provide services or supports the member is receiving at the time of enrollment if they are necessary to ensure health and safety and continuity of care until such time as the IDT staff has completed the initial assessment. Such services may have time limited authorizations until completion of the member's full assessment and member-centered plan.



b. Initial Contact

The PO shall contact the member (face-to-face or via telephone) within three (3) calendar days of enrollment to:

- i. Welcome the member to PACE;
- ii. Make certain that any services needed to assure the member's health, safety and well-being are authorized;
- iii. Provide the member with immediate information about how to contact the PO for needed services;
- iv. Review the stability of current supports in order to identify the services and supports necessary to sustain the member in his/her current living arrangement; and
- v. Schedule a face-to-face contact with the IDT and member.

c. Initial Assessment

Within ten (10) calendar days from enrollment, the IDT shall meet face-to-face with the member to:

- i. Review the member's most recent long-term care functional screen and any other available information.
- ii. Explain the PACE program and the philosophy of managed long-term care, including the member's responsibility as a team member of the IDT;
- iii. Conduct the initial assessment, including an initial brief nursing assessment to examine the member's needs which at a minimum must include:
  - a) Are there imminent dangers to self or others (physical and/or behavioral);
  - b) Does the member require assistance with medication administration?
  - c) Is there a support system change/concern (i.e., loss of spouse, caregiver, no support available, etc.)?
  - d) Is the member demonstrating severe impairment of cognition or orientation?
  - e) Have there been any recent transitions of care (i.e., hospital to home) or recent ER/Urgent Need visits?
  - f) Assess the stability of current supports in order to identify the services and supports necessary to sustain the member in his/her current living arrangement.



- d. Initial Service Authorization
  - i. The initial service authorization shall be developed by the IDT staff in conjunction with the member and shall immediately authorize needed services.
  - ii. The initial service authorization shall be developed and implemented within five (5) calendar days of enrollment and signed by the member or the member's legal decision maker within ten (10) calendar days of enrollment.

- e. Initial MCP Development

The initial assessment and service authorization completed within the first ten (10) calendar days of enrollment is the beginning of the initial MCP. The initial MCP might not yet reflect all of the member's personal experience, or long term care outcomes, but it will reflect health and safety issues the IDT staff have assessed and will provide or arrange for basic services and items that have been identified as needed. It is expected that as the member and IDT staff complete further assessment together, the initial MCP will be more comprehensively developed.

- 2. *Timeframes for Comprehensive Assessment and Signed MCP*

- a. Comprehensive Assessment

A comprehensive assessment shall be completed in a timely manner following enrollment as required by 42 C.F.R. § 460.104.

- b. Member-Centered Plan (MCP)

A fully developed MCP shall be completed and signed by the member or the member's legal decision maker within thirty (30) calendar days of the enrollment date.

- 3. *Document Timelines*

The PO shall document all billable case management activities within a case note within the timeframe(s) defined in a PO policy approved by DHS.

**E. Providing, Arranging, Coordinating and Monitoring Services**

- 1. *Providing and Arranging for Services*

The IDT staff is formally designated as being primarily responsible for coordinating the member's overall long-term care and health care. In accordance with the MCP, the IDT staff shall authorize, provide, arrange for or coordinate services in a timely manner.



2. *Coordination with Other Services*

The IDT staff shall ensure coordination of long-term care services with health care services received by the member, as well as other services available from natural and community supports.

This includes but is not limited to assisting members to access social programs when they are unable to do so themselves and, assisting the member to obtain and maintain eligibility for SSI-E, if applicable (refer to the SSI-E Policy Handbook: <http://www.emhandbooks.wisconsin.gov/ssi-e/ssi-e.htm>).

3. *Access to Services*

The IDT staff will arrange for, and instruct members on how to obtain, services. The IDT staff shall at a minimum:

- a. Within thirty (30) calendar days of enrollment, document the member's primary care provider, specialty care provider(s), and psychiatrist (if applicable);
- b. Obtain the member's authorization, as required by law, to receive and share appropriate health care information;
- c. Provide information about the PO's procedures for accessing long-term care services;
- d. Provide the member with education on how to obtain needed primary and acute health care services;
- e. Educate members in the PO's expectations in the effective use of primary care, specialty care and emergency services; including:
  - i. Any procedures the provider must follow to contact the PO before the provision of urgent or routine care;
  - ii. Procedures for creating and coordinating follow-up treatment plans;
  - iii. Policies for sharing of information and records between the PO and emergency service providers;
  - iv. Processes for arranging for appropriate hospital admissions;
  - v. Processes regarding other continuity of care issues; and
  - vi. Agreements, if any, between the PO and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the PO or emergency services provider in the absence of such an agreement.



4. *Monitoring Services*

IDT staff shall, using methods that include face-to-face and other contacts with the member, monitor the services a member receives. This monitoring shall ensure that:

  - a. The member receives the services and supports authorized, arranged for and coordinated by the IDT staff;
  - b. The services and supports identified in the MCP as being provided by natural and community supports are being provided; and
  - c. The quality of the services and supports received is adequate and still necessary to continue to meet the needs and preferences of the member and support the member's outcomes identified in the MCP.
5. *PO Coordination With the Division of Workforce Development's (DWD) Division of Vocational Rehabilitation (DVR)*
  - a. When the PO receives an updated coordination plan from the DVR, the PO must either upload the plan to the member's record or document the updated plan in the member's record.

**F. Re-Enrollment Assessment and MCP Update**

1. *When to Use Expedited Procedures*

The PO may use the expedited procedures and reduced documentation requirements listed below in place of the procedures and documentation requirements set forth in Article V. Sec. C.1.b. and c. if:

  - a. The member is a re-enrollee;
  - b. An assessment that complies with the procedures and documentation requirements set forth in Article V. Sec. C.1.b. and c. is on file and has been performed within the past 180 calendar days; and
  - c. There has been no significant change in the member's health or other circumstances since the date of disenrollment.
2. *Expedited Procedures*
  - a. The IDT staff must review the most recent assessment that was conducted pursuant to the procedural and documentation requirements set forth in Article V. Sec. C.1.b. and c.
  - b. IDT staff must review the most recent long term care functional screen.
  - c. Within three (3) calendar days of re-enrollment IDT staff must contact the re-enrolled member by telephone and an RN must conduct a health and safety assessment. This assessment can be done by telephone.





- d. If the health and safety assessment reveals that there has been a significant change in the member's circumstances, the PO may not utilize the expedited assessment procedures. The PO must instead comply with the assessment procedures and documentation requirements set forth in Article V. Sec. C.1.b. and c.

3. *Reduced Documentation*

The PO must include the following in the member's file:

- a. Evidence that the IDT contacted or made reasonable attempts to contact the member within three (3) calendar days of re-enrollment and evidence of a completed health and safety assessment as required by Article V. Sec. F.2.c.
- b. Any updates the IDT makes to the most recent comprehensive assessment conducted per Article V. Sec. C.1.

4. *MCP Update*

The IDT must at a minimum review the MCP following an expedited assessment. If there are any changes made to the MCP following an expedited assessment, IDT staff shall review the MCP with the member and obtain the member's signature or the signature of the member's legal decision maker.

**G. Reassessment and MCP Update**

1. *Reassessment*

IDT staff shall routinely reassess, and as appropriate update, all of the sections in the member's comprehensive assessment and MCP as the member's long-term care outcomes change. At a minimum, the reassessment and MCP review shall take place no later than the end of the sixth month after the month in which the previous comprehensive assessment was completed. The reassessment shall include a review of previously identified or any new member long-term care outcomes and supports available. At a minimum:

- a. The PCP, IDT social worker, registered nurse, and any other IDT members that the PCP, RN, or IDT social worker determine are actively involved in the development or implementation of the MCP shall conduct this reassessment in person and, for vulnerable/high risk members, the reassessment shall occur in the member's current residence;
- b. The IDT staff conducting the re-assessment shall ensure that the other IDT members are updated and involved as necessary on the reassessment;
- c. When a complex medication regime or behavior modifying medication or both are prescribed for a member, the requirements in C.1.c.ii. shall be met.



2. *Unscheduled Reassessments*

Unscheduled reassessments are required based on the following:

- a. A significant change in the member's long term care or health care condition or situation;
  - i. The reassessment must be conducted by the PCP, RN, IDT social worker, and any other team members identified by the PCP, RN, or IDT social worker as actively involved in the development or implementation of the MCP.
- b. A request for reassessment by the member, the member's legal decision maker, or the member's primary medical provider.
  - i. The reassessment must be conducted by the appropriate members of the IDT, as identified by the IDT.
  - ii. The IDT members may conduct the reassessment via remote technology when the IDT determines the use of remote technology is appropriate and meets the requirements in 42 C.F.R. § 460.104(d)(2).

3. *MCP Update*

The IDT shall review and update the MCP and service authorization document periodically as the member's outcomes, preferences, situation and condition changes, but not less than the end of the sixth month after the month in which the previous MCP review and update occurred.

**H. Interdisciplinary Team and Member Contacts**

1. *Minimum Required Face-to-Face Contacts*

IDT staff shall establish a schedule of face-to-face contacts based upon the complexity of the member's needs and the risk in the member's life including an assessment of the member's potential vulnerability/high risk per Article V.J.1. At minimum, IDT staff is required to conduct a face-to-face visit with a member every three months. The IDT social worker, registered nurse, and PCP are required to conduct a face-to-face visit in the member's residence at minimum:

- a. Every twelve (12) months as part of the reassessment; and
- b. Every six (6) months for vulnerable/high risk members as part of the reassessment. The scheduled reassessment visits count for two of the face-to-face contacts required by this subsection. The PO shall notify the DHS assigned oversight team of members who meet the vulnerable/high risk criteria but refuse face-to-face visit(s) in their primary residence.

2. *Minimum Required Telephone or Live Video Messaging Contacts*

For any month in which there is not a face-to-face meeting with the member, IDT staff is required to make telephonic or live video contact with the member, the



member's legal decision maker, or an appropriate person associated with the member (for example, a provider, friend, neighbor, or family member) who has been authorized by the member or the member's legal decision maker to speak with IDT staff. IDT staff shall document that each telephone or live video contact covered all aspects of service monitoring as required under section V.E.4., including assuring the member is receiving the services and supports authorized, arranged for and coordinated by the IDT staff and the services and supports identified in the MCP as being provided by natural and community supports are being provided, and that the quality of the services and supports received is adequate and still necessary to continue to meet the needs and preferences of the member and support the member's outcomes identified in the MCP. For live video messaging to be used it must occur in real time and be interactive. The PO may not record the live video conference with the member without prior consent from the member; if consent is given orally, the PO shall follow-up with the member or the member's legal decision maker to confirm the consent in writing. The plan for member's contacts should be discussed with the member, follow PO policy and be documented in the member's record.

3. *Documentation*

The PO shall document care management contacts in a format agreed to by the PO and the Department and provide care management contact data to the Department upon request.

**I. Member Record**

The PO shall develop and maintain a complete member record as specified in Article XIII.A.10, Contents of Member Records, page 170, for each person enrolled. A complete and accurate account of all care management activities shall be documented by IDT staff and included in the member's record. The PO shall document all billable case management activities within a case note within the timeframe(s) defined in a PO policy approved by DHS.

**J. Member Safety and Risk**

1. *Policies and Procedures Regarding Member Safety and Risk*

The PO shall have policies and procedures in place regarding member safety and risk, which shall be submitted to the Department for approval prior to implementation, whenever a change occurs, and upon request. PO staff and other appropriate individuals shall be informed of these policies on an ongoing basis.

The purpose of these policies and procedures is to balance member needs for safety, protection, good physical health and freedom from accidents, with over-all quality of life and individual choice and freedom. These policies and procedures shall identify:

- a. How IDT staff will assess and respond to risk factors affecting members' health and safety;



- b. Guidelines for use by IDT staff in balancing member rights with member safety through a process of ongoing negotiation and joint problem solving;
  - c. Criteria for use by IDT staff to identify risk, including vulnerable/high risk members as defined in Article I.131;
  - d. Training for all IDT staff in identifying risk and coordinating care;
  - e. Guidelines and tools to assist IDT staff in identifying and mitigating risk; and
  - f. Protocols for use by IDT staff to identify, implement and document appropriate, individualized monitoring and safeguards to address and mitigate potential concerns and assure the health and safety of all members including those identified as vulnerable/high risk as defined in Article I.131. At a minimum these protocols must include:
    - i. Documentation of ongoing assessment of risk and conflict of interest, as required under sections V.C.3.b.iv., VIII.N.2.c. and X.B.8.d. of this Contract;
    - ii. Assessment of caregiver stress using caregiver stress tool;
    - iii. Validation of backup plans to assure caregivers who have been identified are capable and willing to provide support as documented in the comprehensive assessment and member centered plan;
    - iv. Validation by appropriate PO staff or arrangement for validation of supportive home care workers pursuant to the *Managed Care Organization Training and Documentation Standards for Supportive Home Care* <https://www.dhs.wisconsin.gov/publications/p01602.pdf> within 10 days of enrollment;
    - v. Documented attempts to collect data and information from the member's support network, including primary care and other health care providers, caregivers identified in the backup plan, and other significant people who regularly see the member to determine if there are any areas of concern or need that IDT staff should consider in connection with their duty to monitor and coordinate services as required in section V.E.4. of this Contract;
    - vi. Considerations of how to add additional external caregivers, as appropriate, to provide additional risk mitigation.
2. *Abuse, Neglect, Exploitation and Mistreatment Prohibited*
- The PO shall implement a policy that expressly prohibits all forms of abuse, neglect, exploitation and mistreatment of members by PO employees and contracted providers. This policy shall include instruction in the proper reporting procedures when abuse or neglect is suspected.



3. *Individual Choices in Safety and Risk*

The PO shall have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues. These mechanisms shall ensure that the PO offers individualized supports to facilitate a safe environment for each member. The PO shall assure its performance is consistent with the understanding of the desired member outcomes and preferences. The PO shall include family members and other natural and community supports when addressing safety concerns per the member's preference.

4. *Use of Isolation, Seclusion and Restrictive Measures*

The PO shall comply with, and as needed, provide training for its providers in compliance with the following requirements:

- a. POs are required to have an internal restrictive measures oversight committee. The PO oversight committee must review restrictive measures proposals prior to submitting the request to DHS.
- b. The PO oversight committee must review restrictive measures proposals and either approve the proposal as submitted, approve the proposal with conditions, deny the proposal, or return it because additional information is needed. All PO decisions must be in writing, must identify each measure separately, describe reasons for the denial (if applicable), include any conditions of approval along with adequate descriptions of these conditions, and be signed by someone in a management position designated by the director of the PO. Denials must also offer information for the member or legal decision maker to grieve the decision including the PO internal grievance procedure, contacting DHS Client Rights Office, or requesting a Department Review.
- c. Requests for use of restrictive measures must be submitted to DHS via the Restrictive Measures database  
<https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login>.
- d. The PO and its providers shall follow the Department's written guidelines and procedures on the use of isolation, seclusion and restrictive measures in community settings, and follow the required process for approval of such measures (<https://www.dhs.wisconsin.gov/publications/p02572.pdf>).
- e. The use of isolation, seclusion and restrictive measures in licensed facilities in Wisconsin is regulated by the Department's Division of Quality Assurance. When providers are subject to such regulation, the PO shall not interfere with the procedures of the Division of Quality Assurance.
- f. The PO and its providers shall comply with Wis. Stat. §§ 51.61(1)(i) and 46.90(1)(i) and Wis. Admin. Code § DHS 94.10 in any use of isolation, seclusion and restrictive measures.



5. *Identifying and Responding to Member Incidents*
- a. The PO shall develop and maintain an incident management system, which manages incidents occurring at the member and provider levels, in order to assure member health and safety, reduce member incident risks, and enable development of strategies to prevent future incident occurrences.
  - b. The incident management system shall include policies and procedures to ensure that:
    - i. The PO IDT staff inform members/legal decision makers (and involved family and other unpaid caregivers, as appropriate) about abuse, neglect, and exploitation protections, at the initial assessment upon member enrollment or at the initial comprehensive assessment, and at each annual comprehensive assessment thereafter. Completion of this task shall be documented in the member record.
    - ii. PO members/legal decision makers (and involved family and other unpaid caregivers, as appropriate) are informed of the process used to report member incidents.
    - iii. PO staff and providers are trained in identifying, responding to, documenting, and reporting member incidents. Completion of training for PO staff shall be documented and provided upon request to DHS. Completion of training for providers shall be documented in the PO's provider file.
    - iv. Contracted providers must report member incidents to designated PO staff no later than one (1) business day after the incident was discovered;
    - v. Effective steps are taken immediately to prevent further harm to or by the affected member(s);
    - vi. Incidents wherein the member is a victim of a potential violation of the law are reported to local law enforcement authorities. Incidents where the member is suspected of violating the law are reported to local law enforcement, to the extent required by law;
    - vii. Incidents meeting criteria in Wis. Stat. §§ 46.90(4) or 55.043(1m) are reported in accordance with the applicable statute to the appropriate authority; the PO is not responsible for or a substitute for Adult Protective Service investigations;
    - viii. The PO, within three (3) calendar days of learning of the incident, notifies the member/legal decision maker of the incident, unless the member/legal decision maker reported the incident to the PO, the PO has within that time determined that the report was



- unfounded or unsubstantiated, or unless the legal decision maker is a subject of the investigation;
- ix. The PO has designated staff to conduct incident investigations who:
- a) Are not directly responsible for authorizing or providing the member's care;
  - b) Have sufficient authority to obtain information from those involved and;
  - c) Have clinical expertise to evaluate the adequacy of the care provided relevant to the member incident.
- x. The PO will designate staff to provide oversight of PO staff or the provider who shall investigate the incident in a manner consistent with the relative scope, severity and implications of any given member incident and determine and document, at a minimum, the following:
- a) The facts of the reported incident (including the date and location of occurrence), the type and extent of harm experienced by the member, any actions that were taken immediately to protect the member and to halt or ameliorate the harm;
  - b) The cause(s) of the incident;
  - c) Whether reasonable actions by the provider or others with responsibility for the health, safety and welfare of the member would have prevented the incident; and
  - d) Interventions and/or preventative strategies which may include changes in the PACE organization's or provider's policies or practices to help prevent occurrence of similar incidents in the future.
- xi. When warranted, an investigation of each reported member incident shall be completed within thirty (30) calendar days of the incident's discovery. If information or findings necessary for completion of the investigation cannot be obtained within 30 days for reasons beyond the PACE organization's control, the investigation shall be completed as promptly as possible.
- xii. The PO shall report member incident data in accordance with the Department's incident data report specifications. The report submission is due on the thirtieth day after the end of the month, or the first business day following the thirtieth day when the thirtieth day is not a business day. The report shall be submitted electronically through the Long Term Care Information Exchange





System.

(<https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html>)

- xiii. Within five (5) business days of completion of the investigation, the PO shall provide notification to the member/legal decision maker (and/or the member's family, as appropriate) of the results or outcomes of the investigation. This notification shall be documented in the member record.

## **K. Service Authorization**

### *1. Service Authorization Policies and Procedures*

#### a. Long-Term Care Services

The PO may use the Resource Allocation Decision Method (RAD) as its service authorization policy. If the PO does not use the RAD, it must seek Department approval of alternative service authorization policies and procedures. The policies and procedures must address how new and continuing authorizations of services are approved and denied.

The PO may choose to create decision-making guidelines for more frequently used items and/or services. When the PO wishes to utilize these guidelines as part of the RAD or alternative service authorization documentation (instead of documenting evidence), the guidelines must be approved by the Department. Services shall be authorized in a manner that reflects the member's ongoing need for such services and supports as determined through the comprehensive assessment and consistent with the member-centered plan.

#### b. Acute and Primary Care Services

The PO shall have documented and Department-approved service authorization policies and procedures for acute and primary care services. Policies and procedures may differ from the authorization policies and procedures for long-term care services and may be based on accepted clinical practices. Decisions about the authorization of acute and primary care services may be made outside of the IDT by other clinical professionals with consideration for member preferences.

#### c. Authorization of Medicare Services

PACE organizations in making authorization decisions about services in PACE shall first use and follow Medicare coverage and authorization policies, procedures and requirements rather than the RAD or other Department-approved service authorization policies and procedures used for the authorization of Medicaid services under this contract. If the PO determines that Medicare will not cover the service, the PO must then use and follow the Medicaid coverage rules, including the RAD, to determine if Medicaid will cover the service.





d. Procedures

The PO's service authorization policies and procedures shall be submitted to the Department for approval prior to implementation, whenever a change occurs, and upon request.

In addition, the PO must submit any decision-making guidelines referenced in section 1.a. above to the Department for approval prior to implementation.

IDT staff shall use the PO's approved standardized service authorization policies, procedures and guidelines, as applicable. IDT staff shall explain to the member the PO's standardized service authorization process (RAD process), the member's role and responsibilities in that process, and when the service authorization process is being used.

The PO must have in effect mechanisms to ensure consistent applications of review criteria for authorization decisions; and consult with the requesting provider when appropriate.

2. *Necessity or Appropriateness of Services*

a. Use of Approved Service Authorization Policies

The IDT shall use the PO's Department-approved service authorization policies and procedures to authorize services. The IDT shall not deny services that are reasonable and necessary to cost-effectively support the member's long term care outcomes identified in the comprehensive assessment as well as those necessary to assist the member to be as self-reliant and autonomous as possible. Long-term care outcomes for which services are authorized may relate to:

- i. The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;
- ii. The ability to achieve age-appropriate growth and development;
- iii. The ability to attain, maintain, or regain functional capacity; and
- iv. The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

b. Amount, Duration and Scope of Medicaid Services

Members shall have access to services that are identified as necessary to support the long term care outcomes in an amount, duration and scope that will support member outcomes and are no less effective than would be achieved through the amount, duration and scope of services that would otherwise be furnished to fee-for-service Medicaid recipients, as set forth in 42 CFR § 440.230.



c. Most Integrated Services

The IDT staff shall provide services in the most integrated residential setting consistent with the member's long-term care outcomes, and identified needs, and that is cost-effective when compared to alternative services that could meet the same needs and support similar outcomes.

Residential care services are services through which a member is supported to live in a setting other than the member's own home.

Residential Care services include Residential Care in Addendum VI.A.17 and Nursing Home in Addendum VI.B.

Residential care services are appropriate when:

- i. The member's long-term care outcomes cannot be cost-effectively supported in the member's home, or when the member's health and safety cannot be adequately safe-guarded in the member's home; or
- ii. Residential care services are a cost-effective option for meeting that member's long-term care needs.

d. Discrimination Prohibited

The IDT staff shall not arbitrarily deny or reduce the amount, duration, or scope of services necessary to support outcomes solely because of the diagnosis, type of illness, disability or condition.

e. Resolving Disputes

Disputes between the PO and members about whether services are necessary to support outcomes are resolved through the grievance and appeals processes identified in Article XI, Grievances and Appeals.

3. *Authorization Limits*

The PO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for the purpose of utilization management, provided the services furnished can reasonably be expected to support the member's long term care outcomes as defined in Article I, Definitions.

After the initial MCP, when a specific service is identified as necessary to support a member's long term care outcomes on an ongoing basis and the IDT has determined that the current provider is effective in providing the service, the service shall generally be authorized for the duration of the current MCP (i.e., until the next regularly scheduled MCP update) in an amount necessary to support the member's outcomes.

The number of units of service or duration of a service authorized may be more limited when the authorization is for:

- a. An episodic service or course of treatment intended to meet a need that is anticipated to be short term in nature, which may be authorized for a



limited length of time or number of units of service that is expected to be sufficient to meet the short term need.

- b. A trial-basis service or course of treatment intended to test whether a particular service or course of treatment is an effective way to support the long term care outcome or need of the member, which may be authorized for a length of time or number of units of service that is expected to be sufficient for the IDT, including the member, to determine whether or not the services or course of treatment is in fact effective in meeting the member's outcome or need.

Services may be discontinued when a limitation in an original service authorization for an episodic service or course of treatment is reached. If the member requests additional services the IDT staff must respond in accordance with paragraph 8, Responding to Direct Requests By a Member for a Service, of this section.

4. *Service Authorization Decisions Made Outside the IDT*

If the PO has Department-approved policies and procedures that require service authorization decisions to be made outside the IDT, including any situations in which IDT staff are required to seek approval for an authorization it would like to make from supervisory, clinical or administrative staff within the PO, the PO shall:

- a. **Maintain Written Decision-Making Criteria**

The review criteria used for decision-making shall have prior approval by the Department, shall be clearly documented, regularly updated and available for review by members and IDT staff. The criteria shall determine the necessity and/or appropriateness of services based on reasonable evidence or a consensus of relevant clinical practitioners, and shall assure that members are provided with services necessary to support long term care outcomes.

- b. **Information Required for a Decision**

The policies and procedures approved by the Department shall specify the information required for service authorization decisions, shall have mechanisms to ensure consistent application of the review criteria for service authorization decisions, and shall include consultation with the requesting provider when appropriate.

5. *Coordination with Primary Care and Health Care Services*

The PO must implement procedures to:

- a. Ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member.



- b. Coordinate the services the PO furnishes to the member with the services the member receives from any other provider of health care or insurance plan, including mental health and substance abuse services.
- c. Share with other agencies serving the member the results of its identification and assessment of special health care needs so that those activities need not be duplicated.
- d. Ensure that in the process of coordinating care, each member's privacy is protected consistent with the confidentiality requirements in Article XIII.A.1.

6. *Prohibited Compensation*

The PO shall not compensate individuals or entities that conduct utilization management or prior authorization activities in such a way as to provide incentives for the individual or entity to deny, limit, or discontinue for members services necessary to support outcomes.

7. *Communication of Guidelines*

The PO shall disseminate to all affected providers practice guidelines used for review and approval of requests for services. Upon request, the PO shall disseminate practice guidelines to members and potential members.

8. *Responding to Direct Requests By a Member for a Service*

When a member requests a health or long-term care service or item, IDT staff shall do all of the following:

- a. Acknowledge receipt of the request and explain to the member the process to be followed in processing the request;
- b. Using the RAD or other Department approved guidelines, promptly determine what the core issue is in relation to the request. Assess if the request meets a need defined in the member's long term outcomes.
- c. Promptly determine whether the IDT has the authority to authorize the requested service or whether the authorization decision must be made outside the IDT (see Section K.4., Service Authorization Decisions Made Outside the IDT, in this article);
- d. Consult as needed with other health care professionals who have appropriate clinical expertise in treating the member's condition or disease necessary to reach a service authorization decision.
- e. Issue a prompt decision as follows:
  - i. If IDT staff are authorized to provide or arrange the service, make a prompt decision to approve or to disapprove the request based on the RAD or other Department-approved service authorization policies and procedures. The member is always a participant in the



- RAD or other Department-approved service authorization policies and procedures.
- ii. If the service authorization process requires that additional PO employees or other professionals be involved in decision-making about a member request for service, the PO shall assure that:
    - a) The additional PO employee(s) shall join with the IDT staff;
    - b) The expanded IDT shall use the RAD or other Department-approved service authorization policies and procedures with the member; and
    - c) The IDT shall make the final decision taking into consideration the recommendations of the PO employees or other professionals.
  - iii. If the service authorization process requires that the IDT seek additional information outside the team prior to authorization or approval, assure that the additional information is obtained promptly.
  - iv. The timeframe for decision-making must be in accordance with the timeframe outlined in paragraph 9, Timeframe for Decisions, below.
- f. If the IDT staff determines that the service or the amount, duration or scope of the service is not necessary or appropriate and therefore approves less service than requested or declines to provide or authorize the service, the IDT staff shall do all of the following:
- i. Within the timeframes identified in paragraph 9 below, , provide the member notice of adverse benefit determination of any decision by the team to deny a request, or to authorize a service in an amount, duration, or scope that is less than requested.  
  
Failure to reach a service authorization decision within the timeframes specified in paragraph 9, Timeframe for Decisions, below constitutes a denial and therefore requires a notice of adverse benefit determination and the member's request must be automatically processed as an appeal as required in Article XI Grievances and Appeals, and in compliance with 42 CFR 460.122.
  - ii. When appropriate, notify the rendering provider of the authorization decision. Notices to providers need not be in writing.
  - iii. All service requests, which are denied, limited, or discontinued, shall be recorded, along with the disposition. Aggregate data on service requests that are denied, limited, or discontinued are



compiled for use in quality assessment and monitoring and shall be made available to the Department upon request.

- iv. The PO is required to inform the member in writing within 72 hours when a request for an excluded service is denied. The PO must utilize DHS' Notification of Non Covered Benefit template (<https://www.dhs.wisconsin.gov/forms/f00950a.docx>). The IDT staff will continue to ensure that the member's health and long-term care outcomes are supported.

9. *Timeframe for Decisions*

The IDT staff shall make decisions on direct requests for services and provide notice as expeditiously as the member's health condition requires.

- a. Standard Service Authorization Decisions
  - i. Decisions on direct requests for services must be made and notice provided as expeditiously as the member's health condition requires but not more than 72 hours after the date the interdisciplinary team receives the request. The interdisciplinary team may extend this 72-hour timeframe by up to five (5) additional calendar days for either of the following reasons:
    - a) The participant or legal decision maker requests the extension, or
    - b) The team documents its need for additional information and how the delay is in the interest of the participant.
  - b. Failure to Comply with Service Authorization Decision Timelines  
Failure to reach a service authorization decision within these specified timeframes constitutes a denial and therefore requires a notice of adverse benefit determination and the member's request must be automatically processed as an appeal as required in Article XI Grievances and Appeals, and in compliance with 42 CFR 460.122. The adverse benefit determination notice must meet the requirements of Article XI, Grievances and Appeals.

10. *Notice of Adverse Benefit Determination*

In accordance with Article XI, Section D.1, the PO shall provide written notice of an adverse benefit determination to the member when a decision is made to:

- a. Deny or limit a member's request for a service ;
- b. Terminate, reduce, or suspend any currently authorized service; or
- c. Deny payment for services.



11. *Notification of Non Covered Benefit*

In accordance with Article XI, Section D.1, the PO shall provide a Notification of Non Covered Benefit (<https://www.dhs.wisconsin.gov/forms/f00950a.docx>) to the member when a decision is made to:

- a. Deny a member's request for an excluded service; or
- b. Deny a member's request for payment of an excluded service.

**L. Services During Periods of Temporary Absence**

Services are provided during a member's temporary absence from the PO service area in accordance with Medicaid rules as specified in Wis. Admin. Code §§ DHS 103.03(3) and 104.01(6). If a member asks the PO to provide services during a temporary absence from its service area, the PO shall conduct two tests to determine whether to provide the services:

1. *Income Maintenance Residency Test*

Request that Income Maintenance complete a residency test to determine whether the member is still considered a resident of a county within the PO's service area.

- a. If no, the member is no longer a resident and he/she loses eligibility and must be disenrolled.
- b. If yes, the member remains a resident and the PO must go on to the second test.

2. *Cost-effective Plan Test*

Using the Department-approved service authorization policy, test whether a cost-effective plan can be developed for supporting the member's outcomes and assuring the member's health and safety during the absence by considering:

- a. Is there a reason, related to the member's long term care outcomes, for the member to be out of the PO service area?
- b. Is there a way for the PO to effectively arrange and manage the member's services during the absence? Factors to consider include:
  - i. Duration of absence;
  - ii. Distance from PO;
  - iii. Availability of providers; and
  - iv. Ability to monitor the care plan directly, through contracting or other arrangements.
- c. Is there an effective way to arrange and manage the member's services during the absence that is cost-effective? Factors to consider include:
  - i. Cost in comparison to effectiveness in supporting the member's long term care outcomes;





- ii. Cost in comparison to the member's care plan costs when in the service area;
- iii. PO staff time and effort in comparison to time and effort when in the service area; and
- iv. Duration of absence.

3. *Cost-Effective Plan*

If the PO decides that it can establish a cost-effective care plan for supporting a member's outcomes and assuring health and safety during the absence, it must do so.

4. *Possible PO-Requested Disenrollment*

If the PO decides that it cannot establish a cost-effective care plan for supporting a member's outcomes and assuring health and safety during the absence, it may request Department approval for disenrollment.

In considering whether to allow a PO-requested disenrollment, the Department will expect the PO to demonstrate that it is unable to continue to support the member's outcomes and assure the member's health and safety with reasonable cost and effort.

The member will be given the opportunity to challenge this contention and demonstrate that her/his outcomes can be met and health and safety assured with reasonable cost and effort, which could include a SDS plan.

**M. PACE Organization Responsibilities When a Member Changes County of Residence**

1. *PACE Organization Responsibilities*

When the PO becomes aware that a member intends to change her or his residence, the PO shall, in addition to updating its records when the change of address occurs, do the following:

- a. For Moves Within a PACE Service Area:
  - i. Inform the member of any changes in IDT staff, service providers or other aspects of the member's care plan that may result from the move.
  - ii. Complete the PACE Member Requested Disenrollment or Transfer Form (F-02484). Do not disenroll the member; only a transfer of Medicaid eligibility between income maintenance consortia is necessary if applicable.
- b. For Moves to Another Service Area Served by the PO:
  - i. Inform the member of any changes in IDT staff, service providers or other aspects of the member's care plan that will result from the move.





- ii. Complete the PACE Member Requested Disenrollment or Transfer Form (F-02484). Do not disenroll the member; only a transfer of Medicaid eligibility between income maintenance consortia is necessary if applicable.
- iii. Inform the member that options counseling is available from the ADRC in the county to which the member is moving should the member wish to consider a change in long term care program.
- c. For Moves to a County without PACE Benefit:
  - i. Unless the move is due to a PO-initiated placement in a nursing home or community residential facility, inform the member that she or he will be disenrolled and lose eligibility for PACE.
  - ii. Explain to the member that the PACE benefit is not available in the county to which the member intends to move. Explain that it is likely, but not certain, that the receiving county can provide services to the member through another program, but if it cannot she or he may be placed on waiting list for home and community-based services; and that if the member is in the special home and community-based waiver eligibility group (Group B or B+) the member will lose Medicaid eligibility while on a waiting list.
  - iii. If the member will move, complete the PACE Member Requested Disenrollment or Transfer Form (F-02484).
  - iv. Advise the member to contact the ADRC in the receiving county for information and assistance. Coordinate PACE disenrollment with enrollment in the new long term care program or placement on a waiting list with the ADRC in the receiving county.

**N. Department Review**

The Department will review the performance of the PO and its staff in carrying out the care management functions specified in this article. The PO shall make readily available member records and any other materials the Department deems necessary for such reviews in accordance with Article XIII.J., Access to Premises and Information.

**O. PACE Organization Duty to Immediately Report Certain Member Incidents**

- 1. *The PO is required to report immediately to its DHS Member Care Quality Specialist any of the following:*
  - a. Upon learning a member's whereabouts are not known for 24 hours or more, under any of the following circumstances:
    - i. The member is under guardianship/protective placement;
    - ii. The member has been identified as a vulnerable/high risk member as defined under Article I. 131;



- iii. The PO has reason to believe that the member's health or safety is at risk;
  - iv. The member is a potential threat to the community or self;
  - v. The member has a significant medical condition that would deteriorate without medications/care;
  - vi. The member lives in a residential facility; or
  - vii. The area is experiencing potentially life-threatening weather conditions.
- b. Upon learning a member has died under any of the following circumstances:
- i. Death involving unexplained, unusual, or suspicious circumstances;
  - ii. Death involving apparent abuse or neglect;
  - iii. Apparent homicide;
  - iv. Apparent suicide;
  - v. Apparent poisoning;
  - vi. Apparent accident, whether the resulting injury is or is not the primary cause of death; or
  - vii. When a physician refuses to sign the death certificate.
- c. Upon learning a member has suffered or caused an injury or accident related to any of the following circumstances:
- i. When unexplained, unusual, or suspicious circumstances exist;
  - ii. When physical abuse, sexual abuse, or neglect exist;
  - iii. When the member has been poisoned; or
  - iv. When law enforcement or a court of law have investigated and/or are involved;
- d. Upon learning a member has been admitted to a state IMD or Intensive Treatment Program (ITP). A list of both county and privately operated IMDs in Wisconsin can be found in section 27.11 of the [Medicaid Eligibility Handbook](#).
2. In addition to the immediate reporting requirements provided by Article V.O.1., the PO shall also comply with all other reporting requirements in this contract, including, but not limited to, the reporting requirements provided at <https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf>



## VI. Self-Directed Supports

### A. Option to Self-Direct

Under Self Directed Supports (SDS) a member may purchase long-term care benefits listed in Addendum VII., Sections A, Home and Community-Based Waiver Services (except for residential care services and care/case management services), if they are identified by the IDT as consistent with the member's outcomes.

### B. PACE Organization Requirements

The PO must present SDS as a choice to all members. Specific responsibilities of the PO are to:

1. Ensure that SDS funds are not used to purchase residential services that are included as part of a bundled residential services rate in a long-term care facility. Members who live in residential settings can self-direct services that are not part of the residential rate.
2. Determine the cost of services to be self-directed, which shall be used in establishing the member's SDS budget.
3. Continue to expand the variety of choices and supports available within SDS.
4. Ensure that all IDT staff understand SDS or have access to PO staff who have expertise in SDS.
5. Ensure that all IDT staff understand how to create a budget with a member or have access to PO staff who have expertise in SDS who can assist with setting budgets.
6. Ensure that all IDT staff understand how to monitor SDS with a member and their IDT or have access to PO staff who have expertise in SDS who can assist with monitoring for quality and safety.
7. Ensure that all IDT staff understand how to mitigate the potential conflicts inherent when a legal decision maker is self-directing on behalf of the member or have access to PO staff who have expertise in SDS who can assist with mitigating such conflicts.
8. Collaborate with the Department in its efforts to develop systems for evaluating the quality of SDS, including members' experiences with SDS.
9. Develop and implement a Department-approved policy and procedure describing conditions under which the PO may restrict the level of self-management exercised by a member where the team finds any of the following:
  - a. The health and safety of the member or another person is threatened.
  - b. The member's expenditures are inconsistent with the established plan and budget.



- c. The conflicting interests of another person are taking precedence over the outcomes and preferences of the member.
- d. Funds have been used for illegal purposes.
- e. The member has been identified as a Vulnerable/High Risk member and insufficient measures have been taken to mitigate risk.
- f. The member refuses to provide access to the home or otherwise refuses to provide information necessary for the IDT to adequately monitor member health and safety.
- g. Additional criteria for restricting the level of self-management exercised by a member may be approved by the Department in relation to other situations that the PO has identified as having negative consequences.

The PO's policy and procedure for limiting SDS shall be submitted to the Department for approval prior to implementation, whenever a change occurs, and upon request.

- 10. Assure that persons providing services to members on a self-directed basis who do not otherwise have worker's compensation coverage for those services have coverage provided as follows:
  - a. Where the member is the common law employer of the person providing services, the fiscal services management entity (also called the fiscal/employer agent) that performs employer-related tasks for the member shall purchase and manage a worker's compensation policy on behalf of the member, who shall be the worker's compensation employer.
  - b. Where the member is the managing co-employer of the person providing services with a co-employment agency (also called an agency with choice) as the common law employer, the co-employment agency shall provide worker's compensation coverage as the worker's compensation employer.

### **C. IDT Staff Responsibilities**

It is the responsibility of the IDT staff to:

- 1. Provide information regarding the philosophy of SDS and the choices available to members within SDS. The information provided to members must include:
  - a. A clear explanation that participation in SDS is voluntary, and the extent to which members would like to self-direct is the members' choice;
  - b. A clear explanation of the choices available within SDS;
  - c. An overview of the supports and resources available to assist members to participate to the extent desired in SDS; and
  - d. An overview of the conditions in which the PO may limit the level of self-management by members, the actions that would result in the removal of



- the limitation, and the members' right to participate in the grievance process, as specified in Article XI, Grievances and Appeals.
2. On a yearly basis, obtain a dated signature from the member or member's legal decision maker on a form, or section of an existing form, where the member must do the following:
    - a. Affirm the statement below:

“My interdisciplinary team has explained the self-directed supports option to me. I understand that under this option I can choose which services and supports I want to self-direct. I understand that this includes the option to accept a fixed budget that I can use to authorize the purchase of services or support items from any qualified provider.”
    - b. Affirm one of the two statements below:
      - i. “I accept the offer of self-directed supports and the interdisciplinary team is helping me explore that option.”
      - ii. “I decline self-directed supports at this time but understand I can choose this option at any time in the future by asking my interdisciplinary team.”
  3. *Maintain the signed form required in paragraph 2 above as part of the member's file.*
  4. Work jointly with members during the comprehensive assessment and member-centered planning process to ensure all key SDS components are addressed, including:
    - a. What specific service/support do members want to self-direct;
    - b. To what extent does the member want to participate in SDS in this service area;
    - c. Are there areas within the comprehensive assessment that indicate that members may need assistance/support to participate in SDS to the extent they desire;
    - d. Identification of resources available to support members as needed, including a thorough investigation of natural supports, as well as identifying the members' preferences regarding how/by whom these supports are provided;
    - e. Identification of potential health and safety issues related to SDS and specific action plans to address these;
    - f. Development of a budget for the support members have chosen to self-direct, and a plan that clearly articulates to what extent members would like to participate in the budgeting/payment process;



- g. Identification of what mechanism members have chosen to assure compliance with requirements for the deduction of payroll taxes and legally mandated fringe benefits for those employed by members; and
      - h. For members with legal decision makers, the identification of the need for their training in the area of identification of member preferences, and member self-advocacy training.
- 5. Ensure all key SDS components are included in the member-centered plan, including:
  - a. Desired outcomes related to SDS;
  - b. Supports/resources that will be utilized to ensure members' participation in SDS to the extent they desire; and
  - c. Identification of potential health and safety issues, and a plan of action to address them.
  - d. Identification of how the member's SDS plan will be monitored to ensure member health, safety and welfare.
- 6. Ensure mechanisms are in place for ongoing check-in and support regarding the members' participation in SDS, including:
  - a. Systems for ensuring member's expenditures are consistent with the agreed upon budget;
  - b. Identification of any changes needed in the SDS budget or identified supports/resources;
  - c. Check-in regarding potential health and safety issues and the action plans developed to address them; and
  - d. Check-in regarding potential conflicts of interest – other persons' views taking precedence over the members' outcomes and preferences.
- 7. Implement the policies and procedures regarding member safety and risk described under Article V.J.1, including the identification of vulnerable/high risk members and documentation of the specific measures implemented to assure the health and safety of such members.
- 8. Validate or arrange for validation of supportive home care workers pursuant to the *Managed Care Organization Training and Documentation Standards for Supportive Home Care*: <https://www.dhs.wisconsin.gov/publications/p01602.pdf>



## VII. Services

### A. General Provisions

#### 1. *Comprehensive Service Delivery System*

The PO will provide members with high-quality long-term care and health care services that:

- a. Are from appropriate and qualified providers;
- b. Are fair and safe;
- c. Serve to maintain community connections, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community; and
- d. Are cost effective.

Services are delivered through a comprehensive interdisciplinary health and social services delivery system appropriate pursuant to this contract and any applicable state and federal regulations.

#### 2. *Sufficient Services*

Services must be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The PACE program benefits that are Medicaid state plan services as defined in Addendum VII., Section B must be no more restrictive than the Medicaid fee-for-service coverage.

#### 3. *Coverage Responsibility*

The PO is responsible for covering services included in PACE program benefits that cost-effectively address any of the following:

- a. The prevention, diagnosis, and treatment of a disease, condition, and/or disorder that results in health impairments and/or disability;
- b. The ability to achieve age-appropriate growth and development;
- c. The ability to attain, maintain, or regain functional capacity; and
- d. The opportunity to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

#### 4. *Medically Necessary Services*

Services must be medically necessary as defined in Article I.84.

#### 5. *PACE Program Benefits*

PACE program benefits must minimally include the services outlined in Addendum VII., Benefit Package Service Definitions.



6. *Inform Members of the Program Benefits*

Members have a right to request any covered service, whether or not the service has been recommended as necessary or appropriate by a professional or the interdisciplinary team responsible for coordinating their care.

The PO will inform members of the full range of services in the program benefits appropriate for their level of care. The PO will provide a range of services to meet the needs and outcomes of its members, as identified in the member-centered planning process (described in Article V.C.).

7. *Long-term Care Services Where Members Live*

Members shall receive the long-term care services where they live, including:

- a. The member's own home, including supported apartments.
- b. Alternative residential settings including, but not limited to:
  - i. State Certified Residential Care Apartment Complexes (RCAC).
  - ii. Community-Based Residential Facilities (CBRF).
  - iii. Adult Family Homes (AFH).
- c. Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID).

8. *Excluded Services*

*The following services are excluded from coverage under PACE, as required by 42 C.F.R. §460.96:*

- a. Any services that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service.
- b. In an inpatient facility, private room and private duty nursing services (unless medically necessary), and nonmedical items for personal convenience such as telephone chargers and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care).
- c. Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
- d. Experimental medical, surgical, or other health procedures.
- e. Services furnished outside of the United States, except as follows:
  - i. In accordance with 42 C.F.R. §424.122 and §424.124.
  - ii. As permitted under the State's approved Medicaid plan.





**B. Provision of PACE Services**

1. *Services for All Members*

All members of PACE shall receive integrated acute, primary and long-term care services pursuant to this contract, state and federal regulations.

- a. The PO shall promptly provide or arrange for the provision of all health and long-term care services, consistent with the member-centered plan described in Article V.C., Assessment and Member-Centered Planning Process.
- b. Coverage of services identified in each individual member's MCP must be consistent with the definition of "Services Necessary to Support Outcomes" in Article I, Definitions.
- c. PACE services include all the following:
  - i. All Medicare-covered items and services;
  - ii. The home and community-based waiver services defined in Addendum VII.A.;
  - iii. All Medicaid State Plan Services identified in Addendum VIII.B.;
  - iv. Any cost-effective health care services the PO substitutes for a service in the Medicaid State Plan identified in Addendum VIII.B.; and

2. *Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status. Requirements Related to Delivery of Specific Services in PACE*

a. Provision of Abortions, Hysterectomies and Sterilizations

The PO shall comply with the following state and federal compliance requirements for the services listed below:

- i. Abortions must comply with the requirements of Wis. Stat. § 20.927 and with 42 C.F.R. § 441 Subpart E - Abortions.
- ii. Hysterectomies and sterilizations must comply with 42 C.F.R. § 441 Subpart F - Sterilizations.
- iii. Sanctions in the amount of ten thousand dollars (\$10,000.00) may be imposed for non-compliance with the above compliance requirements.
- iv. The PO must abide by Wis. Stat. § 609.30.
- v. The PO must comply with all record keeping and retention requirements for abortions, hysterectomies and sterilizations.



b. Transplants

- i. As a general principle, the PO shall cover the same transplants as covered by Medicare regardless of whether the member is enrolled in Medicare. If the transplant is not covered by Medicare, the PO shall follow the procedure outlined in Section E., Determining if Services, Procedures, Items and Treatments are Proven and Effective, to determine coverage.
- ii. In applying the procedure in Section E to determine coverage of transplants for persons not enrolled in Medicare, the PO shall follow the written standards in the State Plan that provide for similarly situated individuals to be treated alike and for any restrictions on facilities or practitioners to be consistent with the accessibility of high quality care to members.
- iii. All individuals who need a transplant, or who have received a transplant are eligible to enroll or remain enrolled in the Program.

c. Emergency and Urgent Care

The PO is responsible to provide care according to the requirements in 42 C.F.R. § 460.100.

d. Outpatient Prescription Drugs

i. Formulary or Preferred Drug List (PDL)

- a) The PO may use its own formulary or preferred drug list or the preferred drug list used by the State plan outpatient drug benefit. It may also apply its own utilization management practices consistent with the requirements of §1927 of the Social Security Act.
- b) The PO must make its formulary or PDL available to members in paper or electronic form. The formulary must indicate which generic and brand name medications are covered and what formulary tier each medication is on, and must be on the PACE organization's website in a machine readable format specified by the Department.

ii. Prior Authorization

- a) The PO shall conduct prior authorization for coverable outpatient drugs in accordance with §1927(d)(5) of the Social Security Act.
- b) The PO shall provide a response to a prior authorization request for a coverable outpatient drug by telephone or other telecommunication device within 24 hours of the request and shall provide for the dispensing of at least a 72 hour supply of a covered drug in an emergency situation.



- c) If the PO's formulary or preferred drug list does not include a coverable outpatient drug that is covered by the State plan drug benefit, the PO must use its prior authorization process to consider requests for coverage of such off-formulary drugs and shall cover them where appropriate and medically necessary.

### **C. Prohibited Services**

In addition to the services excluded by 42 CFR § 460.96, the following services are prohibited:

1. *Provider Preventable Conditions*

The PO is prohibited from making payment to a provider for any provider preventable condition as defined in Article I, Definitions.

2. *Assisted Suicide*

The PO may not pay for an item or service (other than in an emergency but not including when furnished in a hospital emergency room) for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

3. *Physical Infrastructure*

The PO may not pay for an item or service (other than in an emergency but not including when furnished in a hospital emergency room) with respect to any amount expended for roads, bridges, stadiums or services not covered under the Medicaid State Plan, including waivers thereof.

### **D. Second Opinion**

The PO, consistent with the scope of the PACE program benefits, must provide for a second opinion from a qualified health care professional within the network.

### **E. Determining if Services, Procedures, Items and Treatments are Proven and Effective**

1. *Non-coverage of experimental services, procedures, items and treatment*

As a general principle, Medicaid does not pay for services, procedures, items and treatments that it determines to be experimental in nature and which are not a proven and effective treatment for the condition for which it is intended or used. Experimental services are defined in Wis. Admin. Code §§ DHS 107.035(1) and (2).

2. *Services, procedures, items or treatments that are proven and effective*

A service, procedure, item or treatment is not considered experimental when it is proven and effective, generally accepted medical practice and clinically appropriate to treat the member's condition.



3. *Determining if a service, procedure, item or treatment is proven and effective*

The PO shall utilize a process to determine whether a service, procedure, item or treatment is proven and effective.

In this process, the PO can consider:

  - a. The current and historical judgment of the medical community as evidenced by medical research, studies, journals or treatises;
  - b. The extent to which Medicare and private health insurers recognize and provide coverage; and
  - c. The current judgment of experts and specialists in the medical specialty area or areas in which the service is applicable or used.
4. *Coverage of proven and effective services, procedures, items or treatment that is cost effective*

After following the procedures outlined in this section, the PO may cover services, procedures, items and treatments that the PO has determined are proven and effective treatments for the conditions for which they are intended or used, if the services, procedures, items and treatments are cost effective.

**F. Change to Medicaid Covered Services Mandated by Federal or State Law**

1. *Effective Date*

Changes to Medicaid covered services mandated by federal or state law shall be effective as of the date specified in the federal or state law.
2. *Capitation Payment Adjustment*

If any change in Medicaid covered services occurs that is mandated by federal or state law, the Department shall adjust the capitation rate if necessary for the capitation rate to remain actuarially sound.
3. *Notification to the PACE Organization*

The Department will notify the PO at least forty-five (45) calendar days prior to the effective date of any changes to Medicaid covered services resulting from changes mandated by federal or state law.
4. *Notification to Members*

The PO shall notify members at least thirty (30) calendar days prior to the effective date of changes in the type of Medicaid covered services due to changes mandated by federal or state law.



**G. 24-Hour Coverage**

1. *Policies and Procedures*

The PO shall develop and submit to the Department for approval a policy and procedure on the twenty-four (24)-Hour Coverage/On-Call system. The policy and procedure shall identify how the PO meets the following requirements:

- a. Provide a telephone number that members or individuals acting on behalf of members can call at any time to obtain advance authorization for services. This number must provide access to individuals with authority to authorize the services as appropriate. Individuals at this number must also have familiarity with the PO and the PO's provider network.
- b. Respond to such calls within thirty (30) minutes.
- c. Assure adequate communication with the caller in the language spoken by the caller.
- d. Document these calls with time, date and any pertinent information related to person(s) involved, resolution and follow-up instructions and submit this documentation to the Department upon request.
- e. Notify members and the Department of any changes of the phone number within seven (7) business days of change.
- f. Linkages to Adult Protective Services.

**H. Billing Members**

1. *Prohibition on Billing Recipients for Covered Services*

The PO, its providers and subcontractors shall not bill a member for services provided during the member's enrollment period in PACE, except for the purchase of enhanced services as allowed under this article. Post-eligibility treatment of income and PACE premiums in 42 CFR §460.184 are not bills for services. This provision pertains even if the:

- a. PO becomes insolvent;
- b. Department does not pay the PO for covered services provided to the member;
- c. Department or the PO does not pay the provider that furnishes the services under a referral or other arrangement; and
- d. Payment for services furnished under a subcontract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the PO provided the service directly.

2. *Prohibition on Billing in Insolvency*

In the event of the PO's insolvency, the PO shall not bill members for debts of the PO or for services provided during the member's period of PACE enrollment.



3. *Prohibition on Billing Indian Recipients Premiums and Cost-Sharing for Items and Services Furnished by an Indian Health Care Provider*

The PO, its providers and subcontractors, shall not require an Indian member to pay any enrollment fees, premiums, deductibles, co-payments, coinsurance or similar charges if he or she is furnished an item or service by an Indian health care provider (as defined under Article I.62). This prohibition does not apply to any cost-sharing for home and community-based waiver services or patient liability for nursing home services as specified in Article III.C.2. All members who owe such a cost share or patient liability are required to pay it as a condition for continued eligibility for Medicaid.

**I. Department Policy for Member Use of Personal Resources**

1. *Permitted Uses of Member Resources*

A PO provider, or the State Medicaid Program may accept personal resources in excess of cost share or patient liability from a member or the member's family or significant others in the following limited circumstances:

- a. The member, member's family, or significant other wants to voluntarily purchase services, which the PO has denied, provided proper notice of that decision has been given to the member;
- b. The member, member's family, or significant other wants to voluntarily purchase a service or item, limited to the services or items in paragraph 3.a. below, which has not been authorized by the PO or included in the MCP because it has not been identified as needed to support the member's long term care outcomes, provided proper notice of the PO's decision denying the service or item has been given to the member;
- c. The member, member's family, or significant other wants to voluntarily purchase a service or item, limited to the services or items in paragraph 3.a. below, as a substitute for an item or service authorized in the MCP where the member prefers a more costly alternative because it offers a broader scope or additional features than the service or item authorized by the IDT, or because the member prefers an additional amount or longer duration of the service or item authorized by the IDT;
- d. The member, member's family, or significant other wants to voluntarily purchase a non-emergency, non-court-ordered service or item that is authorized by the PO from an out-of-network provider, , and the PO has considered but decided not to authorize the out-of network provider because it does not meet the PO's standards or accept the PO payment rate for the service.
- e. The member, member's family, or significant other wants to make a voluntary donation of cash or something else of value to the PO (see Article I. for definition); or



- f. The member, member's family, or significant other wants to make a voluntary payment to the State Medicaid Program.
- 2. *Counseling to Assure the Use of Personal Resources is Voluntary*
  - a. If a member-requested or received item or service has been denied, reduced, suspended or terminated through the RAD or other department-approved authorization process with notice that meets the requirements under Article XI.D. (Notice of Adverse Benefit Determination), no additional counseling is required.
  - b. In any other situation where use of personal resources is permitted under sub-section 1 the PO shall counsel the member that such use of personal resources is entirely voluntary and shall document this counseling in the case record. The counseling may be done by IDT staff or other PO staff.
- 3. *Additional Conditions, Considerations and Limitations on Member, Family or Significant Others Purchasing PACE Program Services or Items*

These conditions and limits apply to the circumstances set forth in paragraphs I.1.b. and c. above where the PO has not authorized a requested service or has authorized a less costly service than requested which differs in amount, duration, scope or features from the requested service.

- a. Members, family and significant others may use their personal resources to purchase the requested service or item from a PO provider only for the following PACE program benefits:
  - i. All long-term care services that are PACE benefits listed in the Service Definitions, Addendum VII, Section A.
  - ii. Private hospital room when not medically necessary;
  - iii. Durable medical equipment;
  - iv. Prosthetic dental services;
  - v. Prosthesis;
  - vi. Disposable medical supplies;
  - vii. Eyeglasses; and
  - viii. Hearing aids.
- b. Members, family and significant other may not use their personal resources to purchase services or items for the following PACE program benefits:
  - i. Physician services;
  - ii. Hospital inpatient services, except a private room (PO must cover private rooms when medically necessary);
  - iii. Lab and x-ray





- iv. Therapies covered by Medicaid;
- v. Prescribed drugs under the State Plan drug benefit;
- vi. Acute and primary care and other benefits listed in the Service Definitions, Addendum VI, Section B, unless listed in paragraph 3.a. above.

c. Payment Amounts for Services or Items

The member's payment amount for such services or items will be based on the following payment policies:

- i. If the service or item substitutes for a service or item in the member's care plan or is an added value service or item (see paragraph 1.c. above), then the member is responsible for paying the difference between the plan's payment for a covered service or item and the cost of the substitute service or item.
- ii. If the service or item is not a substitute for a service or item in the member's care plan and is not an added value service or item, and is determined to be not necessary to support the member's outcomes (see paragraphs 1.a. and b.), or if it's a non-emergency service the member chooses to purchase from an out-of-network provider not authorized by the PO (see paragraph 1.d.), the member is responsible for paying the full cost of the service or item.

4. *Family or Others Payment for Services for a Member*

Payment for services by someone else on behalf of a member on an ongoing basis may be considered income for the member if the payment is made directly to the member rather than directly to the provider. In this situation, the PO shall refer the member to the income maintenance agency.

5. *Purchase of Services through a Medicaid Eligibility Self-Support Plan*

Nothing in this section precludes a member from establishing a Medicaid eligibility self-support plan in accordance with Medicaid rules and using the income set aside under the self-support plan for the purchase of services related to training or purchasing equipment necessary for self-support. See Medicaid Eligibility Handbook, Section 15.7.2.2, <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>.

6. *Donations*

A member or the member's family or significant others may make a voluntary choice to transfer cash or something else of value to the PO as a recognition of or expression of gratitude for services to the member. Such a choice is considered a donation.

A voluntary transfer of assets for the purpose of becoming or remaining eligible for Medicaid may be considered divestment of an asset and could lead to loss of





Medicaid eligibility. When the PO becomes aware that a member has made or plans to make a donation to the PO or any other organization, the PO shall always advise the member to consult with the local income maintenance agency to determine whether the donation will be considered a divestment.

7. *Voluntary Payments, Prepayments or Repayments*

The voluntary choice of a member or the member's family or significant others to pay an amount to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible or reduce potential claim in an estate is considered a voluntary payment, prepayment or repayment.

When the PO is aware of a planned payment, the PO shall refer to the income maintenance agency a member or the member's family or significant others who wish to make voluntary payments to Medicaid to maintain Medicaid eligibility, prepay a Medicaid deductible, or reduce the potential claim in an estate.

8. *Reporting*

- a. The PO shall report to the PO Governing Board and in the PO quarterly report it submits to the Department:
  - i. All circumstances within the scope of this section where a member or the member's family or significant others made a choice to voluntarily purchase PACE program benefit items or services;
  - ii. All donations directly received by the PO; and
  - iii. All circumstances when the member uses personal resources for PACE program benefit items or services from an out-of-network provider as indicated in Article VII.I.1.d.
- b. The PO does not need to report to the PO Governing Board and in the PO quarterly report it submits to the Department:
  - i. Voluntary payments the PO is unaware of.
  - ii. Use of member resources that amount to less than \$100 for a one time purchase or less than \$50 per month for a service or item purchased on an on-going basis.

9. *Preventing Unacceptable Use of Member Resources*

Notwithstanding any other provision in this Section, the PO shall take steps to investigate any situation in accordance with its Program Integrity Plan under Article XIII, Section Hof this contract if the PO learns that:

- a. A member or the member's family or significant others has privately purchased a service or item within the PACE program benefits or has made a donation directly; and
- b. The PO has reason to believe that this purchase or donation might involve a violation of, or be contrary to its Program Integrity Plan.



**J. Prevention and Wellness**

1. *Prevention and Wellness Plan*

Prevention and wellness shall be part of the normal course of communications with members, and the development of the member's MCP. The PO shall inform all members of contributions they can make to the maintenance of their own health and the proper use of long-term care and health care services.

The activities and materials used in the prevention and wellness activities shall be accessible by the Department and the Centers for Medicare & Medicaid Services (CMS). The PO's plan for implementing the prevention and wellness program must be approved by the Department. At any time the Department determines there has been a significant change in the PO's capacity to offer prevention and wellness services or in the PO's projected membership, the Department may require the PO to submit documentation to demonstrate its capacity to provide prevention and wellness services.

2. *Prevention and Wellness Program*

The PO's prevention and wellness program shall include the following components:

a. Program Coordination

Designated staff are responsible for the coordination and delivery of services in the program.

b. Practice Guidelines

Practice guidelines are guidelines that are developed in consultation with contracting professionals to assist them to apply the current best evidence in making decisions about the care of individual members. The PO will review and update practice guidelines periodically, as appropriate.

The PO shall use practice guidelines for prevention and wellness services that include member education, motivation and counseling about long-term care and health care related services. The PO must disseminate or make available the guidelines to providers for whom the guidelines apply and, upon request, to members.

Practice guidelines that are condition-specific and/or disease related shall include the following elements:

- i. Overview of condition/disease;
- ii. Information related to anticipating, recognizing and responding to condition/disease related symptoms;
- iii. Information related to best practice standards for prevention and management of condition/disease;



- iv. Guidelines/process for interdisciplinary team to use regarding negotiating incorporation of condition/disease prevention and management plan with member into the MCP; and
- v. Plan for quality assurance monitoring of guideline effectiveness.
- c. Measurement

The capacity to collect, analyze and report data necessary to measure the performance of the prevention and wellness program. The reports based on this data shall be communicated to providers and members.
- d. Program Resources

Mechanisms for facilitating appropriate use of prevention and wellness services and educating members on health promotion.
- e. Disease Prevention

Information and policies on the prevention and management of diseases which affect the populations served by the PO. This includes specific information for persons who have or who are at risk of developing health problems that are likely to benefit from preventive practices. Hypertension and diabetes are examples of such health problems.
- f. Independent Functioning

Information and policies on maintaining and improving members' functional status, and the ability to perform ADLs and IADLs more independently, for the populations served by the PO. This includes specific information for persons who have or who are at risk of impaired ability to function independently and are likely to benefit from preventive practices.
- g. Outreach Strategies

Outreach strategies for identifying and reaching members who are least likely to receive adequate preventive services.
- h. Special Health Issues

The dissemination of information relevant to the membership, such as nutrition, alcohol and other drug abuse (AODA) prevention, reducing self-mutilation behaviors, exercise, skin integrity, self care training, and coping with dementia.
- i. General Information

The dissemination of information on how to obtain the services of the prevention and wellness program (e.g., resource center, public health department etc.), as well as additional information on, and promotion of, other available prevention services offered outside of the PO, such as special programs on women's health.



- j. Sensitivity to Population
- Long-term care and health care related educational materials produced by the PO shall be appropriate for its target population(s) and reflect sensitivity to the diverse cultures served.

**K. Court-Ordered Services**

1. *Coordinate with County Agencies*

The PO shall attempt to coordinate the provision of court-ordered services with the county agencies that provide services to the court.
2. *Provide Court-ordered Services*

The PO shall provide for court-ordered services and treatment if the service is a PACE program benefit service for which the PO would be the primary payer and the member has been court ordered into placement or to receive services such as through Wis. Stats. Chs. 51, 54, or 55.
3. *Prompt Referrals or Authorization*

Necessary PO referrals or treatment authorizations for court-related protective, Alcohol and Other Drug Abuse (AODA) and/or mental health services must be furnished promptly. For AODA any services requiring a referral or authorization of services it is expected that no more than five (5) business days will elapse between receipt of a written request by the PO and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the fifth (5th) business day an assumption will exist that an authorization has been made until such time as the PO responds in writing.
4. *Emergency Court-Ordered Services*

The PO has responsibility to pay for protective treatment services in the PACE program benefit provided on an emergency basis or as ordered by the court as the result of court action or as part of a stipulated agreement between the county protective service unit and the member.
5. *Collaborate on the Plan of Care*

Whenever possible, the PO shall collaborate with the appropriate county agency to develop recommendations to the court for a plan of care that meets the protective service and/or treatment needs of the member.
6. *Utilize the PACE Network of Providers*

Whenever possible, protective and/or treatment services shall be provided within the PACE network of providers.



7. *Non-network Providers*

The PO will pay for covered services provided by a non-network provider to any member pursuant to a court order, effective with the receipt of a written request for authorization from the non-network provider, and extending until the PO issues a written denial of authorization. This requirement does not apply if the PO issues a written denial of authorization within five (5) business days of receiving the request for referral.

**L. Elder Adults/Adults at Risk Agencies and Adult Protective Services**

1. *PACE Organization Responsibility*

The PO shall make reasonable efforts to ensure that their members are free from abuse, neglect, self-neglect and exploitation.

2. *Policies and Procedures*

The PO shall have policies, procedures, protocols and training to ensure that PACE staff:

- a. Are able to recognize the signs of abuse, neglect, self-neglect, and exploitation as defined in Wis. Stats. §§ 46.90 and 55.01.
- b. Identify members who may be at risk of abuse, self-neglect and exploitation and in need of elder adult/adult-at-risk or adult protective services (EA/AAR/APS).
- c. Report incidents involving member abuse, neglect, self-neglect and exploitation as provided in Wis. Stats. §§ 46.90(4)(ar) and 55.043(1m)(br).
- d. Refer members at risk or in need of services to the appropriate EA/AAR/APS agency.
- e. Update the member's care plan as needed to balance member needs for safety, protection, physical health, and freedom from harm with overall quality of life and individual choice.
- f. Follow-up to ensure that member needs are addressed on an ongoing basis.

3. *Access to Elder Adults/Adults at Risk (EA/AAR) and Adult Protective Services (APS)*

For members in need of services provided by EA/AAR Agencies or APS, the PO shall involve the entity or Department (which the County has designated to administer EA/AAR/APS) in the following capacities:

- a. Invite an EA/AAR/APS staff person to participate in the member-centered planning process including plan development and updates, comprehensive assessment and re-assessments; and



- b. Invite an EA/AAR/APS staff person to participate on the interdisciplinary team to the extent that the staff person makes recommendations as necessary to fulfill their EA/AAR/APS responsibilities.
- c. Designate a contact person to assist staff working in county EA/AAR/APS agencies to develop service options for PACE members or potential members. This contact person, or a representative of the member's interdisciplinary team, may participate in the county EA/AAR interdisciplinary team.

4. *Examination and Treatment Services*

The PO shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of elder abuse, abuse of vulnerable adults, and domestic violence. Such expertise shall include the identification of possible and potential victims of elder abuse and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of elder abuse and domestic violence.

The PO shall consult with human service agencies on appropriate providers in their community.

The PO shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

5. *Memoranda of Understanding on Adult Protective Services*

The PO shall enter into memorandums of understanding with the Elder Adults/Adults-At-Risk/Adult Protective Services agencies in each of the counties in its service area. These MOUs shall follow the policies and procedures issued by the Department and shall be submitted to the Department for review and approval.

**M. Facility Closures**

The PO shall ensure participation by staff with knowledge about community services at Chapter 50 facility closure/relocation meetings for facilities in the PACE service area. Participation will be:

1. At initial closure planning meetings; and
2. When one or more residents of the facility are PACE members or are interested in and eligible for enrollment in PACE.

Participation may be in person or by telephone. The PO will abide by the direction of the Department relative to the placement of monitors and/or the appointment of receivership under Wis. Stats. § 50.05.

**N. MOU on Institute for Mental Disease (IMD) Discharge Planning**



The PO will negotiate, or make a “good faith” effort to negotiate, an MOU with all counties within their service areas addressing expectations for discharge planning when the member, someone who was a member prior to losing eligibility due to institutional status, or someone who is eligible to enroll upon discharge, is currently a resident of an IMD. The purpose of this discharge planning will be to return the individual to the most integrated setting appropriate to his/her needs. The MOU will state that as part of the discharge planning, a crisis plan will be established for each member designed to maintain the person in his/her community. This plan will be developed in collaboration between the PO, County crisis programs, providers and other stakeholders.

**O. Provider Moral or Religious Objection**

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

1. To the Department;
  - a. With the PACE organization’s application for a Medicaid contract;
2. Whenever the PO adopts the policy during the term of the contract;
3. It must be consistent with the provisions of 42 C.F.R. § 438.10;
4. It must be provided to potential members before and during enrollment;
5. It must be provided to members at least thirty (30) days before the effective date of the policy; and
6. In a written and prominent manner, the PO shall inform an applicant, on or before an individual enrolls, of any benefits to which the member may be entitled but which are not available through the PO because of an objection on moral or religious grounds.

The PACE organization must inform enrollees how they can obtain information from the Department about how to access the excluded service.

**P. Electronic Visit Verification (EVV)**

The PO shall implement EVV for designated service codes by the deadlines established by the Department. The PO will use data collected from the EVV system to validate claims pertaining to affected service codes against approved authorizations during the claim adjudication process. Encounters without a valid EVV record may be excluded in future rate setting development. Prior to implementation, the PO shall outline expectations for contracted providers regarding the use of the EVV data collection system within the subcontract. POs shall also provide assistance and support to DHS and contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested.





## VIII. Provider Network

The PO shall establish and maintain a provider network that furnishes timely, quality services.

### A. Member Choice

#### 1. *Member Choice of Interdisciplinary Teams*

The PO shall allow a member to change interdisciplinary teams up to two times per calendar year if the PO has additional interdisciplinary teams to offer the member.

#### 2. *Member Choice of Intimate Care Providers and Providers Regularly in the Home*

For LTC services that involve providing intimate personal care or when a provider regularly comes into the member's home, the PO shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the PO's standards and reimbursement rates for providers of the same service. (See Section N.3., Intimate Care Services, in this article for intimate care services standards when the PO employs the care worker.) These services include, but are not limited to, personal care, home health, private duty nursing, supportive home care and chore service.

The provisions of provider agreements for services mentioned in this paragraph shall focus on quality and cost effectiveness, and not be constructed in such a way so as to limit the network of providers.

#### 3. *Non-Network Providers*

- a. The PO shall maintain a process to consider a member's request for a non-network provider, which is a provider who does not have an agreement with the PO for providing services to members. Only Non-network providers that satisfy the PO's standards will be considered.
- b. The PO must coordinate payment with non-network providers for out-of-network services authorized by the PO, as well as emergency or court ordered services obtained out-of-network. The PO must ensure that cost to the member is no greater than it would be if the services were provided within the Network.

### B. Member Communications

#### 1. *Licensed Health Care Providers Advising and Advocating*

A PO may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an member who is his/her patient, including any of the following:

- a. For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;





- b. For any information the member needs in order to decide among all relevant treatment options;
- c. For the risks, benefits, and consequences of treatment or non-treatment;
- d. For the member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2. *Information to Members*

Upon the request of members, the PO shall make available:

- a. The licensure, certification and accreditation status of the PO, its staff and providers in the PACE provider network;
- b. The education, board certification and recertification of health professions who are certified by Medicaid and the qualifications of other providers; and
- c. Information about the identity, locations, and availability of services from providers that participate in the PO.

**C. Provider Agreements**

In addition to the requirements specified at Article XIII.C and D. provider agreements must meet the following requirements under Article VIII.C and D;

1. *Certification of Provider Agreements*

- a. The Department shall review PO provider agreements. The Department's provider agreement review will assure that the PO has the standard language in this article in its provider agreements.
- b. By the effective date of this contract, the PO shall have submitted to the Department its provider agreements, or revisions to previously approved provider agreements, for approval. This can occur by one of two means:
  - i. The PO submits each provider agreement; or
  - ii. The PO submits template language planned for use in the PO's provider agreements.
- c. The PO shall attest annually that all provider agreements include the required provisions for provider agreements in this article.

**D. Provider Agreement Language**

In addition to the requirements in 42 C.F.R. § 460.70, the provider must agree to abide by all applicable provisions of this contract. Provider compliance with this contract specifically includes, but is not limited to, the following requirements (except for specific areas that are inapplicable in a specific provider agreement):



1. *Purpose of the Program*

The provider agreement clearly defines the purpose of the program.

2. *Term and Termination*

a. Residential rates

Residential rates shall be for a period of not less than one year, unless there is mutual agreement upon a shorter term. Residential services provider agreements or amendments shall specify a contracted rate, include a fee schedule or reference an acuity-based rate setting model. Rates may be changed:

- i. Anytime, through mutual agreement of the PO and provider.
- ii. When a member's change in condition warrants a change in the acuity-based rate setting model.
- iii. When a rate has been in effect for at least twelve (12) months, and a change is proposed for an individual member or facility:
  - a) The PO must provide a sixty-day written notice to the provider prior to implementation of the new rate.
  - b) The rate change may apply to the entire contract or to specific rates within the contract, but only on a prospective basis.
  - c) Rates which are reduced using sub iii are protected from additional decreases during the subsequent twelve (12) month period.

Nothing herein shall impair the right of either party to terminate a residential services contract as otherwise specified therein.

3. *Supportive Home Care and In-Home Respite Services*

The PO shall specify in its provider agreements with providers of supportive home care or in-home respite care services that the provider shall comply with the *Family Care Training and Documentation Standards for Supportive Home Care and In-Home Respite*, <https://www.dhs.wisconsin.gov/publications/p01602.pdf>.

4. *Legal Liability*

The provider agreement must not terminate legal liability of the PO.

If the PO delegates selection of providers to another entity, the PO retains the right to approve, suspend, or terminate any provider selected by that entity.

5. *Restrictive Measures*

The PO must require its providers to adhere to regulatory requirements and standards set by the PO relative to restrictive measures including any type of



restraint, isolation, seclusion, protective equipment, or medical restraint as required in Article V.J.4. Use of Isolation, Seclusion and Restrictive Measures.

6. *Member Incidents*

The PO shall require its providers to identify, respond to, document, and report member incidents as required in Article V.J.5. Identifying and Responding to Member Incidents.

7. *Insurance and Indemnification*

The provider attests to carrying the appropriate insurance and indemnification.

The provider agreement shall state the specific indemnification requirements the provider is required to satisfy and the minimum insurance the provider is required to carry.

8. *Access to Premises and Audit Rights*

The provider agrees to provide representatives of the PO, as well as duly authorized agents or representatives of the Department and the Federal Department of Health and Human Services, access to its physical premises, equipment, books, contracts, records, and computer or other electronic systems in accordance with Article XIII.J., Access to Premises and Information.

9. *Certification and Licensure*

The provider agrees to provide applicable licensure, certification and accreditation status upon request of the PO and to comply with all applicable regulations. Health professions which are certified by Medicaid agree to provide information about their education, board certification and recertification upon request of the PO. The provider agrees to notify the PO of changes in licensure.

10. *Sanctions/Criminal Investigations*

The provider must notify the PO of any sanctions imposed by a governmental regulatory agency and /or regarding any criminal investigations(s) involving the provider.

11. *Cooperation with Investigations*

To the extent permitted by law, the provider agreement shall require the provider to fully cooperate with any member-related investigation conducted by the PO, the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

12. *Records*

The provider agrees to comply with all applicable Federal and State record retention requirements in Article XIV.F., Records Retention.



13. *Member Records*

The provider agrees to the requirements for the confidentiality protection, maintenance and transfer of member records described in Article XIII.A.

The provider agrees to make records available to members and his/her legal decision makers within ten (10) business days of the record request if the records are maintained on site and sixty (60) calendar days if maintained off site in conformity with the standards in 45 C.F.R. § 164.524 (b)(2).

The provider agrees to forward records to the PO pursuant to grievances and appeals within fifteen (15) business days of the PO's request or, immediately, if the appeal is expedited. If the provider does not meet the fifteen (15) business day requirement, the provider must explain why and indicate when the records will be provided.

14. *Access to Services*

The provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services that are necessary to support outcomes.

15. *Authorization for Providing Services*

The provider agreement directs the provider on how to obtain information that delineates the process the provider follows to receive authorization for providing services to members. The provider agrees to clearly specify authorization requirements to its providers and in any provider agreements with its providers.

The PO shall ensure service authorization is given to the provider prior to the start date of designated services by the provider. When prior written authorization is not practicable, verbal authorization should be provided for the service and written authorization issued thereafter. Services provided on an emergency basis should be followed up with written confirmation of the service, when appropriate.

Revised service authorizations shall be issued to providers promptly, with sufficient notice to allow providers to comply with the terms of the revised service authorization (for example, to prevent providers from unknowingly exceeding reduced authorized service units) and to timely submit accurate claims during the appropriate billing period.

16. *Billing Members /Hold Harmless*

The PO and the provider may not bill a member for covered and non-covered services, except in accordance with provisions in Article VII, Sections G. Billing Members, and H. Department Policy for Member Use of Personal Resources.

17. *Provider Appeals*

The provider agrees to abide by the terms of Section 0,

Appeals to the PO and Department for Payment/Denial of Providers Claims of this article.



The PO must furnish all providers information regarding the provider appeals process at the time they enter into the contract, and through provider materials posted on the PO's website or sent to providers, upon request.

18. *Member Appeals and Grievances*

The PO must furnish the following grievance, appeal and State Fair Hearing procedures and timeframes to all providers and subcontractors at the time that they enter into a contract:

- a. The member's right to request a State Fair Hearing after the member has exhausted the PO's appeal process, the process the member must follow to obtain a State Fair Hearing, and the representation rules at a hearing;
- b. The member's right to file grievances and appeals and their requirements and timeframes for filing;
- c. The availability of assistance in filing;
- d. The toll-free numbers to file oral grievances and appeals;
- e. The member's right to request the continuation of his or her benefits throughout the appeal and State Fair Hearing process when the PO is seeking to reduce or terminate those benefits and, if the PO's adverse benefit determination is upheld in a hearing, the member may be liable for the cost of any continued benefits; and
- f. The member's appeal rights to challenge the failure of the PO to cover a service.

19. *Prohibited Practice*

- a. Marketing/outreach activities or materials distributed by a residential services provider, which claim in marketing its services to the general public, that the PACE programs will pay for an individual to continue to receive services from the provider after the individual's private financial resources have been exhausted are prohibited.
- b. Marketing/outreach activities as described in Article IX.A.5., are prohibited.

20. *Provider Preventable Conditions*

The provider must report to the PO all provider preventable conditions with claims for payment or member treatments for which payment would otherwise be made.

21. *Provider Claim Submission Deadline*

The provider agreement shall specify the number of days that a provider has from the date of service to file a claim.

The provider agreement shall also specify how the above deadline is applied to claims consisting of multiple dates of service.



In the absence of the above required information, the 12-month timeframe specified in 42 C.F.R. § 447.45(d) will apply to the submission of claims.

22. *Overpayments*

The provider agreement requires the provider to do all of the following when it has received an overpayment from the PO:

- a. Report the overpayment to the PO when identified;
- b. Return the overpayment to the PO within sixty (60) calendar days of the date on which the overpayment was identified; and
- c. Notify the PO in writing of the reason for the overpayment. (See Article XIV, Reports and Data, for encounter reporting of recoveries of provider overpayments when received).

23. *Accessibility*

The provider agreement must contain the following language: “The provider agrees to provide, as appropriate, physical access, reasonable accommodations, and accessible equipment to members with physical and/or mental disabilities.”

24. *Electronic Visit Verification*

The PO shall require applicable providers to utilize the DHS EVV system.

**E. Prohibited Provider Agreement Language**

The PO is prohibited from including in a contract for residential services, prevocational services, or supported employment services a provision that requires a provider to return to the PO any funding that exceeds the cost of those services.

**F. Network Providers**

1. *Provider Selection and Retention Process*

- a. The PO shall implement written policies and procedures for network provider selection and retention process that meet the requirements of this article.
- b. The PO must allow any community-based residential facility (CBRF), residential care apartment complex (RCAC), community rehabilitation program, home health agency, day service provider, personal care provider, or nursing facility to serve as a network provider if:
  - i. The provider agrees to be reimbursed at the PO’s contract rate negotiated with similar providers for the same care, services, and supplies; and
  - ii. The facility or organization meets all guidelines established by the PO related to quality of care, utilization, and other criteria



applicable to facilities or organizations under contract for the same care, services, and supplies.

- c. If the PO declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.
- d. In establishing provider agreements and subcontracts, the PO shall seek to maximize the use of available resources and to control costs.
- e. In establishing a provider network, a PO is:
  - i. Not required to contract with providers beyond the number necessary to meet the needs of its members;
  - ii. Not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
  - iii. Not precluded from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.

2. *Discrimination*

- a. The PO shall not discriminate for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification.
- b. The PO shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

3. *Training*

The PO will ensure that providers of services maintain a level of training appropriate to the services that they provide.

- a. The PO will identify areas where the need for further provider training is evident and share information with providers about available resources and training.
- b. The PO shall facilitate training provided by the Department to network providers.

**G. Provider Certification and Standards**

1. *Wisconsin Provider Standards*

The PO shall use only providers that meet Department requirements, and

- a. For waiver services in Addendum VIII.A.:





- i. Meet the provider standards in Wisconsin's approved s. 1915 (c) home and community-based waiver,
  - ii. Meet all required licensure and/or certification standards applicable to the service provided,
  - iii. Are enrolled with the Department; and
  - iv. If a newly licensed or certified residential provider\* or a newly operating non-residential setting in which adult day care, prevocational, adult day habilitation or group supported employment services are provided, the setting has been determined by the certification agency or the Department to be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4). An exception to this requirement is a setting that was operating prior to March 17, 2014 that is subject to heightened scrutiny and is awaiting a determination of compliance from CMS. Any new residential setting or new non-residential setting in which adult day care, prevocational, adult day habilitation or group supported employment services are provided must be in compliance with 42 C.F.R. § 441.301(c)(4) before the PO can use the setting; or
- b. For State Plan services in Addendum VII. B:
- i. Are certified as providers under Wis. Admin. Code § DHS 105 to provide acute, primary or long term care services specified in Wis. Admin. Code § DHS 107,
  - ii. Meet all required licensure and/or certification standards applicable to the service provided. and
  - iii. Are enrolled with the Department; or
- c. Meet the PO's provider standards that have been approved by the Department.

\*Members residing in an existing residential setting that has been determined to not be in compliance with the home and community based setting requirements under 42 C.F.R. § 441.301(c)(4) may continue to reside in that setting pursuant to the Department approved PO member transition plan.

## 2. *Laboratory Providers*

For laboratory providers, the PO will use only laboratories that have a valid Clinical Laboratory Improvement Amendments (CLIA) certification or a certificate along with a CLIA identification number and that comply with the CLIA regulations as specified by 42 C.F.R. § 493D. Those laboratories with certificates will provide only the types of tests permitted under the terms of 42 C.F.R. § 493.



3. *Emergency and Non-Clinical Services*

Exceptions to provider certification standards may include emergency medical services and non-clinical services or as otherwise requested by the PO and approved by the Department.

4. *Excluded Providers*

All providers utilized by the PO must not be excluded from participation in federal health care programs under either section 1128 or section 1128A of the Social Security Act. Except for emergency services, Medicaid payment is not available for excluded providers.

**H. Cultural Competency**

1. *Cultural Competency and Values*

The PO shall encourage and foster cultural competency among PO staff and providers.

The PO shall incorporate in its policies, administration, provider contract, and service practice the values of honoring members' beliefs, being sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and fostering in staff/providers attitudes and interpersonal communication styles which respect members' cultural backgrounds.

The PO shall have specific policy statements on these topics and communicate them to subcontractors and providers.

2. *Cultural Preference and Choice*

The PO shall permit members to choose providers from among the PACE network of providers based on cultural preference, including the choice of Indian members to choose to receive services from any Indian health care provider in the network as long as that provider has capacity to provide the services.

**I. Access to Providers**

1. *Access Standards*

The PO shall demonstrate to the Department that all services and all service providers comply with access standards provided in Article VII, Services and the access standards in this article.

2. *Assuring Member Access to Care and Services*

The PO must do the following to assure access:

- a. Meet and require its providers to meet state standards for timely access to care and services, taking into account the urgency of the need for services.



- b. Ensure that network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service members, if the provider serves only Medicaid members.
  - c. Make services that are necessary to support outcomes or that are medically necessary, available twenty-four (24) hours a day, seven (7) days a week, as appropriate.
  - d. Ensure that network providers, as appropriate, provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.
3. *Assuring Network Capacity*
- The PO shall demonstrate to the Department an adequate internal staff and provider capacity to provide the projected membership in the service area with:
- a. The appropriate range of services to make all PACE program benefits readily available to all members, including those with limited English proficiency or physical or mental disabilities;
  - b. A sufficient number, mix, and geographic distribution of providers of all services;
  - c. Access to prevention and wellness services;
  - d. Specialized expertise with the target population(s) served by the PO;
  - e. Culturally competent providers (see Section H. of this article) including Indian health care providers; and
  - f. Services that are physically accessible and available on a timely basis.
4. *Frequency of Documentation of Network Capacity*
- a. The PO must provide documentation to the Department, in a format specified by the Department, that it satisfies Article VIII.I.3.a. and b. at the following times:
    - i. By the effective date of this contract;
    - ii. Annually; and
    - iii. At any time there has been a significant change (as defined by the Department) in the PO's operations that would affect the adequacy of capacity and services, including:
      - a) An increase or reduction of twenty-five (25) percent or more in the number of members in the PO's service area as compared to the number of members reported in the most recent documentation provided to the Department;



- b) A reduction of five (5) percent or more in the number of providers in the service area as compared to the number of providers reported in the most recent documentation provided to the Department;
  - c) Changes in PACE services, benefits, service area, composition of, or payments to its provider network; or
  - d) Enrollment of new population in PACE.
- b. The PO must provide documentation to the Department, in a format specified by the Department, that it satisfies Article VIII.I.3.c. through f. at the following times:
- i. By the effective date of this contract; and
  - ii. Annually.
5. *Assuring Network Adequacy*
- The PO shall demonstrate that its provider network complies with the state developed network adequacy standards (time and distance and non-time and distance) as specified in the PO Provider Adequacy Policy (<https://www.dhs.wisconsin.gov/publications/p02542.pdf>).
- DHS may grant an exception to these standards if the PO requests an exception and provides all of the following to the Department:
- a. Conclusive evidence that there is an insufficient number of providers for a service in a given county;
  - b. An explanation of the factors beyond the PO's control contributing to the inadequate supply; and
  - c. The PO's strategy to provide a similar service to support member outcomes or other alternatives.
6. *Verification of PO Network Adequacy and Access*
- The PO shall annually submit to the Department, in a format specified by the Department, the following information:
- a. Actual and projected enrollment by target group for each county served by the PO;
  - b. A description of how the PO projects the needs for each target group;
  - c. A current listing of all contracted providers that includes, but is not limited to, the following:
    - i. Provider or facility name;
    - ii. Provider or facility address(es) including satellite or remote office locations that are contracted with the PO;



- iii. Services being provided (e.g. home health or respite);
  - iv. Whether or not physicians and hospitals are accepting new PACE members;
  - v. Whether or not other network providers are accepting new PACE members; and
  - vi. Verification that providers are credentialed, when appropriate.
- d. For residential care facilities, identification of the availability of residential providers offering private rooms, and a process for moving an individual to a private room when one becomes available that is consistent with the member's preferences.
  - e. Current policies with supporting procedures\* for assuring compliance with the state developed network adequacy standards as specified in the PO Provider Adquacy Policy. ;
  - f. Current policies with supporting procedures for provider selection and retention; and
  - g. Other information the Department determines to be necessary for certification of the PACE provider network.

\*For items c. and e., the PO must additionally provide this information when there is a significant change to the PO's operations as described under Article VIII.I.4.a.iii. above.

7. *Monitoring Access to Services*

The PO shall:

- a. Continuously monitor and report to the Department the extent to which it maintains an adequate capacity; and
- b. Take corrective action if the PO or the Department discovers deficiencies in its capacity to meet the requirements of Article VII, Services.

This shall include PO policies and procedures for interdisciplinary teams to notify the PACE network developers when they experience problems in accessing services for members.

8. *Full Enrollment*

Any PO that will, at any time during the term of this contract, operate the PO in a service area where the PACE benefit is available to all entitled persons in the service area shall demonstrate capacity to provide services to all entitled persons who seek enrollment in PACE. The entitlement period is specified in Wis. Stat. § 46.286(3)(c).



**J. Change in Providers**

1. *Required Notifications*

a. Notice to Department

The PO is required to notify the Department at [dhsbmc@dhs.wisconsin.gov](mailto:dhsbmc@dhs.wisconsin.gov) within seven (7) calendar days when:

- i. Any notice is given by the PO to a provider, or any notice given to the PO from a provider, of a provider agreement termination, a pending provider agreement termination, or a pending modification in provider agreement terms that have potential to limit member access or compromise the PO's ability to provide necessary rights.
- ii. A community residential care provider reports to the PO that a PACE member has or will be involuntarily discharged

b. Notice to members and Resource Centers

- i. The PO must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) business days after receipt or issuance of the termination notice, to each member who received his/her primary care from, or was seen on a regular basis by, the terminated provider.
- ii. When the Department determines that a change is significant, the PO shall provide each member and the resource centers in the service area affected by the change, written notice of the change at least thirty (30) calendar days before the effective date of the change. Notices about significant changes in providers that are to be sent to members and shared with the resource center must be submitted to the Department prior to delivery.

2. *Certification of Provider Agreements Related to the Change*

At any time the Department determines there has been a significant change in the PO's capacity to offer services or in the projected membership or in the service area, the Department may, at its discretion, require recertification of the PACE network.

3. *Invoking Remedies*

If the Department determines that a pending provider agreement termination or pending modification in provider agreement terms will jeopardize member access to care, the Department may invoke the remedies provided for in Article XVI.E., Sanctions for Violation, Breach, or Non-Performance. These remedies include contract termination (with notice to the PO and an opportunity to correct provided for), and suspension of new enrollment.



**K. Health Information System**

1. *Accurate and Complete Data*

The PO must ensure that data received from providers is accurate and complete by:

- a. Verifying the accuracy and timeliness of reported data;
- b. Screening the data for completeness, logic, and consistency; and
- c. Collecting service information in standardized formats to the extent feasible and appropriate.

The PO must ensure that providers follow the data requirements in Article XII, Quality Management (QM), and Article XIV, Reports and Data.

2. *Unique Identifier*

The PO must require each physician and other eligible provider to have a unique identifier to the extent required under the Health Insurance Portability and Accountability Act (HIPAA).

**L. Payment**

1. *Payment for Services Provided to Members*

The PO shall be responsible for payment of all approved services provided to members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, the PO agrees to provide or authorize provision of services to all Medicaid members with valid Medicaid ID (identification) cards indicating PACE enrollment without regard to disputes about enrollment status and without regard to any other identification requirements.

Any discrepancies between the cards and the reports will be reported to the Department for resolution. The PO shall continue to provide and authorize provision of all contract services until the discrepancy is resolved. This includes recipients who were PENDING on the Initial Report and held a valid Medicaid identification card indicating PACE enrollment, but did not appear as an ADD or CONTINUE on the Final Report.

2. *Federally Qualified Health Centers (FQHCs)*

a. Payment

If the PO contracts with a facility or program, which has been certified as an FQHC, for the provision of services to its members, the PO must:

- i. Provide payment that is not less than the level and amount of payment which the PO would make for the services if the services were furnished by a provider which is not an FQHC; and





- ii. Increase the FQHC's payment in direct proportion to any annual increase the PO receives from the Department for any type of provider.
  - b. Reporting

If the PO contracts with a FQHC, it must report to the Department within forty-five (45) calendar days of the end of each quarter the total amount paid to each FQHC, per month as reported on the 1099 forms prepared by the PO for each FQHC. FQHC payments include direct payments to a medical provider who is employed by the FQHC.
- 3. *Rural Health Clinics (RHCs)*

If the PO contracts with a facility or program, which has been certified as a RHC, for the provision of services to its members, the PO must provide payment that is not less than the level and amount of payment which the PO would make for the services, if the services were furnished by a provider which is not a RHC
- 4. *Subcapitation*

The PO may expend funds from its capitation payments on a subcapitated basis.
- 5. *Home and Community Based Waiver Services Rates*
  - a. The PO may negotiate the rates it pays to providers of the Home and Community-Based Waiver Services in Addendum VII.A.
  - b. The PO must follow all of the procedures specified in Department memo #10-06, if a current community-based residential provider declines to continue providing services to the member at the rate offered by the PO and the action results in a member move (<https://www.dhs.wisconsin.gov/familycare/mcos/communication/ta10-06.pdf>).
- 6. *Medicaid Rates*
  - a. Negotiated Rates

Except as provided in sub.b., if the PO can negotiate such agreements with providers, the PO may pay providers less than Medicaid fee-for-service rates.
  - b. Payment Rates for Nursing Home Services

In determining the payment rate for the purchase of nursing home services, the PO must employ the Medicaid fee-for-service nursing home rate methodology applied solely to the PO's residents in that nursing facility. POs may use either the acuity of the PO's nursing home residents as of a specific date or each individual member's daily acuity. The Medicaid fee-for-service nursing home rate methodology includes any retroactive adjustments to the Medicaid fee-for-service rates for the nursing home. POs must apply nursing home retroactive rate adjustments



within 90 days of DHS posting an updated rate for the nursing home, utilizing provider submitted member acuity information. DHS will periodically provide POs with member-specific acuity rosters, which POs have the option to use to further reconcile provider-submitted acuity levels. There is no timeframe for this optional reconciliation.

c. Medicaid Fee-For-Service Rates

The PO shall not pay itself or its providers more than the Medicaid fee-for-service rates for Medicaid covered services except when it determines on an individualized basis, that it is unable or impractical to otherwise obtain the service. Paying above the Medicaid fee-for-service rate includes paying more than Medicaid fee-for-service would pay when coordinating benefits with other payers.

A listing of the specific fee-for-service Medicaid services exempt from the requirements in this section can be found in the Care Management Organization (CMO) Pricing Administration Guide on the ForwardHealth website.

d. PO Notification of Payment Above the Medicaid Fee-For Service Rate

In the event that the PO contracts at a rate above the Medicaid fee-for-service rate, the PO will document and track each situation. The PO must submit a single comprehensive report to the Department at [DHSDMSBRS@dhs.wisconsin.gov](mailto:DHSDMSBRS@dhs.wisconsin.gov) in February and August of each year (see <https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf> for the specific due dates) as a component of the Quarterly Report required under Article XIV.C.3. The information will be reported to the Department on a form provided by the Department.

- i. The PO will identify expenditures on the services paid for above the Medicaid Fee-For-Service Rate within the LTCare IES.

7. *Payments for Court-Ordered Services*

The PO will pay for covered court-ordered services that are in the PACE program benefit in accordance with Article VII.K., Court-Ordered Services. Pursuant to a court order for treatment the PO will pay for covered services provided by a provider that is not in the PO's provider network to any member.

Coverage of a service is effective upon receipt of a written request for a referral from the non-network provider, and extends until the PO issues a written denial of the referral. This requirement does not apply if the PO issues a written denial of the referral within five (5) business days of receiving the request for the referral.

8. *Health Professional Shortage Area (HPSA) Payments*

The PO must pay the HPSA enhanced rates outlined under Medicaid FFS policy or the equivalent for PACE covered primary care and emergency care services



provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA. Specified PACE-covered obstetric or gynecological services (see Wisconsin Health Care Programs Online Handbooks) provided to a member living in a HPSA or by a provider practicing in a HPSA must also be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy or the equivalent. However, this does not require the PO to pay more than the enhanced FFS rate or the actual amount billed for these services.

**M. Appeals to the PACE Organization and Department for Payment/Denial of Providers Claims**

1. *Provider Appeal to the PO*

All providers must appeal first to the PO if they disagree with the PO's payment, nonpayment, partial payment, late payment or denial of a claim. To enable a provider to appeal, the PO shall:

- a. Provide written notification to providers of the PO payment, nonpayment, partial payment, or denial determinations. These notifications will include:
  - i. A specific explanation of the payment amount or a specific reason for the nonpayment, partial payment or denial;
  - ii. A statement explaining the appeal process and the provider's rights and responsibilities in appealing the PO's determination by submitting a separate letter or form which:
    - a) Is clearly marked "appeal";
    - b) Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and
    - c) Is submitted to the person and/or unit at the PO that handles Provider Appeals within sixty (60) calendar days of the initial denial or partial payment.
  - iii. The name of the person and/or unit at the PO to whom provider appeals should be submitted.
  - iv. A statement advising the provider of the provider's right to appeal to the Department if the PO fails to respond to the appeal within forty-five (45) calendar days or if the provider is not satisfied with the PO's appeal decision. The statement must include the timeframe within which the provider must submit the appeal and the address to which the appeal must be sent.
- b. Accept written appeals from providers who disagree with the PO's payment, nonpayment, partial payment or denial determination, if the provider submits the dispute in writing within sixty (60) calendar days of the initial payment/denial notice.



- c. Respond in writing to the provider within forty-five (45) calendar days from the date of receipt of the request for reconsideration. If the PO fails to respond within that time frame, or if the provider is not satisfied with the PO's response, the provider may seek a final determination from the Department.

2. *Provider Appeals to the Department*

- a. The Department will review appeals and make final determinations in cases where;
  - i. The provider has requested a reconsideration by the PO according to the terms described above; and
  - ii. The provider continues to dispute the PO's appeal determination; or
  - iii. The PO or provider fails to respond within forty-five (45) calendar days from the date of receipt of the provider's request for reconsideration.
- b. Appeals must be submitted to the Department within:
  - i. Sixty (60) calendar days of the date of written notification of the PO's final decision resulting from a request for reconsideration; or
  - ii. Sixty (60) calendar days after the PO's failure to respond within forty-five (45) calendar days to the provider's request for reconsideration.
- c. Appeals to the Department are submitted to:

Provider Appeals Investigator  
Division of Medicaid Services  
1 West Wilson Street, Room 518  
P.O. Box 309  
Madison, WI 53707-0309
- d. The Department will notify the PO when a provider appeal is received and will share pertinent information so the PO has an opportunity to respond.
- e. The Department will accept written comments from all parties to the dispute prior to making the decision.
- f. The Department can make a decision based on the information that it has even if it might not have all of the information that it has requested because the PO or provider has failed to respond to a request from the Department for information by the deadline set by the Department.
- g. The Department has forty-five (45) calendar days from the date of receipt of all written comments to respond to a provider's appeals.



- h. The Department determinations may include the override of the PO's time limit for submission of claims and appeals in exceptional cases.
- i. The Department determinations may include the override of the time limit for submission of appeals to the Department in exceptional cases.
- j. The PO shall accept the Department's determinations regarding appeals of disputed claims. The PO shall pay provider(s) within forty-five (45) calendar days of receipt of the Department's final determination.

3. *Provider Appeal Log and Summary*

The PO shall submit to the Department a provider appeal log with data summary as specified in Article XIV.C.2. The log with summary will include the:

- a. Name of the provider;
- b. Type of service;
- c. Date of service;
- d. Amount of the claim;
- e. Date of receipt of the appeal;
- f. Appeal decision by the PO;
- g. Reason for the decision;
- h. Total number of appeals denied for the reporting period;
- i. Total number of appeals upheld for the reporting period;
- j. Total number of appeals received year start to date of report;
- k. Percent of appeals denied year start to date of report as percent of total appeals received; and
- l. Percent of appeals upheld year start to date of report as percent of total appeals received.

**N. Standards for PACE Organization Staff**

- 1. The PO shall establish a system for monitoring PO staff who deliver services to assure the provision of quality services. Refer to paragraph 5, Caregiver Background Checks, below for related employee standards.

2. *Relatives and Legal Guardians*

For the purposes of this section, a relative is defined as a person related, of any degree, by blood, adoption or marriage, to the member. Legal guardian is defined in state statute.

The member care plan identifies all services and supports needed by the member, including those which will be provided by natural supports. Natural supports are unpaid supports that are provided to a member voluntarily in lieu of waiver or



State Plan services. Natural supports can, and should, be used when they are available.

Relatives and legal guardians may be paid to perform or provide only the following services: personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services, education (daily living skills training), respite care, skilled nursing, and supported employment.

The PO shall have policies addressing the circumstances in which a relative or legal guardian may be paid by the PO for these services. Those policies must reflect the goal of supporting and maintaining natural supports and may allow for relatives or legal guardians to be paid only if all the following apply:

- a. The service is identified in the MCP;
- b. The member's preference is for the relative or legal guardian to provide the service;
- c. The interdisciplinary team ensures that:
  - i. The service meets identified needs and outcomes in the MCP and assures the health, safety and welfare of the member;
  - ii. The purchase of services from the relative or legal guardian is cost-effective in comparison to the purchase of services from another provider;
- d. The interdisciplinary team monitors and manages any real or potential conflict of interest situation that may occur as a result of the relative or legal guardian providing services;
- e. The relative or legal guardian meets the PO's qualifications and standards for its providers or employees providing the same service;
- f. There is a properly executed provider agreement between the PO and the relative or legal guardian;
- g. The service performed by the relative or legal guardian does not benefit the relative, legal guardian, or other individuals residing in the household with the member (for example, lawn mowing, snow shoveling, family meal preparation, grocery shopping, emptying trash cans, etc.). The service may be of incidental benefit to the relative or legal guardian as long as the service is clearly identified as intended to support the member and is clearly identified as such in the MCP (for example, occasional grocery shopping conducted as a community integration outing for the member); and
- h. For spouses, the individual will either:
  - i. Provide an amount of service that exceeds the normal spousal care giving responsibilities for a spouse who does not have a disability;  
or



- ii. Find it necessary to forego paid employment in order to provide the service

3. *Intimate Care Services*

If the PO is the employer of attendants for the purposes of supportive home care, personal care or home health aide services the following conditions shall be met:

- a. Members are offered the opportunity to participate with the PO in choice and assignment of attendant(s) that provide the service;
- b. Members are involved with training the PO attendant(s) (if desired by the member);
- c. Members are involved in negotiating hours of services;
- d. Members regularly participate in the evaluation of services provided by their PO attendant(s); and
- e. Members are involved in the supervision of PO attendant(s) along with the PO attendant supervisor (if desired by the member and to the extent of his/her abilities).

4. *Federal Department of Labor*

The MCO shall implement and adhere to rules and regulations prescribed by the United States Department of Labor and in accordance with 41 C.F.R. § 60.

5. *Caregiver Background Checks*

The PO shall comply with Wis. Admin. Code Chapters DHS 12 and 13 related to caregiver background and other checks, including:

- a. The PO shall establish and implement a policy consistent with Wis. Admin. Code Chapters DHS 12 and 13 to appropriately respond to a PO employee who is paid to provide services to a member when the employee has a caregiver conviction that is substantially related to the care of a member;
- b. The PO shall perform, or require providers to perform, background checks on caregivers in compliance with Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12;
- c. If the PO requires providers to perform background checks on caregivers, the PO shall ensure that the providers perform the background checks in compliance with Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12;
- d. The PO maintains the ability to not pay or contract with any provider if the PO deems it is unsafe based on the findings of past criminal convictions stated in the caregiver background check.

The PO shall require co-employment agencies and fiscal employer agents to perform background checks that are substantially similar to the background





checks required under Wis. Stat. § 50.065 and Wis. Admin. Code Chapter DHS 12 on individuals providing services to self-directing members who have, or are expected to have, regular, direct contact with the member. Regular contact means scheduled, planned, expected or otherwise periodic contact. Direct means face-to-face physical proximity to a member that may afford the opportunity to commit abuse or neglect or misappropriate property.

**O. Network, Coverage and Payment Provisions Applicable to Indian Health Care Providers and Indian Members**

1. *Network and Coverage Requirements*

- a. Adequate Indian Health Care Provider (IHCP) Network Capacity
  - i. As part its demonstration of network adequacy under Article VIII.I.3, the PO shall document that its provider network includes sufficient participating Indian health care providers to ensure timely access to covered services from such providers for its Indian members.
  - ii. If the PO cannot ensure such timely access due to few or no Indian health care providers in the service area , it will be considered to have met the requirement for timely access if it permits Indian members to access out-of-region and/or out-of-State Indian health care providers.

2. *Payment Requirements*

- a. Payment Requirements for IHCPs - In General

The PO shall pay Indian health care providers, for services within the PACE program benefits provided to Indian members who are eligible to receive services from such providers, either:

  - i. At a rate negotiated between the PO and the provider, or
  - ii. If there is no negotiated rate, at a rate not less than the level and amount of payment that would be made to an in-network provider that is not an Indian health care provider.
- b. Timely Payment

The PO shall pay Indian health care providers promptly in accordance with this section and Article XIII MCO Administration, F.2 Claims Processing Payment Requirement, which incorporates the timely payment requirements under 42 C.F.R. § 447.45 and § 447.46.
- c. Payment Rates for IHCPs That Are Not FQHCs

When an Indian health care provider is not enrolled in the Medicaid program as a FQHC, whether or not it is a network provider for the PO, the PO shall pay it for covered services provided to Indian members at the



applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the rate it would receive under the State plan's fee-for-service payment methodology.

**P. Physician Incentive Plans**

1. *Conduct Surveys*

If the PO implements a physician incentive plan, then the PO must conduct surveys that:

- a. Include either all current Medicare/Medicaid members and individuals previously enrolled who have disenrolled during the past 12 months, or a sample of these same enrollees and disenrollees.
- b. Are designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis.
- c. Address consumer satisfaction with the quality of services provided and the degree of access to the services.
- d. Begin no later than one year after the effective date of the incentive plan. Thereafter, surveys must be conducted at least every two years.

2. *Information Concerning the Plans*

If the PO implements a physician incentive plan, then the PO must provide CMS and the Department information concerning the plans, sufficient to permit the Secretary to determine whether the plan is in compliance. Disclosure must be made upon application for a contract or for a service area expansion, and upon request by CMS or the Department. The disclosure must contain the following information:

- a. Whether the incentive plan covers services not furnished by the physician or physician groups. If the plan covers only the services furnished by the physician or physician group, disclosure of other aspects of the plan is not needed.
- b. The type of incentive arrangement; for example, withhold, bonus, capitation.
- c. If withhold or bonus, the percent of the withhold or bonus.
- d. The amount and type of stop-loss protection.
- e. The panel size and, if patients are pooled according to one of the following permitted methods, the method used.
- f. Commercial, Medicare and/or Medicaid members in the calculation of the panel size.
- g. Pooling together of several physician groups into a single panel.



- h. Capitation payments, if any, paid to primary care providers for the most recent year broken down by percent of primary care services, referral services to specialists, and hospital and other types of provider (for example, nursing home and home health agency) services.
- i. The results of surveys.

3. *Informing Members*

If the PO implements a physician incentive plan, then the PO must inform any Medicare/Medicaid beneficiaries whether they use a physician incentive plan that affects the use of referral services, the type of incentive arrangement, and, if available, the results of surveys.



## IX. Marketing and Member Materials

### A. Marketing/Outreach Plans and Materials

The PO agrees to engage only in marketing/outreach activities and distribute only those marketing/outreach materials that are pre-approved in writing, as outlined in this section.

Marketing/outreach materials are defined in Article I, Definitions. The Department will determine what marketing/outreach materials and activities are subject to the requirements of this contract. The requirements of the contract are specific to the plan being offered.

#### 1. *Marketing/Outreach Plan Approval*

The Department must approve in writing the PACE organization's marketing and outreach plan before the plan is implemented.

#### 2. *Marketing/Outreach Material Approval*

- a. The PO must ensure that members and potential members receive accurate oral and written information sufficient to make informed choices.
- b. The PO shall submit to the Department for approval all marketing/outreach materials that describe the program or the program benefits prior to disseminating the materials.
- c. All marketing/outreach materials must be approved by the Department and CMS prior to distribution.
  - i. The Department will review all marketing/outreach plans and materials in a manner which does not unduly restrict or inhibit the PACE organization's marketing/outreach plans and materials, and which considers the entire content and use of the marketing/outreach materials and activities.
  - ii. Issues identified by the Department will be reviewed with the PO. The PO will be asked to make the appropriate revisions and resubmit the document for approval. The Department will not approve any materials it deems confusing, fraudulent, or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the Program.
  - iii. The Department will assist the PO when issues arise in obtaining CMS approval for materials.
- d. This requirement applies to marketing/outreach materials specific to PO services that are produced by providers or subcontractors who have entered a provider agreement or subcontract with the PO or are owned by the PO in whole or in part.



3. *Timeline for Department's Approval*

The Department will review marketing/outreach materials within thirty (30) calendar days of receipt.

4. *PO Agreement to Abide by Marketing/Outreach and Distribution Criteria*

- a. The PO agrees to engage only in marketing/outreach activities and distribute only those marketing/outreach materials that are pre-approved in writing.
- b. Any marketing/outreach activities must occur in its entire service area in a county. All marketing/outreach materials must be distributed to potentially eligible members in an entire service area, as defined in PO's marketing/outreach plan, and must be equitably available to all consumers eligible for enrollment in the PO's service area.
- c. The PO must provide one electronic or hard copy of all marketing/outreach materials to the resource centers in the service area at the same time these materials are first used. If a hard copy is provided, the PO must provide additional copies to the resource center upon request.

5. *Prohibited Practices*

In addition to the practices listed in 42 CFR §460.82(e), the following marketing/outreach practices are prohibited:

- a. Practices that seek to influence enrollment in conjunction with the sale or offering of any other insurance product;
- b. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:
  - i. The recipient must enroll in the PO in order to obtain benefits or in order to not lose benefits; or
  - ii. The PO is endorsed by CMS, the federal or state government, or other similar entity.
- c. Practices that are reasonably expected to have the effect of denying or discouraging enrollment;
- d. Practices to influence the recipient to either not enroll in or to disenroll from another long term care plan; and
- e. Marketing/outreach activities that have not received written approval from the *Department*.

6. *Sanctions*

The PO that fails to abide by these marketing/outreach requirements may be subject to any and all sanctions available under Article XVI.E., Sanctions for Violation, Breach, or Non-Performance. In determining any sanctions, the



Department will take into consideration any past unfair marketing/outreach practices, the nature of the current problem and the specific implications on the health and well-being of the enrolled member.

In the event that the PO's provider or subcontractor fails to abide by these requirements, the Department will evaluate whether the PO should have had knowledge of the marketing/outreach issue and the PO's ability to adequately monitor ongoing future marketing/outreach activities of the provider/subcontractor(s).

**B. Member Materials – General Requirements**

Member materials are defined in Article I, Definitions.

1. Member materials shall be accurate, readily accessible, appropriate for, and easily understood by the PO target population and in accordance with accessibility of language requirements in this article Section E, Accessible Formats and Languages and Cultural Sensitivity.
2. Member materials shall be available to members in paper form, unless electronic materials are available, the member or member's legal decision maker prefers electronic materials, and the electronic materials meet the requirements in section 3 below. Alternatives for other languages are addressed in Section E.3 of this Article.
3. The PO may provide members with materials using electronic media only if all of the following requirements are met:
  - a. The format is readily accessible;
  - b. The information is placed in a location on the PO's website that is prominent and readily accessible;
  - c. The information is provided in an electronic form which can be electronically retained and printed;
  - d. The information is consistent with the content and language requirements in Section E, of this Article;
  - e. The member is informed that the information is available in paper form without charge upon request and the PO provides it upon request within five (5) business days;
  - f. The PO has obtained member consent to receive materials electronically; and
  - g. The PO has safeguards in place to ensure delivery of electronic materials as follows:
    - i. The member must be able to opt out of receiving electronic communications upon request.



- ii. The PO must ensure that member contact information is current, materials are sent timely, and important materials are identified in a way that members understand their importance.
  - iii. The PO must have a process for mailing of hard copies when electronic communications are undeliverable (e.g., an expired e-mail account).
  - iv. The PO must ensure that it is in compliance with confidentiality laws.
4. The PO shall have all member materials approved by the Department before distribution. The Department will review member materials within thirty (30) calendar days of receipt. The PO is not required to submit model materials required by CMS to the Department for review and approval, but must provide a copy of such materials upon request.
5. The Department will assist the PO when issues arise in obtaining CMS approval for materials.
6. Within ten (10) business days of initial enrollment notification, the PO shall provide new members or their legal decision makers a member handbook and information about how to obtain an electronic copy of the provider network directory. A paper copy of the provider network directory and member handbook must be provided upon request within five (5) business days.
7. The PO is responsible for disseminating the materials to new members:
  - a. Member handbooks;
  - b. Provider network directories;
  - c. Self-directed supports guidebook;
  - d. drug formularies;
  - e. pharmacy network; and
8. For consistency in the information provided to members, the *PO* shall use the Department's standard definitions of managed care terminology ([www.dhs.wisconsin.gov/familycare/mcos/standard-terminology.htm](http://www.dhs.wisconsin.gov/familycare/mcos/standard-terminology.htm)) in member materials.
9. The enrollment agreement and member handbook template will be developed cooperatively with the PACE plan and approved by the Department. Subsequently the PO will submit plan-specific publications, noting the changes, for Department and, if required, CMS approval prior to distribution.
10. Educational materials (e.g., health, safety, fall prevention, etc.) prepared by the PO or by their contracted providers and sent to the PO's other membership do not require the Department's approval, unless there is specific mention of PACE and/or Medicaid. Educational materials prepared by outside entities do not require Department approval.





11. The PO must provide all enrollment notices, informational materials, and instructional materials related to the enrollee and potential enrollees in a manner and format that may be easily understood and is readily accessible.  
  
All materials produced and/or used by the PO must be understandable and readable for the average consumer and reflect sensitivity to the diverse cultures served. The PO must make all reasonable efforts to locate and use culturally appropriate material. Materials shall take into account individuals who are visually limited or who are limited English proficient.
12. Model member notices and templates developed by DHS shall be used by the PO.
13. The PO must have in place mechanisms to help enrollees understand the requirements and benefits of the plan.

### **C. Member Handbook**

1. The PO must develop and maintain an up-to-date member handbook:
  - a. Text must be in easily understood language and format in a font no smaller than 12 point.
  - b. An electronic version of the PO's member handbook must be maintained with complete and current information, readily accessible, and posted in a prominent location on the PO's website.
  - c. The paper version of the member handbook must be updated when significant changes occur and, at minimum, annually.
  - d. The handbook must be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.
  - e. The handbook must include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.
2. The PO must fully review and provide members a complete up-to-date member handbook upon initial enrollment and provide an up-to-date member handbook upon request within five (5) business days. The member handbook will be considered to be provided if the PO:
  - a. Mails a printed copy of the information to the member's mailing address;
  - b. Provides the information by email after obtaining the member's agreement to receive the information by email;
  - c. Posts the information on the PO's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with



- disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or
- d. Provides the information by any other method agreed to by the member that can reasonably be expected to result in the member receiving that information.
3. When significant changes occur, the PO must distribute to its members a full member handbook, an addendum to the member handbook or other written notification at least thirty (30) calendar days in advance of the effective date.
  4. Annually, the PO must distribute to its members either the member handbook or notify members of their right to request and obtain the information listed below in C.5.
  5. The Member Handbook, at a minimum, will include information about:
    - a. Membership in PACE. This information shall include the nature of membership in a Managed Care Organization as compared to fee-for-service;
    - b. How to access auxiliary aids and services, including how to obtain information in alternate formats and the appropriate language, and how to access translation/interpreter services;
    - c. Available assistance for members with cognitive impairments to review materials about membership in PACE;
    - d. The location(s) of the PACE facility or facilities;
    - e. The hours of service;
    - f. The services covered, including:
      - i. A list of services and information about the benefits available in sufficient detail to ensure that members understand the benefits to which they are entitled;
      - ii. The PO's ability to provide an alternative support or service;
      - iii. The services the PO does not cover because of moral or religious objections and how the member can obtain information from the Department on how to access these services;
      - iv. Each member's right to select from the PACE network of providers, and any restrictions on member rights in selecting providers;
      - v. A member's ability to change providers;
      - vi. Any cost sharing related to these services; and
      - vii. A member's liability for unauthorized services.



- g. Electing and maximizing Medicare benefits including obtaining all Medicare Part A, Part B and Part D benefits, if eligible, from the PACE Plan.
- h. The right to receive services from culturally competent providers, and information about specific capacities of providers, such as languages spoken by staff;
- i. Self-Directed Supports and how and where members can get more information;
- j. The extent to which members may obtain services, outside of the provider network;
- k. Obtaining benefits and advance authorization of services, and on the member's ability to obtain services necessary to support outcomes;
- l. Using after hours services and obtaining services out of the PACE service area;
- m. The use of emergency and urgent care facilities including:
  - i. What constitutes emergency medical condition, emergency services, and post-stabilization services;
  - ii. The fact that prior authorization is not required for emergency services;
  - iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; and
  - iv. The fact that, subject to the provisions of this section, the member has a right to use any hospital or other setting for emergency care.
- n. The telephone numbers including:
  - i. The 24 hour a day toll free telephone number that can be used for assistance in obtaining urgent and emergency care; and
  - ii. A toll free telephone number where members can acquire information about the requirements and benefits of the program;
- o. The post-stabilization care services rules set forth in 42 C.F.R. § 460.100 ;
- p. The process of selecting and changing the member's primary provider;
- q. The policy on referrals for specialist care and for other benefits not furnished by the member's primary care provider;
- r. Voluntary enrollment, voluntary disenrollment, and involuntary disenrollment;
- s. Members' rights, responsibilities and protections as defined by the Department and 42 C.F.R. § 460.112;



- t. Abuse, neglect and financial exploitation including:
  - i. What constitutes abuse, neglect and financial exploitation; and
  - ii. Information on how to report suspected fraud and abuse, including the resources that exist for reporting and assistance, including emergency twenty-four (24) hour phone numbers.
- u. Ombudsman and independent advocacy services available as sources of advice, assistance and advocacy in obtaining services;
- v. The appeal and grievance process, including:
  - i. What constitutes an appeal, grievance, or fair hearing request;
  - ii. The right to file appeals or grievances, and the right to request a fair hearing after the PO has made a determination on the member's appeal that is adverse to the member;
  - iii. How to file appeals, grievances, fair hearing requests and expedited review, including the timeframes, the rules that govern representation at the hearing and the member's ability to appear in person before the PO personnel assigned to resolve appeals and grievances;
  - iv. Information about the availability of assistance with the appeal and grievance process, and fair hearings;
  - v. The toll-free numbers that the member can use to register a grievance or an appeal orally and request that the PO put the grievance or appeal into writing;
  - vi. The specific titles and telephone numbers of the PO staff who have responsibility for the proper functioning of the process, and who have the authority to take or order corrective action;
  - vii. The assurance that filing an appeal or grievance or requesting a fair hearing process will not negatively impact the way the PO, its providers, or the Department treat the member; and
  - viii. How to obtain services during the appeal and fair hearing process, including the fact that, when requested by the member:
    - a) The benefits may continue if the member files an appeal or a request for State Fair Hearing and requests continuation of services within the timeframes specified for filing; and
    - b) The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.



- w. Obtaining second medical opinions;
- x. Policies and procedures for advance directives, as described in in 42 C.F.R. § 438.3(j);
- y. How members and their legal decision makers can have input on changes in the PO's policies and services;
- z. The right to obtain results of member surveys;
- aa. Estate recovery provisions applying to PACE membership;
- bb. The notification that members may be asked to voluntarily participate in the quality review process;
- cc. The additional information that is available upon request, including the following:
  - i. Structure and operation of the PO; and
  - ii. Any physician incentive plans as described in in 42 C.F.R. § 438.6(h)

**D. Provider Network Directory and Information**

1. The PO must develop and maintain up-to-date provider network directories and information.
  - a. An electronic version of the PO's provider network directory must be maintained with complete and current information on the PO's website. To be considered current, electronic versions of provider network directories, including internet directories, must be updated no later than thirty (30) calendar days after the PO receives updated provider information.
  - b. The paper version of the provider network directory must be updated at least monthly.
  - c. The PO must make the updated provider directories available to members upon initial enrollment and upon request.
  - d. When significant changes occur in the provider network, the PO must provide members a revised directory, an addendum to the directory or other written notification of the change.
2. Provider directories must be made available on the PO's website in a machine readable file and format as specified by the Department.
3. The PO must make current information on the PO's provider network available to IDT staff for care planning and appropriate authorization of services.
4. The PO must provide all ADRCs in its service area with electronic access to complete and up-to-date provider network information, so that ADRCs can access the information at any time for the purpose of enrollment counseling.



5. The provider directory shall include providers that are under contract with the PO, including physicians, hospitals, pharmacies, behavioral health providers, and long-term care providers. The directory will include the following information for providers under contract with the PO:
  - a. Provider name as well as any group affiliation (individual practitioner, clinic or agency as appropriate) including primary care physicians, specialists and hospitals
  - b. Provider street address(es), telephone number(s), website URL, (as appropriate), and for in-home service providers, the service area;
  - c. Services furnished by the provider;
  - d. Provider specialty (as appropriate);
  - e. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract;
  - f. Whether the provider is accepting new PACE members. If a preferred provider is not accepting new members, the PO will assist the member in obtaining an alternate provider;
  - g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training; and
  - h. Accessibility of the provider's premises (if the member will be receiving services at the provider's premises), including offices, exam rooms and equipment.

**E. Accessible Formats and Languages and Cultural Sensitivity**

The PO shall provide member and marketing/outreach materials in a manner and format that may be easily understood and is readily accessible. Materials shall be understandable in language and format based on the following:

1. *Accessible Language*
  - a. All written materials for potential members must include taglines in the prevalent non-English languages in the State, as well as large print (no smaller than 18 point font), explaining the availability of written translations or oral translation to understand the information, the toll free number of the resource center providing choice counseling, and the toll free and TTY/TDY telephone number of the PO's member/customer service unit. DHS shall determine the prevalent non-English languages in each service area.



- b. Material directed at a specific member shall be in the language understood by the individual or oral interpretation shall be provided to the individual free of charge.
- c. Written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices shall include taglines and be available in prevalent non-English languages in the PACE service area.

2. *Materials Easily Understood and Accessible*

All materials produced and/or used by the PO must:

- a. Use easily understood language and format.
- b. Use a font size no smaller than 12 point.
- c. Be available in alternative formats and through the provision of auxiliary aids and services upon request and at no cost.
- d. Include large print (font size no smaller than 18 point) tagline and information on how to request auxiliary aids and services, including the provision of materials in alternative formats and the toll free and TTY/TDY telephone number of the PO's member/customer service unit.

3. *Cultural Sensitivity*

Materials for marketing/outreach and for health-promotion or wellness information produced by the PO must be appropriate for its target population and reflect sensitivity to the diverse cultures served.

If the PO uses material produced by other entities, the PO must review these materials for appropriateness to its target population and for sensitivity to the diverse cultures served.

**F. Reproduction and Distribution of Materials**

The PO shall reproduce and distribute at the PO's expense, according to a reasonable Department timetable, information or documents sent to the PO from the Department that contains information the PO members and/or the PO-affiliated providers must have in order to implement fully this contract.

**G. PACE Identification (ID) Cards**

The PO may issue its own PACE ID cards. The ForwardHealth and Forward cards will always determine the PO enrollment, even where the PO issues PACE ID cards.





## X. Member Rights and Responsibilities

### A. Protection of Member Rights

The PO shall have in effect written safeguards of the rights of enrolled participants, including a member bill of rights, in accordance with PACE regulations 42 C.F.R. § 460.110, Bill of Rights, and 42 C.F.R. § 460.112, Specific Rights to which a Participant is entitled and state laws that are designed for the protection of PACE members.

The language and practices of the PO shall recognize each member as an individual and emphasize each member's capabilities.

In addition to the rights included in 42 C.F.R. § 460.112 and 460.110, the PO must have written policies regarding the enrollee rights, including but not limited to:

1. The right to refuse treatment and the right to request a second opinion.
2. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
3. Accuracy and confidentiality of member information.
4. Prompt eligibility, entitlement and cost-sharing decisions and assistance.
5. Access to personal, program and service system information.
6. Information about and access to all services of the Department, Resource Centers and POs to the extent that the member is eligible for such services.
7. Support in understanding member rights and responsibilities.
8. Support from the PO in all of the following:
  - a. Self-identifying outcomes and long-term care needs.
  - b. Securing information regarding all services and supports potentially available to the member through the benefit.
  - c. Actively participating in planning individualized services and making reasonable service and provider choices for supporting identified outcomes.
  - d. Identifying, eliminating or monitoring and managing situations where a conflict of interest may exist due to a person or entity having an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.
9. Services identified in the member's member-centered plan.
10. Support in the exercise of any rights and available grievance and appeal procedures beyond those specified elsewhere in this article.



11. Exercise rights, and to be assured that the exercise of those rights does not adversely affect the way the PO and its providers or any state agency treat the enrollee.

**B. Legal Decision Makers**

The PO shall determine the identity of any and all legal decision makers for the member and the nature and extent of each legal decision maker's authority. The PO shall include any legal decision maker in decisions relating to the member only to the extent consistent with the scope of the legal decision maker's authority.

**C. Informal Resolution**

Members shall have the option to be represented by an advocate, peer or other person designated by the member in these processes.

**D. Advance Directives**

1. The PO shall:
  - a. Provide written information at time of enrollment regarding 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, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements, and
  - b. Provide education for staff and the community on issues concerning advance directives including information and/or training about ways to recognize and minimize or eliminate any potential conflicts of interest associated with providing counseling and assistance to members in executing advance directives.
  - c. Provide referral to appropriate community resources, for any member or individual seeking assistance in the preparation of advance directives.
  - d. Have written policies and procedures regarding advance directives for all members that include all requirements listed in this section.
2. The written information must reflect changes in State law related to advance directives as soon as possible, but no later than ninety (90) calendar days after the effective date of change.
3. The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider who, as a matter of conscience, cannot implement an advance directive.



**E. Provision of Interpreters**

The PO shall provide interpreter services for members, as necessary, to ensure availability of effective communication regarding treatment, medical history, health education and information provided to members. The PO must offer an interpreter, such as a foreign language or a sign language interpreter or a transcriber, in all crucial situations requiring language assistance as soon as it is determined that the member is of limited English proficiency or needs other interpreter services. (For related information, refer to Article IX.E., Accessible Formats and Languages and Cultural Sensitivity. The PO shall meet the following requirements in the provision of interpreter services.

1. *Availability*

The PO must provide for twenty-four (24) hour a day, seven (7) days a week access to interpreters conversant in languages spoken by the members in the PO. In a specific situation when a member needs care and requests interpreter services, the PO shall make all reasonable efforts to acquire an interpreter in time to assist adequately with all necessary care.

2. *Professional Interpreters*

Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed.

3. *Family Members as Interpreters*

Family members, especially children, may not be used as interpreters for discussion of technical, medical or treatment information or in assessments, therapy and other situations where impartiality is critical.

4. *Civil Rights Act of 1964*

Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.



## XI. Grievances and Appeals

### A. Purpose and Philosophy

Members have the right to appeal PO adverse benefit determinations and to any action or inaction of a PO that the member perceives as negatively impacting the member.

Members are encouraged, to attempt to informally resolve their issues before filing a grievance or an appeal.

1. The member's interdisciplinary team is usually in the best position to deal with issues directly and expeditiously. The Member Rights Specialist within the PO is the next most direct source of information and assistance.
2. When a concern cannot be resolved through internal review, negotiation, or mediation with the assistance of these individuals, the PO's grievance and appeal process is the next step for resolving differences. It is described in more detail in Section F of this article.
3. Department Review is the final process in resolving members' grievances. For more information about the Department Review process see Section G of this article.
4. The State Fair Hearing process is the final administrative review process for the Department in resolving members' appeals of adverse benefit determinations. It is described in Section H of this article.
5. Other remedies available to members, depending on the circumstance or issue, may include Wis. Admin. § DHS 94, Patient Rights and Resolution of Patient Grievances or seeking resolution in Circuit Court.

### B. Definitions

As used in this article, the following terms have the indicated meanings:

1. *Adverse benefit determination*
  - a. An "adverse benefit determination" is any of the following:
    - i. The denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of the PO's administration of the long-term care functional screen, including a change from nursing home level of care to non-nursing home level of care.
    - ii. The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.



- iii. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
  - iv. The denial, in whole or in part, of payment for a service specified in Addendum VII.
  - v. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
  - vi. The denial of a member's request to obtain services outside the PO's network when the member is a resident of a rural area with only one managed care entity.
  - vii. The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department.
  - viii. The development of a member-centered plan that is unacceptable to the member because any of the following apply.
    - a) The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member.
    - b) The plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes.
    - c) The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member.
  - ix. The involuntary disenrollment of the member from PACE at the PO's request.
  - x. The failure of the PO to act within the timeframes of this article for resolution of grievances or appeals.
- b. An "adverse benefit determination" is not:
- i. A change in provider;
  - ii. A change in the rate the PO pays a provider;
  - iii. A termination of a service that was authorized for a limited number of units of service or duration of a service as defined in Article V.K.3.a. and b.; or
  - iv. An adverse benefit determination that is the result of a change in state or federal law; however, a member does have the right to a



State Fair Hearing in regard to whether he/she is a member of the group impacted by the change.

2. *Appeal*

An “appeal” is a request for PO review of an “adverse benefit determination.” If a member is dissatisfied with the PO’s appeal decision, he or she can request a State Fair Hearing.

3. *Grievance*

“Grievance” is an expression of a member’s dissatisfaction about any matter other than an “adverse benefit determination.” If a member is dissatisfied with the PO’s grievance decision, he or she can request DHS Review of the decision.

When a member expresses dissatisfaction about any matter other than an adverse benefit determination, the member is expressing a grievance. As indicated under section F, the IDT staff will first attempt to resolve this grievance informally unless the member objects. If the IDT staff is unable to resolve the issue to the member’s satisfaction (or if the member objects) then IDT staff will refer the member to the Member Rights Specialist. The Member Rights Specialist will then assist the member in filing a formal grievance while simultaneously attempting to resolve the issue informally unless the member objects.

4. *Grievance and Appeal System*

The term “Grievance and Appeal System” refers to the overall system the PO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

5. *Fair Hearing*

A “fair hearing” means a de novo review under ch. HA 3, Wis. Admin. Code, before an impartial administrative law judge of an action by the Department, a county agency, a resource center, or PO.

**C. Overall Policies and Procedures for Grievances and Appeals**

1. *General Requirement*

The PO must resolve each grievance and appeal, and provide notice of a final decision, as expeditiously as the member’s health condition requires, within timeframes that may not exceed the Department-established timeframes specified in this article.

Only the PO adverse benefit determinations set forth in Article XI.B.1.a.i-ix. can be reviewed by the internal PO appeal process. Financial eligibility decisions and cost share calculations cannot be reviewed by the PO’s internal appeal system. The only means by which members may contest those decisions is through the State Fair Hearing process.



The policies and procedures used by the PO to resolve grievances and appeals shall be approved by the Department in initial certification and when any significant change in the PO's policies and procedures is made.

2. *One Level of Appeal*

The PO must only have one level of appeal and a member must exhaust this level of appeal before he or she can request a State Fair Hearing.

3. *Opportunity to Present Evidence*

A member shall have a reasonable opportunity, in person and in writing, to present evidence testimony and legal and factual arguments, in a PO grievance, PO appeal, or State Fair Hearing. In an expedited review, the PO must inform the member sufficiently in advance of the expedited appeal resolution timeframe described in Article XI.F.5.f of the limited time available to present evidence and testimony and make legal and factual arguments.

4. *Provision of Case File*

The PO must ensure that the member is aware that he or she has the right to access his or her case file, free of charge, and to be provided with a free copy of his or her case file. "Case file" in this context means all documents, records and other information relevant to the PO's adverse benefit determination and the member's appeal of that adverse benefit determination. This includes, but is not limited to, medical necessity criteria, functional screen results, any processes, strategies, or evidentiary standards used by the PO in setting coverage limits and any new or additional evidence considered, relied upon, or generated by the PO (or at the direction of the PO) in connection with the appeal of the adverse benefit determination. This information must be provided to the member sufficiently in advance of the appeal resolution timeframes described in Article XI.F.5.e and f.

5. *Cooperation with Advocates*

POs must make reasonable efforts to cooperate with all advocates a member has chosen to assist him or her in a grievance or appeal.

- a. As used here "advocate" means an individual whom or organization that a member has chosen to assist in articulating his or her preferences, needs and decisions.
- b. "Cooperate" means:
  - i. To provide any information related to the member's eligibility, entitlement, cost sharing, care planning, care management, services or service providers to the extent that the information is pertinent to matters in which the member has requested the advocate's assistance.
  - ii. To assure that a member who requests assistance from an advocate is not subject to any form of retribution for doing so.





- c. Nothing in this section allows the unauthorized release of member information or abridges a member's right to confidentiality.

6. *Reversed Appeal Decisions*

If the PO appeal process or State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished during the appeal, the PO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision.

If the PO appeal process, , or State Fair Hearing process reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, the PO must pay for those services.

7. *Continuation of Benefits While a PO Appeal or State Fair Hearing are Pending*

- a. Services shall be continued by the PO throughout the local PACE appeal process and State Fair Hearing process in relation to the initial adverse benefit determination if all of the following criteria are met:
  - i. The member files the request for an appeal timely in accordance with Section F.5.b of this article;
  - ii. The appeal involves the termination, suspension, or reduction of previously authorized services;
  - iii. The period covered by the original authorization has not expired;
  - iv. The member makes a timely request for continuation of benefits. A request for continuing benefits is timely if it is submitted on or before the effective date in a notice of adverse benefit determination or PACE appeal decision. If the member makes a timely request for continuation of benefits, the PO must continue the benefits even if a previously authorized time period or service limit is reached during the course of the appeal process.
- b. If, at the member's request, the PO continues or reinstates the member's services while the appeal or State Fair Hearing is pending, the services must be continued until one of the following occurs:
  - i. The member elects to withdraw the appeal or request for State Fair Hearing;
  - ii. The member fails to request a State Fair Hearing and continuation of benefits within ten (10) calendar days after the day the PO sends the notice of an adverse resolution to the member's appeal. In this context, sends means putting a hard copy notice in the mail or transmitting the notice to the member electronically.
  - iii. A State Fair Hearing decision is issued upholding the PO's reduction, suspension, or termination of services.



- c. A member does not have a right to continuation of benefits:
  - i. When grieving a change in provider that is the result of a change in the PACE provider network due to contracting changes; however, in such a situation the member does have a right to appeal on the basis of dissatisfaction with her/his MCP.
  - ii. When grieving adverse benefit determinations that are the result of a change in state or federal law; however, in such a situation a member does have the right to appeal whether he/she is a member of the group impacted by the change.
- d. If the final resolution of the appeal or State Fair Hearing, excluding eligibility appeals, is adverse to the member (i.e. upholds the PO's adverse benefit determination), the PO may recover the cost of services continued solely because of the requirements of this section. The Department or the PO may waive or reduce the member's liability if the Department or PO determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided.

#### **D. Notice of Adverse Benefit Determination**

##### *1. Requirement to Provide Notice of an Adverse Benefit Determination*

The PO must provide written notice of an adverse benefit determination in the situations listed below.

The PO must use the Department and/or CMS issued notice of adverse benefit determination form: <https://www.dhs.wisconsin.gov/forms/f00950a.docx> . The notice of adverse benefit determination may be mailed or hand delivered. An oral or e-mail notice or reference to information in the member handbook or other materials does not meet the requirement to provide notice of adverse benefit determination.

##### *a. Denial in Whole or in Part of a Request for Service*

The PO must mail or hand deliver written notice of adverse benefit determination <https://www.dhs.wisconsin.gov/forms/f00950a.docx> to an affected member when the PO intends to deny in whole or in part a request for a service.

The PO is required to inform members in writing when a request for an excluded service is denied. The PO must utilize DHS' Notification of Non Covered Benefit template (<https://www.dhs.wisconsin.gov/forms/f00950a.docx>) and must maintain a copy of the completed form in the member's file.

Denial of a request for an item meeting the definition of medical equipment or appliances (Article I. 82 or medical supplies Article I.83) shall be treated by the PO as a denial of a service regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the



Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the PO.

b. Reduction, Suspension or Termination of a Previously Authorized Service

The PO must mail or hand deliver advance written notice of adverse benefit determination <https://www.dhs.wisconsin.gov/forms/f00950a.docx> to an affected member when the PO intends to reduce, suspend or terminate any service.

c. Denial of Payment for a Service

The PO must mail or hand deliver written notice of adverse benefit determination <https://www.dhs.wisconsin.gov/forms/f00950a.docx> to an affected member when the PO intends to deny a member's request for payment of a service.

The PO is required to inform members in writing when a request for payment of an excluded service is denied. The PO must utilize DHS' Notification of Non Covered Benefit template (<https://www.dhs.wisconsin.gov/library/f-01283.htm>) and must maintain a copy of this completed form in the member's file.

Denial of payment for an item meeting the definition of medical equipment or appliances (Article I.82) or medical supplies (Article I.83) shall be treated by the PO as a denial of a service regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the PO.

2. *Documentation of Notice of Adverse Benefit Determination*

The PO is required to maintain a copy of any notice of adverse benefit determination required in Article XI.D.1. in the member's paper or electronic record.

3. *Language and Format Requirements for Notice of Adverse Benefit Determination*

A notice of adverse benefit determination required in Article XI.D.1. must be in writing. A notice of adverse benefit determination must use easily understood language and format. It must include a statement that written or oral interpretation is available for individuals who speak non-English languages and indicate how such interpretation can be obtained. A notice of adverse benefit determination must meet the language and format requirements of 42 C.F.R. § 438.10(d) and 42 C.F.R. § 438.404 to ensure ease of understanding.

4. *Content of Notice of Adverse Benefit Determination*

The PO will use the DHS issued notice of adverse benefit determination form (<https://www.dhs.wisconsin.gov/forms/f00950a.docx>) required in Article XI.D.1.



The notice must include the date the notice is mailed or hand delivered and explain the following:

- a. The adverse benefit determination the PO or its contractor has taken or intends to take, including the effective date of the adverse benefit determination.
- b. The reason(s) for the adverse benefit determination.
- c. Any laws that support the adverse benefit determination.
- d. The right of the member or any other legal decision maker to request an appeal with the PO of the adverse benefit determination.
- e. The right of the member or any other legal decision maker to request a State Fair Hearing after the member appeals the PO's adverse benefit determination and receives notice that the adverse benefit determination has been upheld by the PO or the PO fails to adhere to the notice and timing requirements described in Article XI.F.5.e. and f. or when the member's request has been automatically processed as an appeal in compliance with 42 CFR 460.122 (i.e. the member is deemed to have exhausted the PO's appeal process).
- f. The procedures for exercising the rights specified in this paragraph, including appropriate phone numbers and addresses.
- g. The member's right to appear in person before the PO grievance and appeal committee.
- h. The circumstances under which expedited resolution is available and how to request it.
- i. The availability of independent advocacy services and other local organizations that might assist the member in an PO grievance or appeal, Department grievance review or State Fair Hearing.
- j. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination and how to obtain copies. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits.
- k. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to re-pay the costs of these continued services.



5. *Timing of Notice of Adverse Benefit Determination*

The PO must mail or hand deliver the notice of adverse benefit determination required in Article XI.D.1. as expeditiously as the member's condition requires and within the following timeframes:

- a. Service Authorization Decisions in Response to a Request for Service
  - i. Standard Service Authorization Denials or Limitations: For standard service authorization decisions that deny or limit a requested service the PO must mail or hand deliver a notice of adverse benefit determination within 72 hours of the request unless the PO extends the timeframe. The PO may extend the timeframe by up to five (5) additional calendar days (for a total timeframe of eight (8) calendar days) if the member or provider requests the extension or the PO justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest

If the timeframe is extended, the PO must mail or hand deliver a written notification of extension to the member no later than 72 hours after the original request. The notification of extension must inform the member:

- a) Of the reason for the extension;
  - b) That the member may file a grievance if dissatisfied with the extension, in which case the extension will be considered a denial, and
  - c) That the member may contact the Member Rights Specialist for assistance.
- ii. A service authorization decision that is not reached within the timeframes specified in paragraphs i. or ii. constitutes a denial. In such situations, the PO must send a notice of adverse benefit determination and automatically process the member's request as an appeal as soon as the timeframes have expired.

b. Termination, Suspension Or Reduction of Services

For termination, suspension, or reduction of previously authorized services, the PO must mail or hand deliver a notice of adverse benefit determination <http://www.dhs.wisconsin.gov/library/f-00232.htm> with an effective date of implementation not less than fifteen (15) calendar days from the date of the notice of adverse benefit determination. This includes five (5) mailing days to ensure that member receives the notice of adverse benefit determination ten (10) days before the effective date of the adverse benefit determination.



In the following circumstances the fifteen (15) calendar day advance notice of adverse benefit determination is not required:

- i. Notice of adverse benefit determination is required five (5) calendar days in advance

The period of advance notice is shortened to five (5) calendar days if probable member fraud has been reported to the county, DHS or DOJ Medicaid Fraud Unit.

- ii. No advance notice of adverse benefit determination is required

In the following circumstances, the PO may take action to immediately reduce or terminate a member's service. The PO shall mail or hand deliver a notice of adverse benefit determination to the member at the same time it takes such an adverse benefit determination in the following circumstances.

- a) The member has requested, in writing, the termination or reduction of service(s). The written request and termination or reduction must be documented in the member's record.
- b) The member has provided information that will require termination or reduction of services and has indicated in writing that s/he understands that will be the result of supplying that information.
- c) An immediate change in the plan of care, including the reduction or termination of a service, is necessary to assure the safety or health of the member or other individuals.

- iii. No notice of adverse benefit determination is required

The PO is not required to provide notice of adverse benefit determination when terminating services when a member is disenrolled.

- c. Denial of Payment

For denial of payment, the PO must mail or hand-deliver a notice of adverse benefit determination on the date of the denial.

## **E. Notification of Appeal Rights in Other Situations**

1. *Requirement to Provide Notification of Appeal Rights*

The PO must provide members with written notification of appeal and grievance rights in the following circumstances.

- a. Change in Level of Care from Nursing Home to Non-Nursing Home

Members whose level of care changes from the nursing home level of care to the non-nursing home level of care must receive a written notice that



clearly explains the potential impact of the change, the member's right to request a functional eligibility re-screening, the member's right to appeal with the PO and the member's right to request a State Fair Hearing following the PO's appeal decision or the PO's failure to issue a decision within the timeframes specified in Article XI.F.5.e. and f. The PO shall provide for functional eligibility re-screening by a different screener within ten (10) calendar days of a request by a member or a member's legal decision maker. The PO must mail or hand deliver the Department issued notice of change in level of care form

<https://www.dhs.wisconsin.gov/library/f-01590.htm> when the PO administers a long-term care functional screen that results in a reduction of the member's level of care from "nursing home" to "non-nursing home," as identified in Article XI.B.1.a.i.

The PO does not need to provide notification of change in level of care if the member is found to no longer meet the nursing home level of care because the ForwardHealth interchange system will automatically issue a Notice of Less of Functional Eligibility to the member which includes an explanation of the member's appeal rights.

b. Adverse PO Grievance or Appeal Decision

When the PO makes a decision in response to a member's grievance or appeal that is entirely or partially adverse to the member it must on the date of the decision mail or hand deliver a written notification to the member of the reason for the decision and any further grievance or appeal rights. For appeal decisions, the PO shall use the following Department mandated templates:

i. PO decision is upheld:

<https://www.dhs.wisconsin.gov/library/f-00232e.htm>

ii. PO decision is reversed:

<https://www.dhs.wisconsin.gov/library/f-00232d.htm>

iii. PO notification of extension for decision:

<https://www.dhs.wisconsin.gov/library/f-00232b.htm>

c. Involuntary Disenrollment of the Member from PACE at the PO's Request

PO requested disenrollments must be approved by the Department. When the Department approves a PO requested disenrollment, the ForwardHealth interchange system will automatically issue a Notice of Disenrollment to the member which includes an explanation of the member's appeal rights.

d. Other Adverse Benefit Determinations

A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.vii.-ix. The PO shall mail or hand deliver to





the member a written notification of the right to appeal these adverse benefit determinations with the PO and the right to request a State Fair Hearing following the PO's appeal decision or the PO's failure to issue a decision within the timeframes specified in Article XI.F.5.e and f.

2. *Documentation of Notification of Appeal Rights*

The PO is required to maintain a copy of any notification of appeal rights required in Article XI.E.1. in the member's paper or electronic record.

3. *Timing of Notification of Appeal Rights*

a. Loss or Change of Functional Eligibility

When administration of the long-term care functional screen results indicate the member no longer meets the nursing home level of care, the PO will verify the results and request a review for deemed eligibility be completed by DHS. The PO must continue to provide services until the final determination is made. After the deemed eligibility determination is made, the screen will also be updated in CARES and automatically updated in ForwardHealth interChange.

i. If the functional screen results in a complete loss of functional eligibility for the program and the member is not deemed eligible, the member will be automatically disenrolled in ForwardHealth interChange and the interChange system will automatically issue a Notice of Loss of Functional Eligibility to the member. The PO must continue to provide services until the date of disenrollment.

b. Adverse PO Grievance or Appeal Decision

i. Grievances

The PO must mail or hand-deliver a written decision regarding a grievance to the member and the member's legal decision maker, if applicable, within the timeframes specified in Article XI.F.4.e. When the PO's decision is entirely or partially adverse to the member, the decision must include the reason for the decision and the member's rights to request DHS review of the PO's grievance decision.

ii. Appeals

The PO must mail or hand-deliver a written decision regarding an appeal to the member and the member's legal decision maker, if applicable, within the timeframes specified in Article XI.F.5.e and f. When the PO's decision is entirely or partially adverse to the member, the decision must include notice of the member's right to request a State Fair Hearing. The notification shall establish the effective date of the implementation of the decision not less than fifteen (15) calendar days from the date of the notification.



c. Other Adverse Benefit Determinations

A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.vii.-viii. On the date it becomes aware of any such adverse benefit determination, the PO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations.

**F. PACE Organization Grievance and Appeal Process**

The PO grievance and appeal process must meet the following requirements.

1. *Assistance in Filing a Grievance or Appeal*

The Member Rights Specialist assigned to assist a member in a specific circumstance may be responsible for scheduling and facilitating meetings, but may not be a member of the PO grievance and appeal committee that considers that specific circumstance. The Member Rights Specialist may not represent the PO at a hearing of the PO grievance and appeal committee, or at a State Fair Hearing.

- a. The interdisciplinary team is the first level of support when a member is dissatisfied. Unless contrary to the expressed desire of the member, the IDT will attempt to resolve the issue through internal review, negotiation, or mediation, if possible. If the IDT cannot resolve the issue, it will refer the member to the Member Rights Specialist or offer assistance to the member or legal decision maker who wishes to file a grievance or appeal.
- b. The PO must provide members with any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, assistance with committing an oral grievance or appeal to writing and providing auxiliary aids and services upon request (such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability).
- c. The PO must allow members to involve anyone the member chooses to assist in any part of the grievance and appeal process, including informal negotiations.

2. *Grievance and Appeal Decision Makers*

The PO must ensure that the PO grievance and appeal committee is comprised of:

- a. Individuals who were not involved in any previous level of review or decision making. A subordinate of an individual who was involved in a previous level of review or decision making may not be included in the PO grievance and appeal committee;
- b. At least one member or guardian, or one person or guardian of a person, who meets the functional eligibility for one of the target populations



served by the PO. This person must be free from conflict of interest regarding his/her participation in the governing board/committee;

- c. Individuals who, if deciding any of the following, are health care professionals possessing the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease:
  - i. An appeal of an adverse benefit determination that is based on lack of medical necessity.
  - ii. A grievance regarding denial of expedited resolution of an appeal.
  - iii. A grievance or appeal that involves clinical issues.
- d. Individuals who will take into account all comments, documents, records, and other information submitted by the member or the member's legal representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

3. *Confidentiality*

The PO shall assure the confidentiality of any member who uses the grievance and appeal process is maintained, including:

- a. Assuring that all members of the grievance and appeal committee have agreed to respect the privacy of members who bring a grievance or appeal before the committee and have received appropriate training in maintaining confidentiality.
- b. Offering a member the choice to exclude any consumer representatives under Article XI.F.2.b. from participation in a hearing on a matter the member is bringing before the grievance and appeal committee.

4. *PACE Organization Process for Medicaid Grievances*

a. Authority to File

A member or a member's legal decision maker or anyone acting on the member's behalf with the member's written permission may file a grievance with the PO.

b. Timing of Filing

A grievance can be filed with the PO at any time.

c. Acknowledgement of Grievance Receipt

The PO must acknowledge in writing receipt of each grievance. The PO's written acknowledgment must include Department issued template language providing the date by which the PO will make a decision on the member's grievance and explaining that the member can request Department Review of the grievance if the PO does not provide the member with its decision by that date. The acknowledgement must be provided to the member, person acting on the member's behalf or the



member's legal decision maker if applicable and must be mailed or hand delivered within five (5) business days of the date of receipt of the grievance. (See Article XI.F.4.a. for a description of individuals who may be authorized to submit a grievance.)

d. Procedures

- i. A grievance may be filed either orally or in writing with the PO. In order to establish the earliest possible filing date for the grievance, the PO must document all grievances whether received orally or in writing.
- ii. Unless contrary to the expressed desire of the member, the PO must attempt to resolve all grievances through internal review, negotiation, or mediation.
- iii. A grievance that cannot be resolved through internal review, negotiation, or mediation, must be reviewed by the PO grievance and appeal committee.
- iv. A member who files a grievance must be given the right to appear in person before the PO grievance and appeal committee or its designee.

e. Grievance Resolution Timeframe

- i. The PO grievance and appeal committee must mail or hand-deliver a written decision on a grievance to the member and the member's legal decision maker, if applicable, as expeditiously as the member's situation and health condition require, but no later than ninety (90) calendar days after the date of receipt of the grievance. This timeframe for resolution may be extended by up to fourteen (14) calendar days, up to a total of one hundred and four (104) calendar days if:
  - a) The member requests the extension; or
  - b) The PO demonstrates (to the satisfaction of the Department, upon the Department's request) that there is a need for additional information and how the delay is in the member's interest.
- ii. For an extension not requested by the member, the PO must:
  - a) Make reasonable efforts to give the member prompt oral notice of the delay; and
  - b) Within two (2) calendar days mail or hand deliver to the member (and the Department if requested) written notice which includes: the reason for the decision to extend the timeframe, the member's right to file a grievance if he/she disagrees with that decision, Department issued template



language providing the date by which the PO will make a decision on the member's appeal and an explanation that the member can request a Department Review if the PO does not provide the member with its decision by that date; and

- c) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

f. Content of Grievance Resolution Decision

The written decision must include the results and date of the decision. For decisions not wholly in the member's favor the notice must include the right to request a Department Review and how to do so.

5. *PACE Organization Process for Appeals*

a. Authority to File

- i. A member or a member's legal decision maker or anyone acting on the member's behalf with the member's written permission may file an appeal with the PO regarding any PO adverse benefit determination, with the exception of the adverse benefit determinations specified in Article XI.F.5.a.ii.
- ii. There is no PO level appeal for loss of financial eligibility under Wis. Stat. § 46.286(1)(a) or calculation of a cost share under Wis. Stat. § 46.286(2).

A member or member's legal decision maker or anyone acting on the member's behalf with the member's written permission may request a State Fair Hearing regarding loss of financial eligibility or calculation of cost share.

- iii. There is no right to a PO level appeal of a decision that has been issued by the PO grievance and appeal committee or an administrative law judge as the result of a State Fair Hearing.

b. Timing of Filing

An appeal must be filed within sixty (60) calendar days of the date on the adverse benefit determination notice.

c. Acknowledgement of Appeal Receipt

The PO must acknowledge in writing receipt of each appeal. The PO's written acknowledgment must include Department issued template language providing the date by which the PO will make a decision on the member's appeal and explaining that the member can request a State Fair Hearing if the PO does not provide the member with its decision by that date. The acknowledgement must be provided to the member, person



acting on the member's behalf or the member's legal decision maker, if applicable, and must be mailed or hand delivered within five (5) business days of the date of receipt of the appeal. See Article XI.F.5.a.i. for a description of individuals who may be authorized to submit an appeal.

d. Procedures

- i. An appeal may be filed either orally or in writing with the PO. However, for standard appeals, the individual must follow an oral filing with a written, signed appeal. In order to establish the earliest possible filing date for the appeal, the PO must document all appeals whether received orally or in writing. The PO will process oral requests for expedited appeals without requiring further action of the member.
- ii. Unless contrary to the expressed desire of the member, the PO must attempt to resolve all appeals through internal review, negotiation, or mediation.
- iii. An appeal that cannot be resolved through internal review, negotiation, or mediation, must be reviewed by the PO grievance and appeal committee.
- iv. A member who files an appeal must be given the right to appear in person before the grievance and appeal committee.
- v. The PO grievance and appeal committee will make its determinations related to authorization of services based on whether services are necessary to support outcomes as defined in Article I, Definitions.
- vi. The PO grievance and appeal committee must make a decision on an appeal as expeditiously as the member's situation and health condition requires. The PO must mail or hand deliver notification of the decision with an effective date of implementation of the decision not less than fifteen (15) calendar days from the date of the decision.

e. Standard Appeal Resolution Timeframe

- i. Unless the member requests expedited resolution, the PO must mail or hand-deliver a written decision on the appeal no later than thirty (30) calendar days after the date of receipt of the appeal. This timeframe for resolution may be extended by up to fourteen (14) calendar days, up to a total of forty-four (44) calendar days if:
  - a) The member requests the extension; or
  - b) The PO demonstrates (to the satisfaction of the Department, upon the Department's request) that there is



- need for additional information and how the delay is in the member's interest.
- ii. For an extension not requested by the member, the PO must:
    - a) Make reasonable efforts to give the member prompt oral notice of the delay; and
    - b) Within two (2) calendar days, mail or hand deliver to the member (and the Department, if requested) written notice which includes: the reason for the decision to extend the timeframe, the member's right to file a grievance if he/she disagrees with that decision, Department issued template language providing the date by which the PO will make a decision on the member's appeal and an explanation that the member can request a State Fair Hearing if the PO does not provide the member with its decision by that date; and
    - c) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires..
  - f. Expedited Appeal Resolution Timeframe
    - i. Members may request an expedited resolution if the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function. The PO must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days.

If the PO denies a request for expedited resolution this written notice must inform the member of his/her right to file a grievance if he or she disagrees with the PO's decision. When the PO denies a request for expedited resolution, it must reach a decision on the appeal within the standard timeframe.

If the request for expedited resolution meets the criteria in this subsection, the PO must make reasonable efforts to orally communicate its decision resolving the appeal to the member and mail or hand-deliver its decision as expeditiously as the member's health condition requires, but not more than seventy-two (72) hours after the date of receipt of the appeal. The timeframe for an expedited appeal may be extended by an additional fourteen (14) calendar days, up to a total of seventeen (17) calendar days if:

      - a) The member requests the extension; or





- b) The PO demonstrates (to the satisfaction of the Department, upon the Department's request) that there is need for additional information and how the delay is in the member's interest.
    - ii. For an extension not requested by the member, the PO must:
      - a) Make reasonable efforts to give the member prompt oral notice of the delay; and
      - b) Within 2 calendar days, mail or hand deliver to the member (and the Department, if requested) written notice of the reason for the decision to extend the timeframe and the member's right to file a grievance if he/she disagrees with that decision; and
      - c) Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
    - iii. In an expedited review, the PO must inform the member sufficiently in advance of the expedited resolution timeframes of the limited time available to present evidence and testimony and make legal and factual arguments. The PO must ensure that punitive action is not taken against a member or provider who either requests an expedited resolution or supports a member's request for an expedited resolution.
  - g. Content of Appeal Resolution Decision

The PO grievance and appeal committee must mail or hand deliver written notice of its appeal decision to the member and, if applicable, the member's legal decision maker. The written decision must include the results and date of the decision. For decisions not wholly in the member's favor the notice must include the right to request a State Fair Hearing and how to do so and the right to continue to receive benefits pending a hearing and how to request the continuation of benefits, and that the member may be liable for the cost of any continued benefits if the PO's decision is upheld in the State Fair Hearing.
  - h. Deemed Exhaustion of Appeals Process

If the PO fails to issue a written decision within the timeframes described in Article XI.F.5.e. and f or according to the notice content requirements described in Article XI.F.5.g., the member is deemed to have exhausted the PO's internal appeals process and may request a State Fair Hearing.
6. *Parties to the Appeal*
- The parties to the PO appeal shall include, as applicable:
- a. The member and his/her legal decision maker; or



- b. The legal representative of a deceased member's estate.

## **G. The Department Review Process**

The Department Review process consists of two components: The formal review of PO grievance decisions when requested by a member and the informal review of all State Fair Hearing requests made by members. The PO will participate in the Department Review Process.

### *1. Grievance Review Process*

- a. If a member files a grievance with the PO and is dissatisfied with the PO's decision regarding the grievance (or the PO fails to make a grievance decision within the required timeframe), the member may request that the Department review the PO's grievance decision.

The Department shall complete a timely review, investigation and analysis of the facts surrounding the member grievance and issue a written, binding decision.

- b. Unless the member and the Department agree to an extension for a specified period of time, the Department has thirty (30) calendar days from the date of receipt of a request for review from a member in which to issue its written, binding grievance decision.
- c. If the Department determines that it needs more than thirty (30) calendar days to issue a decision then it must send the member a written notice which includes:
  - i. The reason for the need for additional time;
  - ii. The amount of additional time needed;
  - iii. The right of the member to deny the Department's request for an extension, in which case the PO's grievance decision is the final decision.
- d. If, during the course of its grievance review, the Department determines that the PO failed to act within the requirements of this contract, the Department may order the PO to take corrective action. The PO shall comply with any corrective action required within the timeframes established by the Department.
- e. The PO shall provide the Department or its delegate with all requested documentation to support the review process within five (5) calendar days of the date of receipt of the request.
- f. The member must file the request for grievance review within forty-five (45) calendar days of the receipt of the PO's written decision regarding the member's grievance or if the PO fails to adhere to the timing requirements described in Article XI.F.4.e within forty-five (45) calendar days from the date the applicable timeframe expires.



- g. The Department will mail or hand deliver to the member and the PO its written, binding decision within seven (7) calendar days of the completion of the grievance review.
2. *Informal Review of State Fair Hearing Requests*
  - a. Whenever the Department receives notice from the Department of Administration's Division of Hearings and Appeals that it has received a State Fair Hearing request, the Department will conduct an informal review of the request.
  - b. The purpose of informal review is to identify, and, as appropriate, intervene in, appeals related to member health and safety, DHS-PACE contract non-compliance and complex situations, if it appears to the Department that informal resolution of the matter may be appropriate.
  - c. If, during the course of its informal review, the Department determines that the PO failed to act within the requirements of this contract, the Department may order the PO to take corrective action. The PO shall comply with any corrective action required within the timeframes established by the Department.

## **H. The State Fair Hearing Process**

The PO will participate in the State Fair Hearing Process.

### *1. Request for State Fair Hearing*

A member, immediate family member, or someone with legal authority to act on the member's behalf (as specified in s. HA 3.05(2), Wis. Admin. Code) can file a request for a State Fair Hearing in response to the adverse benefit determinations listed under Article XI.B.1.a. below.

After the member has received written notice under Article XI.E.1.b that the PO is upholding its adverse benefit determination or after the PO has failed to issue a decision within the applicable timeframe specified under Article XI.F.5.e. or f. (i.e. the member is deemed to have exhausted the PO internal appeals process).

### *2. Time Limits for Requesting a State Fair Hearing*

For the adverse benefit determination described above, the member must file the request for a State Fair Hearing within ninety (90) calendar days of the date of receipt of written notice from the PO that the adverse benefit determination is upheld or, if the PO fails to adhere to the notice and timing requirements described in Article XI.F.5.e-g., within ninety (90) calendar days from the date the applicable timeframe expires..

### *3. PACE Organization Response*

When it is notified by the Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) that a member has requested a State Fair Hearing, the PO must submit an explanation of its actions within ten (10) calendar days to



DHA. A copy of this explanation must also be sent to the member, the member's legal decision maker if known and to the Department if requested by the Department.

4. *Participation of PACE Organization Representative at State Fair Hearing*

The PO will assure that a representative of the PO participates in State Fair Hearings if:

- a. Any PO adverse benefit determination described in Article XI.B. is being appealed; or
- b. The PO has knowledge that the issue being appealed concerns the member's cost share and the PO has relevant information likely to help the Administrative Law Judge reach a decision.
- c. The PO representative will be prepared to
  - i. Represent the PO's position;
  - ii. Explain the rationale and authority for the PO adverse benefit determination that is being appealed;
  - iii. Accurately reference and characterize any policies and procedures in this contract related to the adverse benefit determination that is being appealed; and
  - iv. Accurately reference and characterize any specific PO policies and procedures related to the adverse benefit determination that is being appealed.

5. *Timeline for Resolution of State Fair Hearing*

The Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) is required to make a decision through the State Fair Hearing process within ninety (90) calendar days of the date a member files a request for the hearing.

6. *Parties to the State Fair Hearing*

The parties to the State Fair Hearing include, as applicable:

- a. The member and his/her legal decision maker;
- b. The legal representative of a deceased member's estate;
- c. The Department; and
- d. The PO.

7. *State Fair Hearing Decision*

Any formal decision made through the State Fair Hearing process under this section, shall be subject to member appeal rights as provided by State and federal



laws and rules. The State Fair Hearing process will include receiving input from the member and the PO in considering the appeal.

8. *Access to Services*

If the PO's decision to deny or limit a service is reversed through the State Fair Hearing process, the PO shall authorize or provide the service promptly and as expeditiously as the member's situation or health condition requires, but no later than 72 hours from the date it receives the State Fair Hearing decision reversing the determination.

**I. Documentation and Reporting**

The PO must maintain records of member grievances and appeals. Each record must be adequately maintained in an accessible manner and be made available upon request to the State and CMS. The documentation and reporting required in this article regarding grievances and appeals provide the basis for monitoring by the PO and the Department. The PO and the Department shall review grievance and appeal information as part of its ongoing monitoring procedures and overall quality management strategies.

1. *Content of Grievance and Appeal Records*

The record of each grievance or appeal must contain, at a minimum, all of the following information:

- a. Whether the issue is a grievance or an appeal;
- b. A general description of the reason for the appeal or grievance;
- c. The date the appeal or grievance was received by the PO;
- d. The date receipt of the appeal or grievance was acknowledged by the PO;
- e. The date(s) of any formal or informal reviews or meetings;
- f. The date on which the grievance or appeal was resolved through internal review, negotiation, or mediation or the date a decision was issued by the local grievance and appeal committee;
- g. A summary of the internal review, negotiation or mediation resolution or local grievance and appeal committee decision;
- h. Whether the member's request was upheld by a local committee decision, whether the member's request was partially upheld or whether the committee agreed with the PO decision or response to a grievance or appeal;
- i. Whether a disenrollment occurred during the course of the grievance or appeal or within fourteen (14) calendar days of receipt of a committee decision, and if so, the reason for the disenrollment; and
- j. Name of the member for whom the appeal or grievance was filed.



2. *Confidentiality of Grievance and Appeal Records*

The PO shall keep grievance and appeal records confidential in accordance with Article XIII.A., Member Records.

3. *Retention of Grievance and Appeal Records*

The PO shall retain the documents related to each grievance and appeal in accordance with Article XIV.F., Records Retention.

4. *Notice of Adverse Decisions to the Department*

a. *Applicability*

The notice of adverse decision requirements described in paragraph b. apply only to the following PACE organizations:

- i. Any PO that is in its first year of operation.
- ii. Any PO, after the first year of operation, that has been identified by the Department as needing to comply with the requirements described in paragraph b. The Department will make this determination based on the PACE organization's quality review, quarterly reports, and other factors.

b. *Required Submission*

If the PO makes a decision on a grievance or appeal that is entirely or partially adverse to the member, the PO shall submit the decision to the Department no later than twenty (20) business days after the PO mails or hand-delivers the written decision. In addition, for adverse appeal decisions, the PO must notify CMS at the time the decision is made.

Supporting documentation shall include:

- i. Any transcript and minutes of the PO Appeal and Grievance Committee related to the grievance or appeal, including a list of committee members;
- ii. List of the attendees at the hearing;
- iii. Documentation of Resource Allocation Decision (RAD) or other Department approved authorization process, relating to the decision being grieved or appealed;
- iv. Any notices of adverse benefit determination related to the decision;
- v. Any case notes that are pertinent to the grievance and its decision;
- vi. Any other documents, such as physical therapy notes, that would support the team decision; and
- vii. Copies of evidence presented by the member/ representative.



5. *Quarterly Grievance and Appeal Reports*

The PO shall submit to the Department a quarterly grievance and appeal report as specified in Article XIV.C.3. which consists of a summary and a log, as follows:

a. Summary

The summary shall be an analysis of the trends the PO has experienced regarding types of issues appealed and grieved through the local PO process, the DHS process and the State Fair Hearing process. In addition, the summary should identify whether specific providers are the subject of grievances or appeals. If the summary reveals undesirable trends, the PO shall conduct an in-depth review, report the results to DHS, and take appropriate corrective action.

b. Log

POs must use the Department approved appeal log:  
<https://www.dhs.wisconsin.gov/library/f-02466.htm>





## XII. Quality Management (QM)

### A. Leadership and Organization of the QM Program

#### 1. *Responsibility for the QM Program*

The PO's quality management (QM) program shall be administered through clear and appropriate administrative structures, such that:

- a. The governing board oversees and is accountable for the QM program;
- b. The manager responsible for implementation of the QM plan has direct authority to deploy the resources committed to it;
- c. Responsibility for each aspect of the QM program shall be clearly identified and assigned;
- d. A quality management committee or other coordinating structure that includes both administrative and clinical personnel shall exist to facilitate communication and coordination among all aspects of the QM program and between other functional areas of the organization that affect the quality of service delivery and clinical care (e.g., utilization management, risk management, appeals and grievances, etc.).

#### 2. *Member Participation*

- a. The PACEMember Advisory Committee in Article II.C shall be a means for members to participate in the QM program and the PO shall actively encourage and support the participation of members and other community individuals who represent the PO's target population(s).
- b. The PO shall keep documentation, e.g., minutes of attendance at QM committee meetings or correspondence, that documents the level of member and community participation in the QM program, and make this documentation available to the Department upon request.

#### 3. *Staff and Provider Participation*

- a. The PO shall create a means for PO staff and providers, including attendants, informal caregivers, and long-term care and health care providers with appropriate professional expertise to participate in the QM program and shall actively encourage that participation.
- b. The PO shall keep documentation, e.g., minutes of attendance at QM committee meetings or correspondence, that documents the level of staff and provider participation in the QM program, and make this documentation available to the Department upon request.

#### 4. *Accreditation*

- a. A PO must inform the Department before each calendar year whether it has been accredited by a private independent accrediting entity. The



following validation documentation must be submitted to:  
[DHSBMC@wisconsin.gov](mailto:DHSBMC@wisconsin.gov):

- i. Accreditation status;
  - ii. Accrediting entity, as applicable;
  - iii. Survey type, and level, as applicable;
  - iv. Accreditation results, that include: recommended actions or improvements, corrective action plans, and summaries of findings and expiration date of accreditation.
- b. The Department will publish on its website the accreditation status of each PO, and if applicable, the name of the accrediting entity, accreditation program and accreditation level.

## **B. QM Annual Workplan and Evaluation**

### *1. Creation and Approval of an Annual QM Workplan*

Each year, the PO's governing board or its designee shall approve a written QM workplan that outlines the scope of activity and the goals, objectives, timelines, and responsible person for the QM workplan for the contract period, and contains evidence of the PO's commitment of adequate resources to carry out the program. The PO's annual QM plan shall be based on findings from quality assurance and improvement activities included in the QM program.

### *2. Annual Evaluation and Revision*

The PO shall evaluate the overall effectiveness, including the impact, of its QM program annually to determine whether the program has achieved significant improvement, where needed, in the quality of service provided to its members.

### *3. PACE Quality Reports*

The PO shall submit to the Department any quality reports that it submits to CMS pursuant to Medicare regulations for SNPs or PACE.

## **C. Activities of the QM Program**

*Explanatory Material:* The QM program will assess and improve the quality of care and services provided through PACE staff and through its contracted providers. The purposes of this program include:

- Potential problem identification through ongoing monitoring efforts;
- Identification of quality-related problems and causes;
- Evaluation of problems to determine severity and whether or not further study is warranted by audit or other means;
- Evaluation of care management practice of members identified as vulnerable/high risk members by audit or other means;
- Design of activities to address deficiencies;



- Development and implementation of corrective action plans; and
- Conducting follow-up activities to determine whether identified quality issues have been corrected and whether care meets acceptable standards.

1. *Documentation of QM Activities, Findings, and Results*

The PO shall maintain documentation of the following activities of the QM program and have that documentation available for Department review upon request:

- a. The annual QM workplan and its approval by the governing board or its designee;
- b. Monitoring the quality of assessments and member-centered care plans;
- c. Monitoring the completeness and accuracy of completed functional screens;
- d. Monitoring the member's long term care and personal experience outcomes to ensure the setting in which the member resides supports integration into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community;
- e. Monitoring the results of care management practice related to the support provided to vulnerable/high risk members;
- f. Member satisfaction surveys;
- g. Provider surveys;
- h. Incident Management Systems;
- i. Appeals and grievances that were resolved as requested by the members;
- j. Monitoring of access to providers and verifying that the services were actually provided;
- k. Performance improvement projects;
- l. Results of the annual evaluation of the quality management program; and
- m. Monitoring the quality of sub-contractor services as noted in Article XVI., Contractual Relationship.

2. *Obtaining Member Feedback*

Annually, the Department or its designee shall survey each PO's membership or a representative sample of its enrolled members to identify their level of satisfaction with the PO's services. The PO shall cooperate with the Department or its designee to respond timely to requests for member information that is not available through state-level data systems (e.g., current mailing address) or verify



information provided by the Department. The Department or its designee shall compile the survey results for publication and distribution.

3. *Monitoring the Quality of Care Management*

The PO will conduct an ongoing program of reviews that collects evidence that:

- a. Appropriate risk assessments are performed on a timely basis;
- b. Members and legal decision makers when appropriate participate in the preparation of the care plan and are provided opportunities to review and accept it;
- c. Member-centered plans (MCP) address all participants' assessed needs (including health and safety risk factors) and outcomes;
- d. MCPs are updated and revised in accordance with the applicable standards for timeliness and when warranted by changes in the members' needs and outcomes;
- e. Services are delivered in accordance with the type, scope, amount, and frequency specified in the member-centered plan;
- f. Members are afforded choice among covered services and providers; and
- g. Overall member risk, including risk for VHRMs, is identified through assessment; appropriate interventions are documented on the MCP to mitigate risk.

4. *Monitoring the Quality of Services Provided by PO Staff*

- a. The PO shall operate a system for monitoring the quality of services provided by PACE staff.
- b. The PO shall adopt written standards and procedures to govern quality management for its functional screening activities and will upon request submit those that describe:
  - i. The PO methods employed to monitor the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by the PO or a PO contractor;
  - ii. The criteria employed to evaluate the accuracy, completeness, and timeliness of annual and change-in-condition screens submitted by the PO or a PO contractor;
  - iii. The process by which changes in condition are communicated by IDT staff to screeners who are not members of IDT staff; and
  - iv. The most recent results of the quality management monitoring of functional screen activities.



5. *Monitoring the Quality of Purchased Services*
  - a. The PO shall monitor the performance of providers and collect evidence that both licensed/certified providers and non-licensed/non-certified providers continuously meet required licensure, certification, or other standards and expectations, including those for:
    - i. Caregiver background checks;
    - ii. Education or skills training for individuals who provide specific services; and
    - iii. Reporting of member incidents to the PO.If the PO identifies deficiencies or areas for improvement, the PO and the provider(s) shall take corrective action.
  - b. The scope of activities of the QM program must also include review of the provision of health services by appropriate health professionals.
6. *Monitoring Restrictive Measures*

The PO shall have policies and procedures to ensure:

  - a. Review and decision on all requests for restrictive measures respective to its members prior to submission of the request to the designated state level approving entity unless the request is a concurrent review in which requests are submitted prior to the PO making a decision (see Article V.J.4.).
  - b. Maintenance of data related to all restrictive measures requests and decisions respective to its members regardless of the state level entity utilized for restrictive measures review and approval.
  - c. Education of all individuals involved in the administration of restrictive measures by the Department, designated restrictive measures expert(s), and/or designated competent PACE staff.
  - d. PO report of member restrictive measures data to the Department in accordance with the Department's restrictive measures report specifications. Member restrictive measures data is submitted to the Department on a quarterly basis as described in Article XIV.C.3. The report shall be submitted electronically as specified by the Department.
7. *Compiling and Using Quality and Performance Indicators*
  - a. In addition to the requirements in 42 C.F.R. §460.202, the PACE organization's health information system must:
    - i. Provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility;



- ii. Include systematic data collection relating to achievement of member outcomes;
    - iii. Produce performance indicators for internal use that are relevant and timely for quality-management purposes; and
    - iv. Provide for presentation and interpretation of the indicators to care managers and providers.
  - b. The PO shall submit performance indicators as specified in Addendum III, PO Quality Indicators.
- 8. *Utilization Review*
  - a. The QM program shall include processes to:
    - i. Monitor and detect underutilization and overutilization of services including services specified in 42 C.F.R. §460.134(a)(1).
    - ii. Assess the quality and appropriateness of care furnished to members.
  - b. For medical services, the documented policies and procedures for medical record content and utilization review of medical services shall reflect current standards of medical practice in processing requests for initial or continued authorization of services, and shall:
    - i. Be consistent with the utilization control requirement of 42 C.F.R. § 456, Utilization Control including:
      - a) Safeguards to prevent unnecessary or inappropriate use of Medicaid services available under this plan, and guard against excess payments;
      - b) Under-utilization and over-utilization of services to assure that members receive and have access to services that promote health and safety; and
      - c) Medical record content for hospitals and mental hospitals is consistent with the utilization control requirements of 42 C.F.R. § 456.111 and 42 C.F.R. § 456.211.
    - ii. Have appropriate health professionals reviewing the provision of health services;
    - iii. Provide for systematic data collection of performance and results; and
    - iv. Provide for making needed changes.



**D. Cooperation with the Department QM Program**

1. *Cooperation with Department Review*

The PO is subject to, at a minimum, an annual external independent review of quality outcomes, timeliness of, and access to, the services covered in the benefit package.

2. *The PO must assist the Department and the external quality review organization (EQRO) in identifying and collecting information required to carry out on-site or off-site reviews and interviews with PO staff, providers, and members*  
*Response to Department Findings*

In the event that a review by the Department results in findings that concern the Department, the PO will cooperate in further investigation or remediation, which may include:

- a. Revision of a care plan or any of its elements for correction, if found to be incomplete or unsatisfactory;
- b. Corrective action within a time frame to be specified in the notice, if the effect on the member is determined to be serious;
- c. Additional review by the Department or by the PO to determine the extent and causes of the noted problems; or
- d. Action to correct systemic problems that are found to be affecting additional members.





### XIII. PACE Organization Administration

#### A. Member Records

1. *In addition to the requirements in 42 C.F.R. § 460.200(d),(e), the PO shall:*

a. Duty of Non-Disclosure and Security Precautions

The PO shall protect and secure all confidential information and shall not use any confidential information for any purpose other than to meet its obligations under this contract. The PO shall hold all confidential information in confidence, and not disclose such confidential information to any persons other than those directors, officers, employees, agents, subcontractors and providers who require such confidential information to fulfill the PO's obligations under this contract. The PO shall institute and maintain procedures, including the use of any necessary information technology, which are necessary to maintain the confidentiality of all confidential information. The PO shall be responsible for the breach of this contract in the event any of the PO's directors, officers, employees, or agents fail to properly maintain any confidential information.

b. Limitations on Obligations

The PO's obligation to maintain the confidentiality of confidential information shall not apply to the extent the PO can demonstrate that such information:

- i. Is required to be disclosed pursuant to a legal obligation in any administrative, regulatory, or judicial proceeding. In this event, the PO shall promptly notify the Department of its obligation to disclose the confidential information (unless it has a legal obligation to the contrary) so that the Department may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, the PO shall furnish only that portion of the confidential information that is legally required and shall disclose it in a manner designed to preserve its confidential nature to the extent possible.
- ii. Is part of the public domain without any breach of this contract by the PO;
- iii. Is or becomes generally known on a non-confidential basis, through no wrongful act of the PO;
- iv. Was known by the PO prior to disclosure hereunder without any obligation to keep it confidential;
- v. Was disclosed to it by a third party which, to the best of the PO's knowledge, is not required to maintain its confidentiality;



- vi. Was independently developed by the PO;
- vii. Is the subject of a written agreement whereby the Department consents to the disclosure of such confidential information by the PO on a non-confidential basis; or
- viii. Was a permitted use or disclosure, in accordance with Wis. Stats. Chapter 49, Subchapter IV; Wis. Admin. Code § DHS 108.01; 42 C.F.R. 431, Subpart F; 42 C.F.R. 438; 45 C.F.R. 160; 45 C.F.R. 162; and 45 C.F.R. 164 or other applicable confidentiality laws.

c. *Unauthorized Use, Disclosure, or Loss*

If the PO becomes aware of any threatened or actual use or disclosure of any confidential information that is not specifically authorized by this contract, or if any confidential information is lost or cannot be accounted for, the PO shall notify the Privacy Officer in the Department's Office of Legal Counsel within one day of the PO becoming aware of such use, disclosure, or loss. The notice shall include, to the best of the PO's understanding, the persons affected, their identities, and the confidential information that was disclosed.

The PO shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The PO shall reasonably cooperate with the Department's efforts, if any, to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its confidential information, including complying with the following measures, which may be directed by the Department, at its sole discretion:

- i. Notifying the affected individuals by mail or the method previously used by the Department to communicate with the individual. If the PO cannot with reasonable diligence determine the mailing address of the affected individual and the Department has not previously contacted that individual, the PO shall provide notice by a method reasonably calculated to provide actual notice;
- ii. Notify consumer reporting agencies of the unauthorized release;
- iii. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the Department for one year from the date the individual enrolls in credit monitoring;
- iv. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as determined by the Department; and



v. Adequately staff customer service telephone lines to ensure an actual wait time of less than five (5) minutes for callers.

d. Indemnification

In the event of an unauthorized use, disclosure, or loss of confidential information, the PO shall indemnify and hold harmless the Department and any of its officers, employees, or agents from any claims arising from the acts or omissions of the PO, and its subcontractors, providers, employees, and agents, in violation of this section, including but not limited to costs of monitoring the credit of all persons whose confidential information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the Department in the enforcement of this section. In addition, notwithstanding anything to the contrary herein, the PO shall compensate the Department for its actual staff time and other costs associated with the Department's response to the unauthorized use, disclosure, or loss of confidential information.

e. Equitable *Relief*

The PO acknowledges and agrees that the unauthorized use, disclosure, or loss of confidential information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the Department, which injury will not be compensable by money damages and for which there is not an adequate remedy at law. Accordingly, the PO agrees that the Department, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this contract or under applicable law.

f. Sanctions

In the event of an unauthorized use, disclosure, or loss of confidential information, the Department may impose sanctions, in the form of civil monetary penalties, pursuant to the terms described in Article XVI.E.2.a.xiii. and Article XVI.E.2.d.v.

g. *Compliance Reviews*

The Department may conduct a compliance review of the PO's security procedures to protect confidential information.

2. *Medical Information Available to the PACE Organization*

The PO is a Contractor of the State and is therefore entitled to obtain records according to Wis. Admin. Code § DHS 104.01(3). The Department requires Medicaid-certified providers to release relevant records to the PO to assist in compliance with this section. Where the PO has not specifically addressed



photocopying expenses in their provider agreements or other arrangements, the PO is liable for charges for copying records only to the extent that the Department would reimburse on a fee-for-service basis.

3. *Maintain Complete Records*

Documentation in member records must reflect all aspects of care, including documentation of assistance with transitional care in the event of a disenrollment. Member records must be readily available for member encounters (encounter data via the LTCare IES), and for administrative purposes.

4. *Professional Standards*

The PO shall maintain, or require the PO's providers to maintain, individual member records in accordance with any applicable professional and legal standards.

5. *Provision of Records*

The PO shall make all pertinent information relating to the management of each member's medical and long-term care readily available to the Department. The PO shall provide this information to the Department at no charge. The PO shall have procedures to provide copies of records promptly to other providers for the management of the member's medical and long-term care, and the appropriate exchange of information among the PO and other providers receiving referrals.

6. *Records Available for Quality Management (QM) and Utilization Review*

Member records shall be readily available for PO-wide QM and utilization review activities. The member records shall provide adequate medical and long-term care service information, and other clinical data needed for QM and utilization review purposes, and for investigating member appeals and grievances.

7. *Record Retention*

Records must be retained in accordance with the requirements in Article XIV.F., Records Retention.

8. *Continuity of Records*

The PO shall have adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

9. *Contents of Member Records*

A member record shall contain at least the following items:

- a. Face sheet of demographic information;
- b. Consent forms;
- c. Comprehensive health assessment;
- d. Comprehensive social assessment;



- e. Documentation of re-assessment(s);
- f. Member-centered plan;
- g. Copy of advance directive document (if applicable);
- h. Copy of signed guardianship order (if applicable);
- i. Copy of activated power of attorney document (if applicable);
- j. Case notes by PACE interdisciplinary team members;
- k. Cost share forms/documentation (if applicable);
- l. Notice of change forms (if applicable);
- m. Signed enrollment request;
- n. Reports of consultations;
- o. Notification of the results or outcomes of an investigation described by Article V.J.5.b.xiii; and
- p. Copy or documentation of member's most up to date DVR coordination plan (if applicable).

Minimum member record documentation per chart entry or encounter must conform to the applicable provisions of Wis. Admin. Code § DHS 106.02(9).

## **B. Civil Rights Compliance/Affirmative Action Plan Requirements**

### 1. *Pace Organization*

#### a. Compliance Requirements

All POs must comply with the Department's Affirmative Action/Civil Rights Compliance requirements at <https://www.dhs.wisconsin.gov/civil-rights/index.htm>.

#### b. Affirmative Action Plan

As required by Wisconsin's Contract Compliance Law, Wis. Stat. § 16.765, the PO must agree to equal employment and affirmative action policies and practices in its employment programs:

The PO agrees to make every reasonable effort to develop a balance in either its total workforce or in the project-related workforce that is based on a ratio of work hours performed by handicapped persons, minorities, and women except that, if the department finds that the PO is allocating its workforce in a manner which circumvents the intent of this chapter, the department may require the PO to attempt to create a balance in its total workforce. The balance shall be at least proportional to the percentage of minorities and women present in the relevant labor markets based on data prepared by the department of industry, labor and human relations, the office of federal contract compliance programs or by another appropriate



governmental entity. In the absence of any reliable data, the percentage for qualified handicapped persons shall be at least 2% for whom the PO must make a reasonable accommodation.

The PO must submit an Affirmative Action Plan within fifteen (15) working days of the signed contract. Exemptions exist, and are noted in the Instructions for Contractors posted on the following website:  
<http://vendornet.state.wi.us/vendornet/contract/contcom.asp>.

The PO must submit its Affirmative Action Plan or request for exemption from filing an Affirmative Action Plan to:

Department of Health Services  
Division of Enterprise Services  
Bureau of Strategic Sourcing  
Affirmative Action Plan/CRC Coordinator  
1 West Wilson Street, Room 655  
P.O. Box 7850  
Madison, WI 53707  
[dhscontractcompliance@dhs.wisconsin.gov](mailto:dhscontractcompliance@dhs.wisconsin.gov)

c. Civil Rights Compliance (CRC)

As required by Wis. Stat. § 16.765, in connection with the performance of work under this contract, the PO agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in Wis. Stat. § 51.01 (5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the PO further agrees to take affirmative action to ensure equal employment opportunities. The PO agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

In accordance with the provisions of Title VI of the Civil Rights Act of 1964 (nondiscrimination on the basis of race, color, national origin), Section 504 of the Rehabilitation Act of 1973 (nondiscrimination on the basis of disability), the Age Discrimination Act of 1975 (nondiscrimination on the basis of age), regulations of the U.S. Department of Health and Human Services issued pursuant to these three statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91, the PO shall not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits



under any of its programs and activities, and in staff and employee assignments to patients, whether carried out by the PO directly or through a sub-contractor or any other entity with which the PO arranges to carry out its programs and activities.

Additionally, in accordance with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)), the PO shall not exclude, deny benefits to, or otherwise discriminate against any person on the basis of sex in admission to, participation in, or receipt of the services and benefits under any of its health programs and activities, and in staff and employee assignments, whether carried out by the PO directly or through a sub-contractor or any other entity with which the PO arranges to carry out its programs and activities.

i. **Civil Rights Compliance Plan**

The PO must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of January 1, 2014 through December 31, 2017, within fifteen (15) working days of the effective date of the contract. If the PO employs fifty (50) or more employees and receives at least \$50,000 in funding, the PO must complete a Civil Rights Compliance Plan (CRC Plan). The CRC Plan must be kept on file by the PO and made available upon request to any representative of DHS. The Civil Rights Compliance Requirements are published by the Department of Health Services, either on its own or in conjunction with other state agencies, and includes the Civil Rights Compliance Requirements and all appendices thereto. The current Civil Rights Compliance Requirements and all appendices for the Civil Rights Compliance period of January 1, 2014 to December 31, 2017 is hereby incorporated by reference into this Agreement and is enforceable as if restated herein in its entirety. The Civil Rights Compliance Requirements, including the template and instructions, for the CRC Plan can be found at <https://www.dhs.wisconsin.gov/civil-rights/requirements.htm> or by contacting:

Department of Health Services  
Civil Rights Compliance Officer  
Attn: Attorney Laura Varriale  
1 West Wilson Street, Room 651  
P.O. Box 7850  
Madison, WI 53707-7850  
Telephone: (608) 266-1258 (Voice)  
711 or 1-800-947-3529 (TTY)  
Fax: (608) 267-1434





Email: [dhsrcc@dhs.wisconsin.gov](mailto:dhsrcc@dhs.wisconsin.gov)

If the PO subcontracts/enters into a provider agreement to administer its federally-funded (through the Department of Health Services) programs, services and/or activities, it must require its subcontractor or provider to provide the PO a CRC LOA within fifteen (15) working days of the effective date of the subcontract or provider agreement. If the subcontractor or provider employs fifty (50) or more employees and receives at least \$50,000 in funding, the Contractor must require its subcontractor or provider to complete a Civil Rights Compliance Plan (CRC Plan) as a term of its sub-contract or provider agreement. The CRC Plan must be kept on file by the subcontractor or provider and made available upon request to any representative of Department of Health Services.

ii. Civil Rights Compliance Letters of Assurances should be sent to:

Department of Health Services  
DES/BSS – AA/CRC Coordinator  
1 West Wilson Street, Room 672  
P.O. Box 7850  
Madison, WI 53707-7850

[dhscontractcompliance@dhs.wisconsin.gov](mailto:dhscontractcompliance@dhs.wisconsin.gov)

iii. The Contractor agrees to all of the following:

- a) Design and implement an effective limited English proficiency (LEP) plan to ensure meaningful access to LEP persons at no cost to the LEP persons, in compliance with Title VI of the Civil Rights Act of 1964, and Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)). The LEP plan will identify individuals who need LEP language assistance, describe language assistance measures that may be provided, require training staff to implement the plan, provide a mechanism for notice to LEP persons who are in need of the services, provide accurate and timely language assistance to LEP persons at no cost to themselves, and provide for monitoring and updating the LEP Plan.
- b) Design and implement a plan to ensure that the PO communicates effectively with people who have vision, hearing, or speech disabilities, in compliance with Title II of the Americans with Disabilities Act and Section 1557 of the Patient Protection and Affordable Care Act of 2010,



42 U.S.C. § 18116, and rules promulgated to implement Section 1557 (81 Fed. Reg. 31376 et seq. (May 18, 2016) (amending 45 C.F.R. Part 92 to implement Section 1557)). The plan must require that the PO shall provide auxiliary aid and services when needed to communicate effectively with people who have communication disabilities to ensure that a person with a vision, hearing or speech disability can communicate with, receive information from, and convey information to, the PO at no cost to the person with a disability.

- c) The PO agrees to cooperate with DHS in any complaint investigations, monitoring or enforcement related to civil rights compliance of the PO or its sub-contractor under this Agreement.
- d. Failure to Comply  
Failure to comply with Article XIII.B.1.b.-c. may result in the following consequences:
  - i. Termination of this Contract after a 30-day notice to cure deficiencies;
  - ii. Designation of the PO as "ineligible" for future consideration as a responsible qualified bidder or proposer for state contracts; or
  - iii. Withholding of payment(s) due under the Contract until the PO is in compliance

2. *PACE Organization Subcontracts and Provider Agreements*

- a. A vendor that subcontracts or enters into a provider agreement with a PO is required to develop and provide a copy of a civil rights compliance/affirmative action plan to the PO, except:
  - i. A vendor that provides only PACE program benefits; or
  - ii. A vendor that:
    - a) Is under a contract with the PO of less than \$25,000; or
    - b) Has less than twenty-five (25) employees regardless of the amount of the contract; or
    - c) Is a foreign company with a work force of less than twenty-five (25) employees in the United States; or
    - d) Is a federal government agency or a Wisconsin municipality; or
    - e) Has a balanced work force.



**C. Subcontracting and Entering Provider Agreements**

1. *Ability to Subcontract and Enter Provider Agreements*

The PO may subcontract or enter a provider agreement for any or all functions covered by this contract, subject to the requirements of this contract.

2. *PO Responsibility and Accountability for Subcontracts and Provider Agreements*

The PO retains responsibility for fulfillment of all terms and conditions of this contract when it enters into a subcontract or provider agreement and will be subject to enforcement of the terms and conditions of this Subcontract or Provider Agreement including assurance of civil rights compliance. The PO oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor or provider. In order to meet these requirements the PO must assure that:

- a. All subcontractors and providers agree to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance, and contract provisions.
- b. The PO evaluates the prospective subcontractor or provider's ability to perform the activities to be delegated; and
- c. The PO and the subcontractor or provider have a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

3. *Department's Discretion Regarding Subcontracts and Provider Agreements*

- a. At any time, the Department may review, approve, approve with modification, impose conditions or limitations or deny any and all subcontracts or provider agreements under this contract at its sole discretion and without the need to demonstrate cause. The Department may consider factors to protect the interests of the State and members, including but not limited to, the subcontractor's or provider's past performance.
- b. If as the result of a Department action under paragraph 3.a., the Department requires the PO to find a new subcontractor or provider, the PO shall secure a new subcontractor or provider in one hundred-twenty (120) calendar days, and allow sixty (60) calendar days to implement any other change required by the Department:
  - i. The PO may request a waiver of this deadline for subcontracting or entering into a provider agreement and for any other change, justifying the reasons the extension is needed.
  - ii. The Department, at its own discretion, may extend the deadline if the PO shows to the satisfaction of the Department that additional time is needed.



- c. Any disapproval of subcontracts or provider agreements or failure of the PO to comply with conditions or limitations imposed under paragraph 4.a. may result in the application by the Department of remedies pursuant to Article XVI.E., Sanctions for Violation, Breach, or Non-Performance.
4. *Notification of Procurement or Termination of Subcontracts*

The PO will notify the Department when considering procurement of new contracts or termination of current contracts for:

  - a. Care management under Article V, Care Management;
  - b. Claims administration under Article XIII, PACE Administration, Section F, Claims Administration; or
  - c. Quality management under Article XII, Quality Management (QM).
5. *Department Approval for Subcontracts*

The PO may subcontract part of the functions in Article XIII, PACE Administration, Section C.4., Notification of Procurement or Termination of Subcontracts, only with the prior written approval of the Department. In addition, Department approval may be required prior to completing an award process, selection of a subcontractor or finalizing the terms and conditions of the subcontracts and the subcontractors selected.

Approval of a subcontractor, subcontract, provider or provider agreement will be withheld if the Department reasonably believes that the intended subcontractor or provider will not be responsible in terms of services provided and costs billed.

Approval is not required for renewal of existing subcontracts or provider agreements, unless the subcontract or provider agreement changes.

Failure to receive approval for a subcontract or provider agreement prior to execution of the subcontract or provider agreement may result in application by the Department of remedies pursuant to Article XVI.E., Sanctions for Violation, Breach, or Non-Performance.

#### **D. Management of Subcontractors and Providers**

1. *Establishing and Maintaining Subcontracts and Provider Agreements*

The PO must:

- a. Establish mechanisms to monitor the performance of subcontractors and providers to ensure compliance with provisions of the subcontract or provider agreement on an ongoing basis, including formal review according to a periodic schedule, consistent with industry standards or state laws and regulations.
- b. Identify deficiencies or areas for improvement.
- c. Take corrective action if there is a failure to comply.



2. *Quality Monitoring of Providers Regulated by the Division of Quality Assurance (DQA)*

Each PO shall have a system for monitoring the quality of subcontracted DQA-regulated provider services. The PO must:

- a. Establish mechanisms to monitor the performance of DQA-regulated provider services to ensure member health and welfare and provider compliance with member-care-related provisions of the subcontract on an ongoing basis.
- b. Identify provider deficiencies or areas for improvement (inclusive of monitoring statements of deficiency (SOD) issued by the Department of Health Services, Division of Quality Assurance).
  - i. The PO shall have specific SOD review processes in place to address SODs with significant enforcement action, such as: directed plan of correction, no new admission orders, impending revocations, repeat citations, immediate jeopardy with unresolved deficiencies, or situations of actual serious harm or risk for serious harm to members not already identified via the PO's internal critical incident reporting system.
- c. Take corrective action if a provider fails to comply, including proactive prevention activities.
  - i. Each PO shall respond to SODs by taking reasonable and prudent actions to assure member health and safety.
  - ii. As available, each PO shall review relevant provider plans of correction submitted to DQA and determine whether to require any additional plan of correction.

Each PO shall monitor the quality improvement of any of its DQA-cited providers.

3. *Additional Requirements for Subcontracts*

Subcontracts are subject to additional review to assure that rates are reasonable:

- a. **Services and Compensation**

Subcontracts must clearly describe the services to be provided and the compensation to be paid.
- b. **Bonuses, Profit Sharing**
  - i. Any potential bonus, profit-sharing, or other compensation not directly related to costs of providing goods and services to the PO, shall be identified and clearly defined in terms of potential magnitude and expected magnitude during the subcontract period.



- ii. Any such bonus or profit sharing shall be reasonable compared to services performed. The PO shall document reasonableness.
- iii. A maximum dollar amount for such bonus or profit sharing shall be specified for the subcontract period.

4. *Additional Requirements for Provider Agreements*

Article VIII, Provider Network, provides additional Department requirements for provider agreements.

**E. Memorandum of Understanding (MOU)**

1. *Entering into an MOU*

A PO may enter into an MOU with a business, provider or similar entity. Such an MOU may not violate any of the requirements found in this contract concerning contracts, subcontracts or provider agreements between the PO and a business, provider or similar entity.

2. *Submission of Memoranda of Understanding (MOUs) to the Department*

The PO shall submit MOUs referred to in this contract to the Department within fifteen (15) business days of the effective date of the MOU.

The PO shall submit copies of changes in MOUs to the Department within fifteen (15) business days of the effective date of the MOU.

**F. Claims Administration**

The PO must maintain a management information system that is in accordance with:

- The claims administration requirements in this section; and
- Article XIV, Reports and Data, Section A., Management Information System.

The PO is responsible for ensuring claims administration for all services provided to members in compliance with the requirements enumerated in this contract.

1. *Claims Retrieval System*

The PO shall maintain or contract for a claims retrieval system that can, on request, identify the date a service was received, action taken on all provider claims (e.g., paid, denied, other), and when action was taken. All provider claims shall be date stamped upon receipt.

2. *Claims Processing Payment Requirement*

a. *Definitions*

The following definitions apply in this section:

- i. Authorized service means a service or item in the benefit that, if required, has been authorized by the PO in accordance with Article V.K., Service Authorization.



- ii. Claim means a single transaction submitted by a provider as a bill or other approved document or format for all authorized services for one member.
  - iii. Clean claim means a claim that can be processed without obtaining additional information from the provider of the service. A claim is still considered a clean claim if the only error(s) in the submitted information are the result of an error originating in the Department's system or with errors originating from an PO's claims processing system problem, a PO's internal claims or a PO's business process problem. A clean claim does not include a claim that is under review for medical necessity or any claim from a provider who is under investigation for fraud or abuse.
  - iv. Date of receipt means the date the PO or its third party administrator (TPA) receives the claim, as indicated by its date stamp on the claim.
  - v. The date of adjudicating and mailing or transmitting the remittance advice with payment, partial payment or denial of payment is the date on which the remittance advice with payment, partial payment or denial of payment is mailed or otherwise transmitted.
- b. Except to the extent providers or subcontractors have agreed to later payment, the PO shall adjudicate and mail or transmit the remittance advice with payment, partial payment or denial of payment as follows:
- i. Ninety (90) percent of clean claims within thirty (30) calendar days of receipt; and
  - ii. Ninety-nine (99) percent of clean claims within ninety (90) calendar days of receipt; and
  - iii. One hundred (100) percent of clean claims within one hundred eighty (180) calendar days of receipt.
3. *Claims Inventory Reports*
- If the Department has indications that the PO's claims processing is not in compliance with Article XIII, PACE Administration, F. Claims Administration, the PO will be required to submit claims inventory reports documenting its claims inventory status.
4. *Failure to Pay or Inappropriate Payment Denials*
- a. The PO must notify the Department immediately if it is unable to meet the standards in Article XIII, PACE Administration, Section F., Claims Administration.
  - b. A PO must establish a Department-approved process to assure payment of at-risk providers if claims are delayed beyond 30 days.





At-risk providers are either:

- i. All providers of home and community-based services as defined in Addendum VIII, Service Definitions, Section A., Home and Community-Based Waiver Services; or
  - ii. Providers that are determined to be at-risk as defined by the PO's Department-approved policies and procedures.
- c. If the PO inappropriately fails to provide timely payment or denies payment for services, the PO may be subject to the following sanctions:
- i. Article XVI.E., Sanctions for Violation, Breach, or Non-Performance;
  - ii. Limiting risk-sharing or enhanced payments;
  - iii. Reducing administrative funding;
  - iv. Requiring an increased amount in the PO's reserves;
  - v. Requiring administrative actions necessary to assure timely and appropriate payment of claims under current funding levels.

These sanctions may be applied not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal has been made.

5. *New Contracts, Renewal Contracts, and Contract Amendments for Claims Administration by a Third Party Administrator and New Purchases of a Claims Processing System or Software that Will be Developed Into an Internal PO Claims Processing System*

- a. Any new contracts, contract renewals, or contract amendments between the PO and a third party administrator (TPA) for claims administration and any purchase of a new claims processing system or software that will be developed into an internal PO claims processing system must meet standards established by the Department.

Any claims administration contract shall not include penalties or high fees that make it difficult to terminate a contract.

- b. The PO must receive Department approval prior to either finalizing an external contract with a TPA for claims administration services or finalizing a contract to purchase a claims processing system or software that will be developed into an internal PO claims processing system. A PO may request from the Department variances for pre-approval of specified types of contract amendments, as part of their submittal of the original contract for Department approval.

A PO using TPA must submit the contract, along with all documentation identified by the Department to the Department at least sixty (60) calendar days prior to finalizing the contract. A PO that has purchased a claims



processing system or software to develop an internal claims processing system must submit all documentation identified by the Department at least sixty (60) calendar days prior to implementation.

The Department will complete its review within forty-five (45) calendar days of receipt.

## **G. Required Disclosures**

### *1. Disclosure of Ownership or Controlling Interest*

In accordance with 42 C.F.R. § 438.602(c), the MCO agrees to submit to the Department the Disclosure of Ownership or Controlling Interest. This form requires full and complete information as to the identity of each person or corporation with an ownership or controlling interest in the PO, or any subcontractor or provider in which the PO has a five percent (5%) or more ownership interest, at the following times:

- Within thirty (30) calendar days of contract signing;
- When the Department renews or extends the PACE contract; and
- Within thirty five (35) calendar days after any change in ownership of the PO.

#### *a. Definition of “Ownership or Controlling Interest”*

A “person with an ownership or controlling interest” means a person or corporation that:

- i. Owns, directly or indirectly, five percent (5%) or more of the PO’s capital or stock or receives five percent (5%) or more of its profits;
- ii. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the PO or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the PO; or
- iii. Is an officer, director (if the PO is organized as a corporation), partner (if the PO is organized as a partnership), or managing employee of the PO. Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the PO.

#### *b. Calculation of Five Percent (5%) Ownership or Control*

The percentage of direct ownership or control is the percentage interest in the capital, stock or profits. The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns ten (10) percent of the stock in a



corporation which owns eighty (80) percent of the stock of the PO, the person owns eight (8) percent of the PO. The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest which a person owns in that obligation by the percent of the PO's assets used to secure the obligation. Thus, if a person owns ten (10) percent of a note secured by sixty (60) percent of the PO's assets, the person owns six (6) percent of the PO.

c. Information to be Disclosed

The following information must be disclosed:

- i. The name and address of each person with an ownership or controlling interest of five percent (5%) or more in the PO or in any subcontractor or provider in which the PO has direct or indirect ownership of five percent (5%) or more;
- ii. The date of birth and Social Security Number of each individual with an ownership or controlling interest of five percent (5%) or more in the PO or in any subcontractor or provider in which the PO has direct or indirect ownership of five percent or more;
- iii. The other tax identification number of each corporation with an ownership or controlling interest of five percent (5%) or more in the PO or in any subcontractor or provider in which the PO has direct or indirect ownership of five percent or more;
- iv. The name, address, date of birth and social security number of any managing officer, director, partner or managing employee of the PO.
- v. A statement as to whether any of the persons with ownership or controlling interest is related to any other of the persons with ownership or controlling interest as spouse, parent, child, or sibling; and
- vi. The name of any other organization in which the person also has ownership or controlling interest. This is required to the extent that the PO can obtain this information by requesting it in writing. The PO must keep copies of all of these requests and responses to them, make them available upon request, and advise the Department when there is no response to a request.

d. Reporting Information on Disclosure

The PO shall submit ownership and control information on the DHS designated form as required in sub. 1.

The Department must provide this information to CMS upon CMS's request. Failure to provide this required disclosure information puts the



federal financial participation (FFP) portion of the capitation payments at risk, and the PO shall be liable for any penalty or disallowance imposed by CMS resulting from the PO's failure to report this information as required.

2. *Disclosure of Business Transactions*

a. Business Transactions with a Party-In-Interest. The PO must disclose to the Department information on certain types of transactions that it has with a "party in interest" as defined in the Public Health Service Act and 1903(m)(2)(A)(viii) and 1903(m)(4)(A) of the Social Security Act.

i. Definition of a Party in Interest. As defined in s. 1318(b) of the Public Health Service Act, a party in interest is:

- a) Any director, officer, partner, or employee responsible for management or administration of the PO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the PO; any person who is the beneficial owner of more than five percent (5%) of the PO; or, in the case of the PO that is organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
- b) Any organization in which a person described in subsection (a) directly above is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the PO; or, has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the PO;
- c) Any person directly or indirectly controlling, controlled by, or under common control with the PO; or
- d) Any spouse, child, or parent of an individual described in subsections (a-c) above.

ii. Types of Transactions That Must Be Disclosed. Business transactions which must be disclosed include:

- a) Any sale, exchange, or lease of any real or personal property between the PO and a party in interest;
- b) Any lending of money or other extension of credit goods, services (including management services) or facilities between the PO and the party in interest; and
- c) Any furnishing for consideration of goods, services (including management services) or facilities between the PO and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.



- iii. The information which must be disclosed in the transactions listed in subsection (ii.) between the PO and a party in interest includes:
    - a) The name of the party in interest for each transaction;
    - b) A description of each transaction and the quantity or units involved;
    - c) The accrued dollar value of each transaction during the fiscal year; and
    - d) Justification of the reasonableness of each transaction.
  - iv. If this contract is renewed or extended, the PO must disclose information on these business transactions which occurred during the prior contract period within thirty (30) calendar days of contract signing. If the contract is an initial contract with Medicaid but the PO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving the Medicaid enrollment. All of these business transactions must be reported.
- b. Business Transactions required under 42 C.F.R. § 455.105. In addition to the above described disclosures, the PO must disclose, within 35 days of a request from the Department, full and complete information about:
- i. The PO's ownership of any subcontractor or provider with whom the PO has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of the request; and
  - ii. Any significant business transactions between the PO and any wholly owned supplier, or between the PO and any subcontractor or provider, during the five (5) year period ending on the date of the request. A significant business transaction is any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and five (5) percent of the PO's total operating expenses.

#### **H. Ineligible Organizations and Individuals**

In implementing this section the PO shall check at least monthly the federal DHHS OIG List of Excluded Individuals /Entities (LEIE), the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), and the System for Award Management (SAM), as required by 42 C.F.R. § 455.436, as well as any other databases that may be required by the federal DHSS or the Department. Upon obtaining information from a database of excluded entities or individuals receiving information from the Department or from another verifiable source, the PO shall disclose



to the Department, and exclude from participation in the PO, all individuals or organizations which could be included in any of the following categories (references to the Act in this section refer to the Social Security Act):

1. *Ineligibility*

Entities which could be excluded under Section 1128 (b) (8) of the Social Security Act are entities in which a person: (1) who is an officer, director, agent or managing employee of the entity; (2) who has a direct or indirect ownership or controlling interest of five percent or more in the entity; (3) who has beneficial ownership or controlling interest of five percent or more in the entity; or (4) who was described in (2) or (3) but is no longer so described because of a transfer of ownership or control interest to an immediate family member or a member of the household (as defined in 1128(j)(1) and 1128(j)(2)) in anticipation of (or following) a conviction, assessment, or exclusion has:

- a. Been convicted of the following crimes:
  - i. Program related crimes, such as, any criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (see Section 1128 (a) (1) of the Act);
  - ii. Patient abuse, such as, criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128 (a) (2) of the Act);
  - iii. Fraud, such as, a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government (see Section 1128 (b) (1) of the Social Security Act);
  - iv. Obstruction of an investigation or audit, such as, conviction under state or federal law of interference or obstruction of any investigation or audit related to any criminal offense described directly above (see Section 1128 (b) (2) of the Act); or,
  - v. Offenses relating to controlled substances, such as, conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance (see Section 1128 (b) (3) of the Act).
- b. Been excluded from participation in Medicare or a state health care program.

A state health care program means a Medicaid program or any state program receiving funds under Title V or Title XX of the Act (See Section 1128 (h) of the Act). Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described



in section H.1.a. above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

- c. Been assessed a civil monetary penalty under Section 1128A or 1129 of the Act.

Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the federal Department of Health and Human Services Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards (See Section 1128 (b) (8) (B) (ii) of the Act).

2. *Contractual Relations*

Entities which have a direct or indirect substantial contractual relationship with an individual or entity listed above in section H.1. Substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

- a. The administration, management, or provision of medical or long-term care services;
- b. The establishment of policies pertaining to the administration, management, or provision of medical or long-term care services; or
- c. The provision of operational support for the administration, management, or provision of medical or long-term care services.

3. *Excluded from Participation in Medicaid*

Entities which employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A of the Act, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the PO shall exclude from contracting with any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

The PO attests by signing this contract that it excludes from participation in the PO all individuals and organizations which could be included in any of the above categories.

4. *Disclosure of Excluded Individuals or Entities*

The PO shall disclose to the Department any relationship with an excluded individual or entity described under H.1 within ten (10) days of discovery of the individual or entity's excluded status. This disclosure will be made to





DHSLTCFiscalOversight@dhs.wisconsin.gov and will contain the following information:

- a. The name, address, phone number, Social Security number/Employer Identification number and operating status/ownership structure (sole proprietor, LLC, Inc., etc.) of the individual or organization;
- b. The type of relationship and a description of the individual or entity's role (for example, provider and service type or employee and classification);
- c. The initial date of the relationship, if existing;
- d. The name of the database that was searched, the date on which the search was conducted and the findings of the search;
- e. A description of the action(s) taken to exclude the individual or entity from participation in PO contracted and business operations and the date(s) on which such action(s) occurred.

5. *Foreign Entity Exclusion*

- a. Participation in Medicaid  
Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with a PO located outside of the United States. In the event a PO moves outside of the United States, this contract will be terminated.
- b. Capitation rate development  
No claims paid by a PO to a network provider, out-of-network provider, subcontractor or financial institution outside of the United States will be considered in the development of actuarially sound capitation rates.

**I. Compliance with Applicable Law and Cooperation with Investigations**

The PO shall observe and comply with all federal and state law in effect when this contract is signed or which may come into effect during the term of this contract, which in any manner affects the PO's performance under this contract. These federal and state laws include all the provisions of 45 C.F.R. § 74 Appendix A, the Byrd Anti-Lobbying Amendment that specifies that federal funds must not be used for lobbying, the Clean Air Act and Federal Water Pollution Control Act, the rights of the federal government and PACE members to inventions in accordance with 37 C.F.R. § 401.

To the extent permitted by law, the PO shall fully cooperate with any member-related investigation conducted by the Department, the Federal Department of Health and Human Services, CMS, law enforcement, or any other legally authorized investigative entity.

The PO must have conflict of interest safeguards in place at least equal to federal safeguards (41 USC 423, Section 27).



**J. Access to Premises and Information**

1. *Access to Premises*

The PO shall allow duly authorized agents or representatives of the state or federal government, including CMS, the HHS Inspector General, the Comptroller General, or their designees or representatives, at any time, access to the PO's premises, physical facilities, and equipment, the PACE providers' premises, physical facilities, and equipment or the PO subcontractors' premises, physical facilities, and equipment to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of the PO's or subcontractors' contractual activities and shall forthwith produce all records or documents, including but not limited to financial, member or administrative records, books, contracts, and computer or other electronic systems requested as part of such review or audit.

The Department may inspect and audit any financial, care management, member, administrative or other records of the PO, its providers, or its subcontractors. There shall be no restrictions on the right of the state or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and the reasonableness of their costs or for any purpose the Department deems necessary for administration or operation of the program. When requested by the Department or CMS, the PO shall provide access to electronic records in any circumstance when the PO uses electronic records.

In the event right of access is requested under this section, the PO, provider, or subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The Department may perform off-site audits or inspections to ensure that the PO is in compliance with contract requirements.

All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the PO's, provider's, or subcontractor's activities. The PO shall be given fifteen (15) business days to respond to any findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

2. *Access to and Audit of Contract Records*

Throughout the duration of this contract, and after termination of this contract, the PO shall provide duly authorized agents of the state or federal government access to all records and material relating to the contract's provision of and reimbursement for activities contemplated under this contract. The rights of access in this paragraph are not limited to the required retention period, but shall



last as long as records are retained, if longer. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of this contract. All information so obtained will be accorded confidential treatment as provided under applicable law. The rights to access, inspect, and audit premises and contract records described in Article XIII.H.1.-2. exist for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, these access and audit rights may be exercised at any time.

**K. Program Integrity Plan, Program and Coordination**

The PO must establish a Regulatory Compliance Committee on the PO's governing board and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

The PO must have administrative and management arrangements or procedures, and a Program Integrity Plan, that are designed to guard against fraud, waste, and abuse.

The PO's governing board or its designee shall approve a written Program Integrity Plan that is developed by a designated PO program integrity compliance officer and a compliance committee which is accountable to senior management. The plan will describe the PO's commitment to operational initiatives designed to prevent, detect, and correct instances of fraud and abuse including details describing the scope of activity, goals, objectives and timelines associated with the monitoring program. The program integrity plan must be submitted to the Department and approved on an annual basis prior to the effective date of the new contract year. In this subsection, the term abuse means any practice that is inconsistent with sound fiscal, business or medical practices and results in unnecessary program costs.

1. *Procedures*

The PO's arrangements or procedures must include the following:

- a. Written policies, procedures, and standards of conduct that relate to the following:
  - i. Articulating the organization's commitment to comply with all applicable federal and state standards, including occupational safety and health standards.
  - ii. Conducting regular reviews and audits of operations.
  - iii. Assessing and strengthening internal controls.
  - iv. Educating employees, network providers and members about fraud and abuse and how to report it.
  - v. Effectively organizing resources to respond to and process complaints of fraud and abuse.



- vi. Rights of employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers
  - b. The designation of a compliance officer and compliance committee that are accountable to senior management.
  - c. Effective training and education for the compliance officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract.
  - d. Effective lines of communication between the compliance officer and the organization's employees.
  - e. Enforcement of standards through well-publicized disciplinary guidelines.
  - f. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the PACE contract with the Department.
  - g. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.
  - h. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.
  - i. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.
2. *Reporting*
- a. The PO shall report any suspected fraud, waste, or abuse involving the program to the Department as soon as possible, but within ten (10) business days.

All credible provider and member allegations must be reported through the fraud and financial abuse toll-free reporting hotline 1-877-865-3432 or the on-line reporting system at [www.reportfraud.wisconsin.gov](http://www.reportfraud.wisconsin.gov). In addition, the PO must also send notification of the credible allegation of fraud to the BFAM mailbox at [DHSLTCFiscalOversight@dhs.wisconsin.gov](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov).



Reporting details must include information required for the quarterly reporting listed in Article XIII.K.2.k.ii.a)-i) below.

- b. Quarterly, as specified below, the PO shall submit a Program Integrity report to the BFAM mailbox at [DHSLTCFiscalOversight@dhs.wisconsin.gov](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov) and to the BAQO mailbox at [DHSBMC@dhs.wisconsin.gov](mailto:DHSBMC@dhs.wisconsin.gov) describing any instances of suspected fraud, waste, or abuse and OIG Provider suspensions for contracted providers that arose during the quarter, including the following:
  - i. Number of complaints of suspected fraud and abuse made to the PO that warrant preliminary investigation.
  - ii. For each situation which warrants investigation, supply the:
    - a) Name and ID number;
    - b) Source of complaint;
    - c) Type of provider;
    - d) Nature of complaint;
    - e) The approximate range of dollars involved;
    - f) Timeline in which it was handled;
    - g) Outcome;
    - h) Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred; and
    - i) Description of any corrective action that was taken.
- c. The PO shall comply with any other federal, state or local requirements for reporting fraud, waste, and abuse.

3. *Suspension of Provider Payments*

- a. The PO shall suspend payments to a sub-contracted provider pursuant to 42 C.F.R. § 455.23 if the Department informs the PO that the Department has suspended fee-for-service Medicaid payments to the provider because of a credible allegation of fraud, unless the PO believes there is good cause for not suspending its payments. If the PO believes based on the criteria under 42 C.F.R. § 455.23 (e) or (f) that there is good cause for not suspending its payments or for only suspending them in part, it shall submit written documentation to the Department describing the basis for such a good cause exception to suspending payment. The Department shall approve or disapprove the PO's request for a good cause exception within ten (10) business days. If the Department disapproves the request the PO shall suspend payments to the provider.



- b. If the Department determines that a report by a PO under Section 2.j. of suspected fraud by a provider is a credible allegation, the PO shall suspend its payments to the provider unless the PO believes there is good cause for not suspending its payments. If the PO believes based on the criteria under 42 C.F.R. § 455.23 (e) or (f) that there is good cause for not suspending its payments or for only suspending them in part, it shall request and the Department shall approve or disapprove an exception to payment suspension as in Section 3.a. above.
- c. If the PO suspends its payments in whole or in part to a provider because the Department has determined that there is a credible allegation of fraud and there fails to be good cause to not suspend payments, the PO shall:
  - i. Provide notice to the provider that meets the timeframe and content requirements of 42 C.F.R. § 455.23 (b).
  - ii. Terminate the suspension when the Department or a prosecutorial authority determines there is insufficient evidence of fraud by the provider or legal proceedings related to the alleged fraud are completed, or when the Department determines there is good cause under 42 C.F.R. § 455.23 (e).
  - iii. Maintain documentation for at least five (5) years of all payment suspensions, instances where a payment suspension was not imposed, imposed only in part or discontinued for good cause, as provided in 42 C.F.R. § 455.23 (g).

4. *Investigations*

The PO shall cooperate with any investigation of fraud and abuse, including directly conducting investigations as needed. The PO shall assist the Department and any other entity legally authorized to investigate fraud and abuse in determining any amounts to be repaid, and with other follow up as requested.

**L. Business Continuity**

The PO shall have a Business Continuity Plan and a Disaster Recovery Plan on file with the Department which will be updated and submitted annually as part of the certification process.

1. *Business Continuity Plan*

Business Continuity Plans shall address, at a minimum, the following:

- a. A description of the organization and the urgency with which activities and processes will need to be resumed in the event of a disruption.
- b. Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a



- disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.
- c. Inclusion of a risk assessment that reviews the probability and impact of various threats to the PO's operations. This involves stress testing the PO's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the PO in refining its business impact analysis and in developing a business continuity strategy.
  - d. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.
  - e. Criteria for executing the business continuity plan, including escalation procedures.
  - f. A detailed communication plan with members, employees, providers, the Department and other stakeholders.
  - g. Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.
  - h. A description of the organization and the urgency with which activities and processes will need to be resumed in the event of a disruption.
  - i. Recovery time for each major business function, based on priority.
  - j. Business workflow and workaround procedures, including alternate processing methods and performance metrics.
  - k. Recording and updating business events information, files, data updates, once business processes have been restored.
  - l. Documentation of security procedures for protection of data.
  - m. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
  - n. A description of an annual testing and evaluation plan.
  - o. A description of the PO familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The PO will negotiate, or make a "good faith" effort to negotiate, an MOU with each county in their service area addressing the PO's and county's role in emergency response.
  - p. A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.





2. *Disaster Recovery Plan*

The Disaster Recovery Plan shall address, at a minimum, the following:

- a. Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.
- b. Communication plan for critical personnel, key stakeholders and business partners.
- c. Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).
- d. Full and complete back-up copies of all data and software.
- e. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
- f. Policies and procedures for purging outdated backup data.
- g. Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.
- h. Identification of a back-up processing capability at a remote site(s) from the primary site(s) such that normal business processes and services can continue in the event of a disaster or major hardware problem at the primary site(s).
- i. Policies and procedures to ensure and preserve member safety and wellbeing in the event of a disruption or disaster/

**M. Resource Center Conflict of Interest Policies and Procedures**

1. *Written Conflict of Interest Policies and Procedures*

The PO shall have written conflict of interest policies and procedures that prohibit PACE employees and employees of subcontractors and providers from attempting to influence the independence of options counseling, enrollment counseling, disenrollment counseling and advocacy provided by resource center staff.

2. *Conflict of Interest Regarding Specific Care Management Services*

When the PO subcontracts for care management services through a county or with the same agency that is responsible for the resource center, the PO and the subcontracted care management agency shall comply with its policies and procedures regarding conflict of interest.

3. *Policies Regarding the PACE Organization and Resource Center*

The PO shall comply with all Department policies regarding PO coordination and conflict of interest with resource centers.



**N. Commercial Leases**

1. If the PO enters into leases of real property to support the administrative responsibilities of the PO, at the time the PO enters into a new lease or renews an existing lease the PO shall include a termination clause in that lease allowing the PO to terminate the lease on reasonable notice to the landlord, not to exceed 90 days, that the PO will cease to operate as an PO due to a discontinuation of this Contract with the Department. Such termination must not be considered a default of the lease, must occur without penalty and must limit any future rent liability.
2. The PACE Organization is not required to negotiate such a clause into any existing lease.
3. If after a good faith attempt to negotiate, the PO is unable to include such a clause in a lease of real property but determines that such a lease is essential to the operation of the PO, the PO may apply to the Department for a waiver of this requirement. Any such waiver shall be at the discretion of the Department.
4. If the PO enters into leases of commercial property other than real property on a long-term basis, e.g., office equipment, the PO shall attempt to include a termination without penalty clause in those leases, to the extent practicable.

**O. PACE Organization's Insurance Responsibility**

The PO shall maintain the following coverage for the organization(s) covered under this contract:

1. Worker's compensation, as required by Wisconsin Statutes for all PO employees;
2. Commercial liability, bodily injury and property damage insurance against any claim(s), which might occur in carrying out this contract with a minimum coverage of one million dollars (\$1,000,000) per occurrence liability for bodily injury and property damage including products liability and completed operations;
3. Motor vehicle insurance for all owned, non-owned and hired vehicles that are used in carrying out this contract, with a minimum coverage of one million dollars (\$1,000,000) per occurrence combined single limit of automobile liability and property damage;
4. Professional Liability (malpractice) or Managed Care Liability with a minimum coverage of one million dollars (\$1,000,000) per occurrence;
5. Director and Officers liability or equivalent coverage specific to the entity structure;
6. Umbrella coverage; and
7. Employee Dishonesty or Fidelity Bond as a stand-alone policy or included under the entity's Commercial property coverage.

Entities operating under a subsidiary or related party organizational structure shall maintain required coverage at the subsidiary or related party level identified as the



contracting PO in this contract. The PO shall submit a certificate of insurance to demonstrate coverage with the State of Wisconsin listed as a certificate holder annually with the required business plan submission or as otherwise indicated but prior to contract renewal with the Department.

**P. Business Associate Agreement**

Due to the PO using and/or disclosing protected health information subject to HIPAA, the PO shall review and execute a Business Associate Agreement (BAA) F-00759 with the Department as a mandatory and critical exhibit to the Contract. A BAA must be executed before the PO performs any work of any kind for DHS as a result of this Contract.



#### XIV. Reports and Data

##### A. Management Information System Requirements

The PO must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas that include, but are not limited to: utilization, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

The PO must collect, maintain and report data on member and provider characteristics and on services furnished to members through an encounter data system.

The PO shall:

1. Meet all of the reporting requirements as specified in this contract in a timely way, assure, to the best of their knowledge and beliefs, the accuracy and completeness of the data, and submit the reports/data in a timely manner.
2. Support data submitted to the Department by having records available for inspection or audit by the Department.
3. Submit data and/or reports to the Department, and receive data and/or reports from the Department in a secure format.
4. Designate a primary contact person responsible for data reporting who is available to answer questions from the Department and resolve any issues regarding reporting requirements. At the same time, designate a back-up person who will be available to perform this function when needed.
5. Ensure that data, documentation or information is certified by either the PO's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification provided by the individual described above attests that, based on best information, knowledge and beliefs, the data, documentation or information transmitted via the Data Certification Form (provided by the Department) is accurate, complete and truthful. This certification must be submitted concurrently with the data, documentation or information it is certifying.
6. Ensure that its Management Information System (MIS) is sufficient to support quality assurance/quality improvement requirements described in Article XII, Quality Management (QM).

##### B. Encounter Data

###### 1. *Encounter Data – Reports*

The PO shall report member-specific data on the LTCare IES as directed by the Department. PACE staff will participate in the planning and development of data



reporting requirements for implementation during the term of this contract consistent with all HIPAA requirements applicable to the PO. This participation will include attending workgroup meetings, addressing necessary changes to local applications or databases, and cooperating with the Department on data submission protocol and testing.

Prior to the effective date of this contract, the PO shall demonstrate it has the ability to:

- a. Analyze, integrate and report data;
- b. Process coordination of benefits as outlined in the LTCare IES Implementation Guide.
- c. Capture and maintain a member level record of all services provided to members by the PO and its providers, in a computerized data base adequate to meet the reporting requirements of the contract;
- d. Monitor enrollment and disenrollment, in order to determine which members are enrolled or have disenrolled from PACE on any specific day;
- e. Collect and accurately produce data, reports, and member histories including, but not limited to, member and provider characteristics, encounter data, utilization, disenrollments, solvency, member and provider appeals and grievances as specified by the Department; and
- f. Ensure that data received from providers, and reported to the Department and upon request to CMS, is timely, accurate and complete, by:
  - i. Verifying the accuracy and timeliness of reported data;
  - ii. Screening the data for completeness, logic, and consistency;
  - iii. Collecting information on services in standardized HIPAA-compliant formats, such as the CMS 1500 or UB04 format, or other uniform format, to the extent possible; and
  - iv. Recording and tracking all services with a unique member identification number.

2. *Encounter Data – Format*

The PO shall assure member-specific data is reported to the Department in an encounter-data format (XML) specified by the Department and according to any HIPAA deadlines/standards/requirements applicable to the PO. The specifications and HIPAA deadlines, standards and requirements are identified in documents found on the Department's website at:

<https://www.dhs.wisconsin.gov/ies/index.htm>.

The PO shall meet certification standards that demonstrate it has the ability to meet the Department's reporting requirements in the formats and timelines prescribed by the Department. The PO will provide data extracts, as necessary, for testing the reporting processes and will assist with and participate in the testing



processes. The Department will provide POs with reasonable advance notice of required changes to encounter reporting standards, formats and MIS capacity necessary to meet federal and state requirements.

3. *Encounter Data – Submission Testing*

The PO shall test encounter record submissions with the Department prior to undertaking claims systems or claims processing vendor changes or prior to the addition of new DHS lines of business requiring encounter data reporting.

Information can be found on the Department’s website at:

<https://ltcareies.forwardhealth.wi.gov/ltcareIES/secureLogin.html>.

4. *Encounter Data - Submission*

The Encounter Reporting Submission is a monthly file submission. The file submission is due on the thirtieth day after the end of the month, or the first business day following the thirtieth day when the thirtieth day is not a business day. The Encounter Data Reporting Submission will be used to report member specific enrollment and disenrollment, utilization of services and expenditure in, receipts for payments not received directly from the state, recoveries to include overpayments to subcontractors/providers when received or recovered by the PO, and member characteristic/demographics. Other member specific data may be required by the Department in the future. The Encounter Reporting Submission shall be reported on-line through the LTCare IES application.

Mandatory versus voluntary requirements for encounter data reconciliation and certification are currently defined by line of business. Changes to these requirements are likely during the course of this contract. The PO agrees to accommodate the mandated requirements in the eLTCare IES implementation guide for waiver program encounter reporting in the event that they are enforced for the PO’s line(s) of business during the course of this contract, if they are not already accommodating reconciliation and certification requirements for their line(s) of business.

5. *Encounter Data - Non-Compliance Resolution Process*

The Department shall have the right to audit any records of the PO and to request any additional information. If at any time the Department determines that the PO has not complied with any requirement in this section, the Department will issue a corrective action to the PO. The PO shall comply within the timeframe defined in the corrective action. If the PO fails to comply, the Department may pursue action against the PO as provided under Article XVI.E.2.i.

**C. Reports: Regular Interval**

1. *General*

The PO agrees to furnish information from its records to the Department, and to the Department’s authorized agents and upon request to CMS, which may be required to administer this contract. See



<https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf>, for a compilation of these and other reports/documents and due dates which are specified in this contract.

2. *Monthly Report*

The monthly member incident report is due on the thirtieth day after the end of the month, or the first business day following the thirtieth day when the thirtieth day is not a business day. The reports shall be submitted electronically through the Long Term Care Information Exchange System (see Article V.J.5.b.xii).

3. *Quarterly Restrictive Measures Reporting*

Approved restrictive measures reporting is due quarterly. The report shall be submitted no later than forty-five (45) calendar days after the end of the reporting period, as provided at <https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf>. The reporting shall be submitted electronically through the Restrictive Measures database: (<https://ltcareies.forwardhealth.wi.gov/restrictiveMeasures/#/login>).

4. *Quarterly Report*

The Quarterly Report is due forty-five (45) calendar days after the reporting period. The Department may from time to time revise elements to be included in the Quarterly Report and shall give the PO notice of new elements to include in the Report prior to the commencement of the next reporting period. The Quarterly Report contains the following components:

- a. Appeal and grievance summary and log as specified in Article XI, Grievances and Appeals, Section I.
- b. Provider appeal log as specified in Article VIII.M.3., Provider Appeal Log.
- c. Financial report as defined in Article XVII.B., Financial Reporting, page 235 and required Financial Statement certification form(s), as shown in Addendum V, Data Certification.
- d. Payments the PO received for enhanced services and donations directly received by the PO from members, the member's family or significant others as specified in Article VII.I.9.
- e. Identified provider-preventable conditions, if any, as defined in Article I, Definitions.
- f. The number of members who were forced to move from one community-based residential care facility to another, or from a community-based residential care facility to a nursing home, due to the member's lack of financial resources sufficient to meet the room and board costs.





- g. Total overpayments recovered, split out by those retained by the PO, those returned to the Department because the PO is not permitted to retain them, and those due to potential fraud.
- h. Overpayments identified but not recovered.
- i. Payments above the Medicaid fee-for-service rate as described in Article VIII.6.d. (2<sup>nd</sup> and 4<sup>th</sup> quarter only).

5. *Quarterly Employment Data Report*

The PO shall report employment data for members working in Competitive Integrated Employment (CIE) quarterly for members who do and do not have a vocational service provider. The PO shall use a prepopulated Excel list of members provided by DHS and is required to add individuals who are working in CIE without supports. The PO may choose to require employment services providers to report employment data to them; however, the PO will be responsible for the uploading and certification of the employment data sent to DHS. The tool the PO will use for employment data collection and submission of these reports will be the Integrated Exchange System (IES) through Business Objects.

**D. Reports: As Needed**

The PO agrees to furnish reports which may be required to administer this contract, to the Department and the Department's authorized agents. Such reports include but are not limited to corporate restructuring or any other change affecting the continuing accuracy of information previously reported by the PO to the Department.

The PO shall report each such change in information as soon as possible, but not later than thirty (30) calendar days after the effective date of the change. Changes in information covered under this section include all of the following:

- 1. Any change in information relevant to Article XIII.H, Ineligible Organizations.
- 2. Article XIII, PACE Administration.

**E. Disclosure of Financial Information**

The PO and any subcontractors or providers shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the PO, subcontractors or providers which relate to the PO's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this contract. The PO shall comply with applicable record-keeping requirements specified in Wis. Admin. Code §§ DHS 105.02(1)-(7), as amended.

**F. Record Retention**

The PO shall retain, preserve and make available upon request all records or documents relating to the performance of its obligations under this contract, including paper and electronic claim forms, for not less than ten (10) years following the end of this contract



period. Records and documents that must be retained include, but are not limited to, the following:

1. *Member grievance and appeal records, as described by Article XI.1.1.*
2. *As described by 42 C.F.R. §438.5(c), base data used for developing capitation rates, including:*
  - a. Validated encounter data;
  - b. Fee-for-service data; and
  - c. Audited financial reports that demonstrate experience for the populations to be served by the PO.
3. *As described by 42 C.F.R. §438.8(k), documents and data used to prepare annual MLR reports, including:*
  - a. Total incurred claims to include care management expenses;
  - b. Expenditures on quality improving activities;
  - c. Expenditures related to program integrity requirements;
  - d. Non-claims costs;
  - e. Premium/capitation revenue;
  - f. Taxes, licensing, and regulatory fees;
  - g. Methodology(ies) for allocating expenditures;
  - h. Any credibility adjustment applied;
  - i. The calculated MLR;
  - j. Any remittance owed to the State;
  - k. A comparison of the information reported with the audited financial reports described by 42 C.F.R. § 438.3(m);
  - l. A description of the aggregation method used to determine the total in a., above; and
  - m. The number of member months.
4. *As described by 42 C.F.R. §§438.604 and 438.606, data, information, and documentation, including:*
  - a. Encounter data;
  - b. Data used to determine the actuarial soundness of the PACE capitation rates;
  - c. Data used to determine the PO's medical loss ratio requirements and compliance;



- d. Data used to determine whether the PO has made adequate provision against the risk of insolvency;
  - e. Documentation used to determine whether the PO has complied with requirements regarding availability and accessibility of services, including the adequacy of its provider network;
  - f. Information on ownership and control of the PO and its subcontractors;
  - g. The annual report of overpayment recoveries; and
  - h. Documentation certifying the data, information, or documentation referenced in Article XIV.F.4.a.-g.
5. *As described by 42 C.F.R. §§438.608 and 438.610, data, information, and documentation related to program integrity requirements, including:*
- a. The detection and prevention of fraud, waste, and abuse;
  - b. Compliance with all requirements and standards under this contract, including all federal and state requirements;
  - c. The identification and recovery of overpayments, specifically including, but not limited to, recoveries of overpayments due to fraud, waste, or abuse;
  - d. Notifications regarding changes in members' circumstances which may impact eligibility;
  - e. Notifications regarding changes in a network provider's circumstances which may impact the provider's ability to provide services to members or to remain as a network provider;
  - f. Verification that services that were represented to have been delivered were actually received by members;
  - g. Compliance with the False Claims Act;
  - h. Compliance with requirements regarding the enrollment of providers with the state as Medicaid providers;
  - i. Disclosure of information regarding ownership and control of the PO and its subcontractors;
  - j. Disclosure of any prohibited affiliations, including:
    - i. Individuals, entities, or their affiliates (as defined in 48 C.F.R. §2.101) acting as: a director, officer, partner, or subcontractor (as defined by 42 C.F.R. §438.230) of the PO; a person with beneficial ownership of five percent or more of the PO's equity; or a network provider or person with employment, consulting, or other arrangement with the PO for the provision of items and services that are significant and material to the PO's contractual obligations with the state if those individuals, entities, or affiliates are



debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under associated implementing guidelines;

- ii. Individuals or entities excluded from participation in any federal health program under section 1128 or 1128A of the Social Security Act.

The PO shall provide these records or documents to the Department at no charge. Records or documents involving matters that are the subject of any litigation, claim, financial management review or audit shall be retained for a period of not less than ten (10) years from the end of this contract period, following the termination or completion of the litigation, claim, financial management review or audit or disposition of real property and equipment acquired with Federal funds, whichever is later. The retention requirements described above shall include records or documents related to recoveries of all overpayments from the PO, to a provider, including specifically recoveries of overpayments due to fraud, waste, or abuse.

#### **G. Data Integrity and Systems Assessments**

Health and long-term care service information from the PO is transmitted to the Department on a regular basis through the encounter reporting process, utilizing the LTCare IES application. This information is used for research, capitation rate calculations, and various other ad hoc applications. The accuracy of encounter data may be impacted by various systems maintained by the PO.

The purpose of data integrity and system assessments is to assure the data that exist in the organizations' originating system are accurately reflected in the data existing in the encounter data repository, and that the repository accurately reflects the service records present in the PO systems. The objectives of the data integrity and systems assessments are to verify that:

- Claims and encounter data exist in PO systems;
- Data from PO systems is presented to the State correctly;
- Data submitted to the State accurately reflects encounters; and
- Data that resides with the State is an accurate reflection of what exists in the PO system.

PO system and data integrity assessments will be scheduled and conducted on an as needed basis as determined by the Department. The PO data integrity and system assessments are specific to the PACE processes. These assessments include processes or activities regarding the operation of specific managed care programs, the operation of the LTCare IES application, or PACE financial systems and processes.



1. *PACE Organization Responsibilities*

When an assessment is scheduled, the PO shall:

- a. Appoint a primary assessment contact person to be the Department audit team's contact for scheduling and reviewing assessment activities, and to provide acceptance of the final assessment report. At the same time, designate a back-up person who will be available to perform this function when needed;
- b. Supply ad hoc reconciliation reports as requested by the Department assessment team within 30 calendar days of the request, using date parameters specified by the Department's assessment team; and
- c. Comply with an onsite visit by the Department's assessment team to make available all relevant data in order to complete the assessment.

2. *Department Responsibilities*

The Department assessment team shall:

- a. Contact the PO regarding the scheduling of onsite visits at least thirty (30) calendar days prior to the visit;
- b. Develop, after completion of the assessment, an initial draft report of the findings of the assessment and share these findings with the PO within thirty (30) calendar days of the visit;
- c. Schedule a phone conference (or meeting, as appropriate) to discuss the findings of the draft report within two weeks of the release of the report. Any issues regarding the report will be jointly resolved with the PO assessment contact; and
- d. Provide a written final report to both the PO and the Department's program managers within six weeks of the phone call. The assessment report shall identify areas of compliance as well as inconsistencies found, system or data integrity vulnerabilities, and process deficiencies that may put system or data integrity at risk.

**H. Required Use of the Secure ForwardHealth Portal**

Each PO must use the secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions and other business with the Department.

POs must assign and remove users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. POs must ensure all users log in to the secure Managed Care Organization Portal to submit or retrieve account or member information that may be sensitive and/or fall under the requirements of the Health Insurance Portability and Accountability Act (HIPAA) regulations.



**I. Access to CARES Data**

The PO is authorized to have access to, and make use of, data found in the Client Assistance for Reemployment and Economic Support system (CARES) operated for the Department so that the PO will be able to help its members maintain their eligibility to receive Medicaid and remain enrolled in a PO.

1. *Department Responsibility*

- a. The Department shall give the PO query access to certain data in the CARES mainframe computer system and the CARES Worker Web system. The types of data to which the PO shall have access in CARES are data used to determine a member's eligibility to receive Medicaid and remain enrolled in a PO and data used to help a member understand and/or meet any financial or other type of obligation that he/she is required to meet in order to remain eligible to receive Medicaid. These types of data include:
  - i. Data used to calculate a member's initial room and board expense when the member first enrolls in the PO or data used to calculate any change in this expense after the member enrolls;
  - ii. Data used to calculate a member's medical and remedial expenses, cost share, or any similar financial expense or obligation or data used to calculate any changes in these expenses or obligations; and
  - iii. Data used to help a member complete his/her annual Medicaid eligibility review.
- b. The Department shall designate a data steward for providing the PO with access to CARES data who shall be responsible for:
  - i. Approving or denying requests from the PO asking that staff be given access to CARES;
  - ii. Working with staff in the Department's systems security unit to develop, implement, and/or monitor the procedures for providing PACE staff with access to data found in CARES; and
  - iii. Coordinating any other CARES data exchange requests between the Department and the PO for data that it is unable to obtain using the limited access to CARES under this contract. The Department has sole discretion as to whether to grant such requests. The PO may be required to reimburse the Department for the costs incurred in obtaining this data for the PO.

2. *PACE Organization Responsibility*

- a. The PO shall identify a PACE security and data exchange coordinator who shall be responsible for:



- i. Forwarding to the Department's data steward all requests from the PO to give or delete CARES access for individual staff members;
- ii. Working with the Department's data steward and, as necessary and appropriate, staff in the Department's systems security unit to develop, implement, and/or monitor the procedures for designating those PACE staff that will have access to data found in CARES; and
- iii. Coordinating any other data exchange requests between the Department and the PO in accordance with this agreement.

The PO will use the Agency Data Security Staff User Agreement (<https://www.dhs.wisconsin.gov/forms/f0/f00639.docx>) to notify the Department of new designations or changes to the primary or secondary PACE Security and Data Exchange Coordinator.

- b. The PO shall protect the confidentiality of data it obtains by exercising its right to access CARES. Protecting the confidentiality of this data includes, but is not limited to, protecting it from access by, or disclosure to, individuals who are not authorized to see it. The PO shall:
  - i. Give access to CARES data only to authorized staff members;
  - ii. Use the data that it obtains under this agreement only for the purpose listed in this section;
  - iii. Store the data that it obtains under this agreement in a place that has been physically secured from access by unauthorized individuals in accordance with the Department's security rules and security system rules;
  - iv. Make sure that data that it obtains under this agreement that is in an electronic format, including but not limited to, magnetic tapes or discs, is stored and processed in such a way that unauthorized individuals cannot retrieve this information by using a computer or a remote terminal or by any other means;
  - v. Comply with federal and state laws, regulations, and policies that apply to and protect the confidentiality of CARES data that the PO obtains;
  - vi. Provide information and/or training to all staff members who have access to CARES data to ensure they understand PACE policies and procedures to protect the confidentiality of this data, and the federal and state laws, regulations, and policies related to confidentiality; and
  - vii. By the signature of its representative on the Agency Data Security Staff User Agreement, the PO attests that all of its staff members with access to any CARES data the PO obtains shall be required to





follow all of the policies and procedures of the Department and of the PO that apply to and protect the confidentiality of this data.

- c. The PO shall not disclose any data that it obtains under this agreement to any third party other than an individual member without prior written approval from the Department unless federal or state law requires or authorizes such a disclosure. The PO may, without prior written approval from the Department, disclose CARES data that it obtains about an individual member:
  - i. To the individual member;
  - ii. To the individual member's guardian;
  - iii. To any person who has an activated power of attorney for health care for the individual member; and
  - iv. To any person who has been designated as the individual member's authorized representative for the purpose of determining the individual's eligibility for Medicaid.
- d. Provisions related to confidentiality and disclosure of CARES data shall survive the term of this contract.

The PO shall permit authorized representatives of the Department or its agents as well as authorized representatives of federal oversight agencies and their agents to make on-site inspections of the PO to make sure that the PO is meeting the requirements of the federal and state laws, regulations, and policies applicable to access to CARES or to the use of CARES data.

### 3. *Suspension of Access to CARES for Default*

The Department shall suspend access to CARES in the event of any of the following:

- a. The PO uses any data that it obtains under this agreement for a purpose not specified in this article;
- b. The PO fails to protect the confidentiality of CARES data that it obtains or to protect it against unauthorized access or disclosure; or
- c. The PO fails to allow on-site inspections as required in this article.

Any suspension shall last until the Department is satisfied that the PO is capable of complying with the responsibilities specified in this article.

## **J. Access to LTCare Data Warehouse**

The PO is authorized to have access to, and make use of, data found in the LTCare Data Warehouse operated for the Department. The PO will be able to use the data for utilization management, network development and quality assurance and improvement.



1. *Department Responsibility*
  - a. The Department shall give the PO access to certain data in the LTCare Data Warehouse. These types of data include:
    - i. Appropriate personally identifiable member data; and
    - ii. Reference data.
  - b. The Department shall designate a data steward and/or security processes for providing the PO with access to the LTCare Data Warehouse data which shall be responsible for:
    - i. Approving or denying requests from the PO asking that staff be given access to the LTCare Data Warehouse; and
    - ii. Working with staff in the Department's systems security unit to develop, implement, and/or monitor the procedures for providing PACE staff with access to data found in the LTCare Data Warehouse.
2. *PACE Organization Responsibility*
  - a. The PO shall designate a data steward and/or security processes which shall be responsible for:
    - i. Managing all requests from the PO to give or delete LTCare Data Warehouse access for individual staff members; and
    - ii. Working with the Department's data steward and/or security processes, as necessary and appropriate, to develop, implement, and/or monitor the procedures for designating those PACE staff that will have access to data found in the LTCare Data Warehouse.
  - b. The PO shall protect the confidentiality of data it obtains by exercising its right to access the LTCare Data Warehouse. Protecting the confidentiality of this data includes, but is not limited to, protecting it from access by, or disclosure to, individuals who are not authorized to see it. The PO shall:
    - i. Give access to LTCare Data Warehouse data only to authorized staff members;
    - ii. Use the data that it obtains under this agreement only for the purpose listed in this section;
    - iii. Store the data that it obtains under this agreement in a place that has been physically secured from access by unauthorized individuals;
    - iv. Make sure that data that it obtains under this agreement that is in an electronic format, including but not limited to, magnetic tapes or discs, is stored and processed in such a way that unauthorized



individuals cannot retrieve this information by using a computer or a remote terminal or by any other means;

- v. Comply with federal and state laws, regulations, and policies that apply to and protect the confidentiality of LTCare Data Warehouse data that the PO obtains; and
- vi. Provide information and/or training to all staff members who have access to the LTCare Data Warehouse data to ensure they understand PO policies and procedures to protect the confidentiality of this data, and the federal and state laws, regulations, and policies related to confidentiality.

- c. Provisions related to confidentiality and disclosure of LTCare Data Warehouse data shall survive the term of this contract.
- d. The PO shall permit authorized representatives of the Department or its agents as well as authorized representatives of federal oversight agencies and their agents to make on-site inspections of the PO to make sure that the PO is meeting the requirements of the federal and state laws, regulations, and policies applicable to access to LTCare Data Warehouse or to the use of LTCare Data Warehouse data.

3. *Suspension of Access to LTCare Data Warehouse for Default*

The Department shall suspend access to the LTCare Data Warehouse in the event of any of the following:

- a. The PO uses any data that it obtains under this agreement for a purpose not specified in this article.
- b. The PO fails to protect the confidentiality of the LTCare Data Warehouse data that it obtains or to protect it against unauthorized access or disclosure.
- c. The PO fails to allow on-site inspections as required in this article.

Any suspension shall last until the Department is satisfied that the PO is capable of complying with the responsibilities specified in this article.



## **XV. Functions and Duties of the Department**

### **A. Division of Medicaid Services**

The Division of Medicaid Services (DMS), is the primary point of contact between the Department, the PO and other portions of the Department and the Department's contract agencies responsible for the administration and implementation of the PACE program. DMS shall assist the PO in identifying system barriers to implementation of the programs and shall facilitate intra- and interagency communications and work groups necessary to accomplish full implementation.

### **B. Reports from the PACE Organizations**

The Department will acknowledge receipt of the reports required provided at <https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf>. The Department shall have systems in place to ensure that reports and data required to be submitted by the PO shall be reviewed and analyzed by the Department in a timely manner. The Department shall respond accordingly to any indications that the PO is not making progress toward meeting all performance expectations (e.g., providing timely and accurate feedback to the PO, and offering technical assistance to help the PO correct any operational problems).

### **C. Enrollment and Disenrollment Reporting**

The Department shall notify the PO two times per month of all members that are enrolled in the PO and disenrolled from the PO under this contract. Notification shall be effected through PACE Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final PACE Enrollment Reports are members of the PO during the enrollment month indicated in the report. All members listed as a Disenroll with an effective date on either the Initial or Final PACE Enrollment Reports are members no longer enrolled in the PO.

The reports shall be generated as specified in Section E, Capitation Payment Reporting, of this article. The PO shall review the Enrollment Reports upon receipt and report inaccuracies to the Department as soon as possible but no later than ninety (90) calendar days following receipt of the reports. The PO receives Enrollment Reports and the HIPAA 834 EDI X12 File transaction. The reports are available via the ForwardHealth MCO Portal and Trading Partner Portal accounts.

### **D. ForwardHealth ID Cards**

The Department will issue new ForwardHealth cards to Medicaid recipients after they are determined to be eligible for Medicaid. When providers verify Medicaid eligibility using the ForwardHealth card, they are given managed care enrollment information for the member on the requested dates.



**E. Capitation Payment Reporting**

The Department provides the PO with Capitation Payment Reports on a weekly basis. The capitation payment report provides a detailed listing of each member and his/her enrollment and disenrollment date that is associated with each monthly capitation payment for that member. ForwardHealth interChange creates monthly capitation payments and reports on the first Friday of each month for that month. Capitation adjustments and reports are also created each week for members whose eligibility and/or enrollment information changed after a regular monthly capitation payment was made. The PO receives both the Capitation Payment Listing Report and the HIPAA 820 EDI X12 File transaction. The reports are available via the ForwardHealth MCO Portal and Trading Partner Portal accounts.

**F. Utilization Review and Control**

The Department shall waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services including LTC services provided by the PO to members.

**G. Right to Review**

The Department will submit to the PO for prior approval materials that describe the PO and that will be distributed by the Department, County or Resource Center to potential members and members.

**H. Review of Study or Audit Results**

1. *Release to the Public*

The Department shall submit to the PO for a fifteen (15) business day review/comment period, any studies or audits that are going to be released to the public that are about the PO and Medicaid.

2. *Plan of Correction*

Under normal circumstances, the Department will not implement a plan of correction prior to the PACE organization's review and response to a preliminary report. The Department may do so, however, if the circumstances warrant immediate action (i.e., if delays may jeopardize or threaten the health, safety, welfare, rights or other interest of members).

**I. Provider Certification**

The Department shall give the PO access to the names and contact information for all Medicaid certified providers in the PACE service area; in the alternative, the Department shall continue to give the PO timely responses to requests for confirmation of particular providers' Medicaid certification status.



**J. Technical Assistance**

The Department shall review reports and data submitted by the PO and shall share results of this review with the PO. In conjunction with the PO, the Department shall determine whether technical assistance may be available to assist in improving performance in any areas of identified need. The Department, in consultation with the PO, shall develop a technical assistance plan and schedule to assure compliance with all terms of this contract and quality service to members of PACE.

**K. Conflict of Interest**

The Department maintains that Department employees are subject to safeguards to prevent conflict of interest as set forth in Wis. Stats. Ch. 19.



## XVI. Contractual Relationship

### A. Contract

This document, the Contract between the PO and the Department, constitutes the entire contract between the PO and the Department and no other expression, whether oral or written, constitutes any part of this contract.

### B. Precedence When Conflict Occurs

In the event of any conflict among the following authorities, the order of precedence is as follows:

1. Federal law, state statutes, and administrative code;
2. CMS-State-PACE Program Agreement;
3. This contract;
4. DHS numbered memos (including Contract Interpretation Bulletins and Technical Assistance Series documents); and
5. PACE Organization certification documents;

Each Contract Interpretation Bulletin and Technical Assistance Series document shall be provided to the PO for review and comment at least thirty (30) calendar days prior to its effective date.

### C. Cooperation of Parties and Dispute Resolution

#### 1. *Agreement to Cooperate*

The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

#### 2. *Contract Dispute Resolution*

The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a dispute arises that the PO and the Department have been unable to resolve, the Department reserves the right to final interpretation of contract language.

#### 3. *Audit Dispute Resolution*

If the PO is dissatisfied with the Department's interpretation of an audit related issue, the PO may pursue the review process used for audits to resolve the dispute.

#### 4. *Performance of Contract Terms During Audit Dispute*

The existence of a dispute notwithstanding:

- a. Both parties agree to continue without delay to carry out all their respective responsibilities which are not affected by the dispute; and





- b. The PO further agrees to abide by the interpretation of the Department regarding the matter in dispute while the PO seeks further review of that interpretation.

**D. PACE Organization Certification**

1. *Certification*

The PO is required to demonstrate that it meets certification standards as defined by the Department.

2. *Certification Standards*

The certification standards are based on Wis. Stat. §§ 46.284(2) and (3) and Wis. Admin. Code § DHS 10.43. In addition, the PO must meet standards of performance as outlined in this contract.

3. *Certification Information and Documents*

The PO shall provide to the Department whatever information and documents the Department requests so that the Department can determine whether the PO is meeting these standards.

The PO agrees to submit the requested information by the deadlines identified in the request.

**E. Sanctions for Violation, Breach, or Non-Performance**

1. *Authority to Impose Sanctions*

The Department may impose sanctions or terminate the contract, as set forth in this article, if it determines the PO has failed to meet the performance expectations described herein. The Department may base its determinations on findings from any source.

The Department may pursue all sanctions and remedial actions with the PO that are taken with Medicaid fee-for-service providers, including any civil penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997, s.4707(a). If a basis for imposition of a sanction exists as described in this article, the PO may be subject to sanctions as described herein.

2. *Sanctions*

a. Bases for Imposing Sanctions

The Department may impose sanctions if it determines the PO has failed to meet any of the following performance expectations:

- i. The PO shall provide all necessary services that the PO is required to provide, under law or under this contract to any member covered under the contract.



- ii. The PO shall not impose premiums or charges on members that are in excess of the premiums or charges permitted under the Medicaid program.
- iii. The PO shall not act to discriminate among members on the basis of their health status or need for health care services. This includes, but is not limited to, termination of enrollment or refusal to reenroll a recipient, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by recipients whose medical condition or history indicates probable need for substantial future contractual services.
- iv. The PO shall not misrepresent or falsify information that it furnishes to CMS or to the Department.
- v. The PO shall not misrepresent or falsify information that it furnishes to a member, potential member, subcontractor, or a provider.
- vi. The PO shall comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. § 422.208 and 422.210 and Article VIII.P., Physician Incentive Plans
- vii. The PO shall not distribute directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- viii. The PO shall not violate any of the other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.
- ix. The PO shall meet financial performance expectations for solvency and financial stability as set forth in Article XVII.
- x. The PO shall meet the quality standards and performance criteria of this contract such that members are not at substantial risk of harm.
- xi. The PO shall not distribute directly or indirectly through any agent or independent contractor, any materials which describe or provide information regarding the PACE programs, which have not been approved by the Department.
- xii. The PO shall meet the encounter reporting submission and data certification due dates provided at <https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf>.



- xiii. The PO shall meet all obligations described in Article XIII.A in order to prevent the unauthorized use, disclosure, or loss of confidential information.
- xiv. The PO must not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising on behalf of a member who is his or her patient, for the following:
  - a) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
  - b) Any information the member needs to decide among all relevant treatment options.
  - c) The risks, benefits, and consequences of treatment or non-treatment.
  - d) 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 future treatment decisions.
- xv. The PO shall meet all other obligations described in federal law, state law, or the contract, not otherwise specifically described, above.

b. Types of Sanctions

The Department may impose the following sanctions for the violations described in Article XVI.E.2.a. :

- i. Civil monetary penalties.
- ii. Appointment of temporary management for a PO.
- iii. Notifying the affected members of their right to disenroll.
  - a) The PO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new PO or MCO.
  - b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new PO or MCO of the member's choosing.
- iv. Suspension of all new enrollments after the effective date of the sanction.

The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may



- extend up to the expiration of the contract as provided under Article XIX, PACE Specific Contract Terms.
- v. Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
  - vi. Imposition of a plan of correction and/or intensive oversight of PACE operations by the Department without appointment of a temporary manager.
  - vii. Denying payments for new members as provided for under the contract when, and for so long as, payment for those members is denied by CMS.
  - viii. Withholding or recovering of capitation payments.
  - ix. Termination of the contract.
  - x. Any other sanction which the Department determines, in its sole discretion, to be appropriate.
- c. Notice of Sanctions
- i. Notice to PO

Except as provided in Article XVI.E.2.e.iv. before imposing any of the sanctions described in Article XVI.E.2., the Department must give the affected PO written notice that explains the following:

    - a) The basis and nature of the sanction.
    - b) Any other due process protections that the Department elects to provide.
  - ii. Notice to CMS

The Department must notify CMS no later than thirty (30) calendar days after the imposition or lifting of any sanction described in Article XVI.E.2. The notice shall include the name of the PO, the kind of sanction and the reason for the Department's decision to impose or lift the sanction.
- d. Amounts of Civil Monetary Penalties
- Civil monetary penalties may be imposed as follows:
- i. A maximum of \$25,000 for each violation of:
    - a) Article XVI.E.2.a.i. (Failure to provide services);
    - b) Article XVI.E.2.a.v. (Misrepresentation or false statements to members, potential members, subcontractors or providers);



- c) Article XVI.E.2.a.vi. (Failure to comply with physician incentive plans); or
    - d) Article XVI.E.2.a.vii. (Marketing violations)
  - ii. A maximum of \$100,000 for each violation of:
    - a) Article XVI.E.2.a.iii. (Discrimination); or
    - b) Article XVI.E.2.a.iv. (Misrepresentation or false statements to CMS or the Department)
  - iii. A maximum of \$15,000 for each recipient the Department determines was not enrolled because of a discriminatory practice (subject to the \$100,000 overall limit above).
  - iv. 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 Department must deduct from the penalty the amount of overcharge and return it to the affected member(s).
  - v. A maximum of \$50,000 per incident for a violation described by Article XVI.E.2.a.xiii., consisting of:
    - a) \$100 for each individual whose confidential information was used, disclosed, or lost; and
    - b) \$100 per day for each day that the MCO fails to substantially comply with the Department's directives described by Article XIII.A.1.c.
    - c) In addition, in the event of a federal citation for a breach of confidentiality caused by an action or inaction of the PO, the PO is responsible for the full amount of any federal penalty imposed without regard to the limit set forth above.
  - vi. A maximum of \$100,000 for any other violation described by Article XVI.E.2.a.
- e. Special Rules for Temporary Management
  - i. Optional Imposition of Temporary Management

The Department may impose temporary management, as described by Article XVI.E.2.b.ii., only if it finds that:

    - a) There is continued egregious behavior by the PO, including but not limited to behavior that is described by Article XVI.E.2.a. or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act; or



- b) There is substantial risk to members' health; or
- c) The sanction is necessary to ensure the health of the PACE organization's members:
  - While improvements are made to remedy violations under this contract; or
  - Until there is an orderly termination or reorganization of the PO.
- ii. **Mandatory Imposition of Temporary Management**

The Department must impose temporary management (regardless of any other sanction that may be imposed) if it finds that a PO has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act, or this contract.
- iii. **Terminating Member Enrollment**

Upon appointment of temporary management, the Department must notify the affected members of their right to terminate enrollment.

  - a) The PO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new PO or MCO.
  - b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new PO or MCO of the member's choosing.
- iv. **Hearing**

The Department may not delay imposition of temporary management to provide a hearing before imposing this sanction.
- v. **Duration of Sanction**

The Department may not terminate temporary management until it determines that the PO can ensure that the sanctioned behavior will not recur.
- f. **Special Rules for Plans of Correction and Intensive Oversight**
  - i. **Plan of Correction**

If the PO fails to meet the performance expectations described in Article XVI.E.2.a., the Department may impose a plan of correction to ensure that the PO thereafter meets all performance expectations.



ii. Imposition of Intensive Oversight

The Department may also implement intensive oversight of the PACE organization's operations in order to assist the PO to come into compliance with its performance expectations.

When intensive oversight is imposed, the Department may place Department staff or designated representatives at the PO to assist the PO in meeting its performance expectations by providing technical guidance and correcting deficiencies.

g. Special Rules for Denying Payments for New Members

i. Basis for Denying Payments for New Members

The Department may recommend that CMS impose the denial of payment sanction described in Article XVI.E.2.b.vii. and 42 C.F.R. 438.730(e) if the Department determines that the PO committed a violation described in Article XVI.E.2.a.i. through Article XVI.E.2.a.vi.

ii. Effect of Department Determination

a) The Department's determination becomes CMS's determination for purposes of section 1903(m)(5)(A) of the Social Security Act unless CMS reverses or modifies it within 15 days.

b) When the Department decides to recommend denying payments for new members, this recommendation becomes CMS's decision, for purposes of section 1903(m)(5)(B)(ii) of the Social Security Act, unless CMS rejects this recommendation within 15 days.

iii. Notice of Sanction

If the Department's determination becomes CMS's determination as described in Article XVI.E.2.g.ii.b). the Department shall take the following actions:

- a) Give the PO written notice of the nature and basis of the proposed sanction;
- b) Allow the PO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommendation sanction;
- c) The Department may extend the initial 15-day period for an additional 15 days if:
  - The PO submits a written request that includes a credible explanation of why it needs additional time;





- The request is received by CMS before the end of the initial period; and
  - CMS has not determined that the PO's conduct poses a threat to a member's health or safety.
- iv. Informal Reconsideration
- a) If the PO submits a timely response to the notice of sanction, the Department shall:
    - Conduct an informal reconsideration that includes a review of the evidence by a Department official who did not participate in the original recommendation;
    - Give the PO a concise written decision setting forth the factual and legal basis for the decision; and
    - Forward the decision to CMS.
  - b) The Department decision described by Article XVI.E.2.g.iv.a). becomes CMS's decision unless CMS reverses or modifies the decision within 15 days from the date of receipt by CMS.
  - c) If CMS reverses or modifies the Department's decision, the Department shall send the PO a copy of CMS's decision.
- v. Denial of Payment
- a) CMS, based upon the recommendation of the Department, may deny payment to the State for new members of the PO under section 1903(m)(5)(B)(ii) of the Social Security Act in the following situations:
    - If a CMS determination that a PO has committed a violation described in Article XVI.E.2.a.i. through Article XVI.E.2.a.vi., is affirmed on review under Article XVI.E.2.g.iv.; or
    - If the CMS determination is not timely contested by the PO under Article XVI.E.2.g.iii.
  - b) In accordance with 42 C.F.R. 438.726(b), CMS's denial of payment for new members automatically results in a denial of Department payments to the PO for the same members. (A new member is a member that applies for enrollment after the effective date in Article XVI.E.2.g.iv.a).
- vi. Effective Date of Sanction
- a) If the PO does not seek reconsideration, a sanction is effective 15 days after the date PO is notified under Article XVI.E.2.g.iii. of the decision to impose the sanction.



- b) If the PO seeks reconsideration, the following rules apply:
- Except as specified in Article XVI.E.2.g.iv.b)., the sanction is effective on the date specified in CMS's reconsideration notice.
  - If CMS, in consultation with the Department, determines that the PO's conduct poses a serious threat to a member's health or safety, the sanction may be made effective earlier than the date of the Department's reconsideration decision under Article XVI.E.2.g.iv.a).
- vii. CMS' Role
- a) CMS retains the right to independently perform the functions assigned to the Department under Article XVI.E.2.f.i. through Article XVI.E.2.f.iv.
  - b) At the same time the Department sends notice to the PO as described by Article XVI.E.2.f.iii.a)., CMS forwards a copy of the notice to the Office of the Inspector General.
  - c) CMS conveys the determination described by Article XVI.E.2.g.ii. to the OIG for consideration of possible imposition of civil money penalties under section 1903(m)(5)(A) of the Act and part 1003 of Title 42 of the Code of Federal Regulations. In accordance with the provisions of part 1003, the OIG may impose civil money penalties on the PO in addition to, or in place of, the sanctions that may be imposed by this contract.
- h. Special Rules for Withholding or Recovering Capitation Payments
- i. Amount of Capitation Payment to be Withheld or Recovered and Recovery of Damages

The Department may withhold future capitation payments otherwise due to the PO or may recover capitation payments already paid to the PO in an amount determined by the Department to be appropriate based on the severity and persistency of the violation, breach, or non-performance.

In any case under this contract where the Department has the authority to withhold or recover capitation payments, the Department also has the authority to use all other legal processes for purposes including, but not limited to, the recovery of damages.
  - ii. Timeliness of Encounter Reporting

Notwithstanding other provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the PO if the PO fails



to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department. The Department may immediately impose liquidated damages in the amount of \$1,500 per day for each day beyond the deadline that the PO fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the PACE capitation payments.

Additionally, if it is found that the MCO failed to submit accurate and complete encounter data prior to the submission deadlines, the PO may be held responsible for reimbursing the Department for the staffing and out-of-pocket costs incurred by the Department and its contractors associated with reviewing the delayed data submission, and developing and publishing revised rates.

iii. Notice to PO

In the event the Department intends to withhold or recover capitation payments as described in this Article, the Department shall include as part of its notice described in Article XVI.E.2.d.i., documentation of:

- a) The basis for withholding or recovering capitation payments; and
- b) The amount of capitation payments that will be withheld and/or recovered, or the length of time in which capitation payments will be withheld.

3. *Termination of Contract*

a. Authority to Terminate Contract

The Department has the authority to terminate a PACE contract and enroll that entity's members in other PO or MCOs of the member's choosing, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the PO has failed to do either of the following:

- i. Carry out the substantive terms of this Contract; or
- ii. Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

b. Notice and Pre-Termination Hearing

Before terminating a PACE contract for failing to carry out substantive terms of the contract or to meet applicable requirements described in sections 1932, 1903(m), or 1905(t) of the Social Security Act and 42



C.F.R. § 438.708, the Department must provide the PO a pre-termination hearing.

The Department must do the following:

- i. Give the PO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing;
- ii. After the hearing, give the PO written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and
- iii. For an affirming decision, give members of the PO notice of the termination and information, consistent with 42 C.F.R. § 438.10, on their options for receiving Medicaid services following the effective date of termination.

c. **Disenrollment During Termination Hearing Process**

After the Department notifies a PO that it intends to terminate the contract for failing to carry out substantive terms of the contract or to meet applicable requirements described in sections 1932, 1903(m), or 1915(t) of the Social Security Act and 42 C.F.R. § 438.708, the Department may do the following:

- i. Give the PO members written notice of the Department's intent to terminate the contract.
- ii. Notify PACE members of their right to disenroll.
  - a) The PO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new PO or MCO.
  - b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new PO or MCO of the member's choosing.

**F. Modification and Termination of the Contract**

1. *Modification*

- a. This contract may be modified at any time by written mutual consent of the PO and the Department.
- b. This contract will be modified if changes in federal or state laws, rules, regulations or amendments to Wisconsin's CMS approved waivers or the state plan require modification to the contract. In the event of such change, the Department will notify the PO in writing. If the change materially



affects the PO's rights or responsibilities under the contract and the PO does not agree to the modification, the PO may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination.

- c. The capitation payment rate to the PO can be modified only as provided in Article XVIII.D., Annual Determination of Capitation Rates.

If the Department exercises the right to renew this contract, the Department will recalculate the capitation payment rate for succeeding calendar years. The PO shall have sixty (60) calendar days to accept the new capitation payment rate in writing or to initiate termination of the contract.

2. *Mutual Consent for Termination*

This contract may be terminated at any time by mutual written consent of both the PO and the Department.

3. *Unilateral Termination*

This contract may be unilaterally terminated only as follows:

- a. Termination for Convenience

Either party may terminate this Contract at any time, without cause, by providing a written notice to the other party at least 90 days in advance of the intended date of termination.

- b. Changes in Federal or State Law

This contract may be terminated at any time, by either party, due to modifications mandated by changes in federal or state law or regulations that materially affect either party's rights or responsibilities under this contract.

In such case, the party initiating such termination procedures must notify the other party in writing, at least ninety (90) days prior to the proposed date of termination, of its intent to terminate this contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the PO's reasonable and necessary costs to end operations and does not include ongoing expenses such as lease payments due after the date of termination.

- c. Changes in Reporting Requirements

If the Department proposes additional reporting requirements during the term of the contract, the PO will have thirty (30) days to review and comment on the fiscal impact of the additional reporting requirements. The Department will consider any potential fiscal impact on the PO before requiring additional reporting. If the change has significant fiscal impact, the PO may provide the Department with written notice of termination at



least ninety (90) days prior to the proposed date of termination and will not be required to provide the additional reporting.

d. Termination for Cause

If either party fails to perform under the terms of this Contract, the other party may terminate this Contract by providing written notice of any defects or failures to the non-performing party. The non-performing party will have 30 calendar days from the date of receipt of notice to cure the failures or defects established within the notice sent by the other party. If the failures or defects are not cured within 30 days of the non-performing party receiving the notice, the other party may terminate the Contract.

e. Termination when Federal or State Funds are Unavailable

i. Permanent Loss of Funding

This contract may be terminated by either party, in the event federal or state funding of contractual services rendered by the PO becomes permanently unavailable and such lack of funding would preclude reimbursement for the performance of the PO's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the PO will become unavailable, the Department shall immediately notify the PO, in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will end. In the event of termination, the contract will terminate without termination costs to either party.

ii. Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department will suspend the PO's performance of any or all of the PO's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department shall attempt to give notice of suspension of performance of any or all of the PO's obligations sixty (60) days prior to said suspension, if possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the PO will resume the suspended services within thirty (30) days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

4. *Automatic Termination of Foreign Entity*

Pursuant to 42 C.F.R. § 438.602(i), DHS is prohibited from contracting with a PO located outside of the United States. In the event a PO moves outside of the United States, this contract will be terminated.



5. *Contract Non-Renewal*

The PO or the Department may decide to not renew this contract. In the case of a non-renewal of this contract, the party deciding to not renew this contract must notify the other party in writing at least ninety (90) calendar days prior to the expiration date of this contract, and follow the procedures in para 6. and 7. of this section.

6. *Transition Plan*

In the case of this contract being terminated or a decision to not renew this contract, the PO shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to PACE members and their successful transition to applicable programs (e.g., Medicaid fee-for-service). The plan will include provisions for the transfer of all member related information held by the PO or its providers and not also held by the Department.

a. *Submission of the Transition Plan*

The PO shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the PO decides to not renew the contract; within ten (10) business days of notice of termination by the Department; or along with the PO's notice of termination.

b. *Management of the Transition*

The PO shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

c. *Continuation of Services*

If the PO has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the PO shall continue operating as a PO under this contract until all members are successfully transitioned. The Department will determine when all members have been successfully transitioned to applicable programs.

If the Department determines it necessary to do so, the PO will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the PO remains responsible, and shall provide, the services, and all terms and conditions of the contract will apply during this period.





7. *Obligations of Contracting Parties*

When termination or non-renewal of this contract occurs, the following obligations shall be met by the parties:

a. Notice to Members

The Department shall be responsible for developing the format for notifying all members of the date of termination and process by which the members continue to receive services;

b. PO Responsibilities

The PO shall be responsible for duplication, mailing and postage expenses related to said notification;

c. Return of Advanced Payments

Any payments advanced to the PO for coverage of members for periods after the date of termination or expiration shall be returned to the Department within forty-five (45) calendar days;

d. Transfer of Information

The PO shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims; and

e. Recoupments

Recoupments will be handled through a payment by the PO within ninety (90) calendar days of the end of this contract.

**G. Delegations of Authority**

The PO shall oversee and remain accountable for any functions and responsibilities that it delegates to a subcontractor or provider. For all major or minor delegation of function or authority:

1. The PO shall receive prior Department approval before entering into, changing or terminating a subcontract for the major functions in Article XIII.C.4. – care management, claims administration or quality management.

A proposed subcontract, change or termination shall be submitted by the PO not less than sixty (60) calendar days prior to the effective date of the proposal.

2. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor or provider and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's or provider's performance is inadequate.
3. Before any delegation, the PO shall evaluate the prospective subcontractor's or provider's ability to perform the activities to be delegated.



4. The PO shall monitor the subcontractor's or provider's performance on an ongoing basis and subject the subcontractor or provider to formal review at least once a year.
5. The PO shall maintain oversight of subcontractors' and providers' quality of services within the PO's internal Quality Management (QM) program.
6. If the PO identifies deficiencies or areas for improvement, the MCO and the subcontractor or provider shall take corrective action.
7. If the PO delegates selection of subcontractors or providers to another entity, the PO retains the right to approve, suspend, or terminate any subcontractor or provider selected by that entity.

## **H. Indemnification**

### *1. PACE Organization and the Department's Liability*

The PO will indemnify, defend if requested and hold harmless the state and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the operations of the PO or any of its contractors, in prosecuting work under this contract.

The Department acknowledges that the State may be required by Wis. Stat. § 895.46(1) to pay the cost of judgments against its officers, agents or employees, and that an officer, agent or employee of the State may incur liability due to negligence or misconduct. To the extent protection is afforded under Wis. Stat. §§ 893.82 and 895.46(1), the Department agrees to be responsible to the PO and all of its officers, agents and employees from all suits, actions, or claims of any character brought for or on account of any injuries or damages received by any persons or property resulting from the negligence of the Department, its employees or agents in performing under this contract.

### *2. Pass Along Federal Penalties*

- a. The PO shall indemnify the Department for any federal fiscal sanction taken against the Department or any other state agency which is attributable to action or inaction by the PO, its officers, employees, agents, providers or subcontractors that is contrary to the provisions of this contract.
- b. Prior to invoking this provision, the Department agrees to pursue any reasonable defense against the federal fiscal sanction in the available federal administrative forum. The PO shall cooperate in that defense to the extent requested by the Department.
- c. Upon notice of a threatened federal fiscal sanction, the Department may withhold payments otherwise due to the PO to the extent necessary to protect the Department against potential federal fiscal sanction. The



Department will consider the PO's requests regarding the timing and amount of any withholding adjustments.

**I. Independent Capacity of the PACE Organization**

The Department and the PO agree that the PO and any agents or employees of the PO, in the performance of this contract, shall act in an independent capacity, and not as officers or employees of the Department.

**J. Omissions**

In the event that either party hereto discovers any material omission in the provisions of this contract that is essential to the successful performance of this contract, said party may so inform the other party in writing. The parties hereto will thereafter promptly negotiate the issues in good faith in order to make reasonable adjustments necessary to perform the objectives of this contract.

**K. Choice of Law**

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The PO shall be required to bring all legal proceedings against the Department in the state courts in Dane County, Wisconsin.

**L. Waiver**

No delay or failure by the PO or the Department to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

**M. Severability**

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

**N. Force Majeure**

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.



**O. Headings**

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

**P. Assignability**

Except as allowed under subcontracting and entering into provider agreements, this contract is not assignable by the PO either in whole or in part, without the prior written consent of the Department.

**Q. Right to Publish**

The Department agrees to allow the PO to write and have such writings published provided the PO receives prior written approval from the Department before publishing writings on subjects associated with the work under this contract. The PO agrees to protect the privacy of individual members, as required under 42 C.F.R. § 434.6(a)(8).

**R. Survival**

The terms and conditions contained in this contract that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration or termination of the contract. This specifically includes, but is not limited to recoupments and confidentiality provisions. All rights and remedies of the parties provided under this contract, including but not limited to any and all sanctions for violation, breach or non-performance, survive from one contract year to the next, and survive the completion of the performance, expiration or termination of the contract.



## XVII. Fiscal Components/Provisions

### A. Financial Management

**Purpose:** The PO shall ensure continuity of care for enrolled members through sound financial management systems and practices. Financial management systems shall be sufficient to track, reconcile, report, and project the operational and financial results of the PO, and support informed decision-making. Financial management practices shall ensure the overall financial health of the organization and support the maximization of quality services with the funds expended. A PO shall also demonstrate the capacity for financial solvency and stability and the ability to assume the level of financial risk required under this contract and ensure continuity of care for enrolled members. The PO shall demonstrate its overall financial management capacity to both the Wisconsin Department of Health Services and the Wisconsin Office of the Commissioner of Insurance.

1. *Capacity for Financial Solvency and Stability – programs operated under a Licensed HMO*

PACE is required to operate under a state-licensed HMO. Under a licensed HMO, the PO must demonstrate the ability to retain operating capital and minimum risk and solvency reserves as required by the Wisconsin Office of the Commissioner of Insurance (OCI).

2. *Reporting a Substantial Proposed Change in Business Operations*

The HMO shall notify the DHS and the OCI in writing at least ninety (90) calendar days prior to any substantial change in business operations. Substantial changes include changes in articles and bylaws, organization type, geographical service areas, provider agreements, provider availability, plan administration, financial projections and guarantees, changes to the HMO's Medicaid, Medicare, or private lines of business, and any other change that might affect the financial solvency or create additional financial risk for the HMO. In addition, any transaction, or series of transactions, that exceed the lesser of 5% of the HMO's assets or 10% of net assets as of December 31 of the immediately preceding calendar year shall be deemed material and considered a substantial change. Furthermore, any changes in the items listed in Administrative Code Ins. 9.05(3) (FCP) and Ins 57.05(4) (FC) shall also be filed under this section.

The OCI, consulting with DHS as needed, shall evaluate the potential impact of the change(s) on the ongoing financial stability and day-to-day contracted operations of the HMO and may disapprove the change prior to the effective date or determine that the proposed change requires submission by the HMO of modifications to its approved business plan or revised financial projections. The HMO is referred to 9.06 for HMOs for guidance and specific requirements.

The PO should follow the guidance in Article XIX, Section B..4. when notifying DHS about geographical service area changes.



## B. Financial Reporting

**Purpose:** The PO will communicate the fiscal health of the organization and demonstrate the integrity of the financial operations consistent with the conditions of the contract and the goal to maximize services across the enrolled members through financial reporting.

### 1. *Financial Reporting to the Department*

Financial reporting for all entities is due to the Department within forty-five (45) calendar days of the close of each of the first three (3) calendar quarters as described at <https://www.dhs.wisconsin.gov/familycare/mcos/2020-report-reqs.pdf>, and in accordance with Generally Accepted Accounting Principles (GAAP). Financial reporting for the fourth quarter of the contract year is due by March 15 of the following year.

The submission of financial reports and calculations may be required on a more frequent basis at the discretion of the Department. Requests for an extension to the above stated reporting deadline(s) must be made prior to the due date and include the length of extension requested and a reason for the extension request.

The Financial Statement Certification in Addendum V, Data Certification shall be signed by the PO's financial officer and accompany the financial reporting submission.

### 2. *Financial Reporting to the Office of Commissioner of Insurance*

A licensed HMO will submit financial reporting to the Office of Commissioner of Insurance (OCI) consistent with the OCI reporting requirements.

### 3. *Medicare Bid Information*

Any contractor operating a Special Needs Plan (SNP) or PACE program for dual-eligible members must provide their annual comprehensive Medicare bid information to the Department concurrently with its submission to CMS. The PO must also file the final bid with the Department, if it differs from the original submission, or notify the Department if it did not differ, within one month of final approval by CMS.

### 4. *Payments in Excess of Capitation or Other Amounts Specified in the Contract*

The PO will submit a monthly report of any capitation payments or other payments in excess of amounts specified in the contract within sixty (60) calendar days of identification. The report will contain the following information:

- a. The PO's name;
- b. The member's Medicaid number;
- c. The member's name;
- d. The capitation month or number of capitation days if partial month;
- e. The capitation rate paid;



- f. The correct capitation rate;
- g. The reason for the overpayment, if known;
- h. The original date the overpayment was reported to DHS; and
- i. The action taken by the PO, if any.

**C. Financial Certification Process**

**Purpose:** The organization will demonstrate that it has policies, procedures, and a Department approved three year business plan, as defined by the Department, in place to continue fiscal operations required to serve the enrolled members.

The PO shall submit financial certification materials as defined by DHS to the Department.

**D. Financial Examinations**

The PO shall comply with financial examinations carried out by the Wisconsin Office of the Commissioner of Insurance, including, but not limited to, providing access to the premises and property of the PO, complying with all reasonable requests of the financial examiners, and paying the reasonable costs associated with such examinations.

Examination findings may result in DHS follow up to evidence that required changes are implemented.

**E. Financial Audit**

**Purpose:** The organization will demonstrate annually through a financial audit by an independent certified public accountant the reasonable assurance that the organization's financial statements are free from material misstatement in accordance with Generally Accepted Accounting Principles (GAAP). The audit report should demonstrate to the Department that the PO's internal controls, and related reporting systems in operation by the PO, are sufficient to ensure the integrity of the financial reporting systems.

1. *Deadline for Submission of Audited Financial Statements*

The audited financial statements are due to the Department by June 1 of the contracted fiscal period. However, if the PO is part of a county financial audit, the deadline for the PO audit is nine (9) months after the close of the county fiscal year.

Requests for an extension must be made within ten (10) calendar days prior to the audit submission due date and include the length of extension requested and provide a reason for the extension request.

2. *Auditor Qualifications*

- a. The PO will communicate to the OCI the designation of the Independent CPA that is required under Wis. Admin. Code § Ins 57.31(1) and 57.31(3).





- b. The PO will provide to the Department the required CPA Qualification Letter annually that is required under Wis. Admin. Code § Ins 57.37.

3. *Financial Audit*

The financial audit will be performed by an independent certified public accountant following Generally Accepted Auditing Standards in accordance with GAAP and should include procedures outlined in the Managed Long-term Care Audit Guide (<https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm>). The full audit report will include the following:

- a. Comparative financial statements other than audit schedules and reports required for the type of financial audit necessary for the PO entity and resulting audit report and opinion;
- b. Consolidated financial statements in a comparative format to support full reporting for the entity and all related companies;
- c. A report on the PO internal control environment over financial reporting;
- d. A report describing the system of cost allocation for shared overhead and direct services between programs or lines of business as required;
- e. A supplemental financial report that demonstrates the financial results and segregated reserves of the PO business for each state program contract where the organization serves members under multiple Medicaid managed care contracts and/or other lines of business. The report shall be in columnar format for the various programs as required;
- f. Letter(s) to Management as issued or written assurance that a Management Letter was not issued with the audit report;
- g. Management responses/corrective action plan for each audit issue identified in the audit report and/or Management letter; and
- h. The completed CPA audit checklist signed by a Financial Officer/Finance Director of the PO  
(<https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm>).
- i. A completed supplemental audit report summarizing the number of claims sampled from the auditors' work papers and the number of claims that did and did not satisfy each of the required elements in the report.  
(<https://www.dhs.wisconsin.gov/familycare/mcos/fiscal.htm>)

4. *Programs operated by a Licensed HMO(s) - Financial Audit Reports*

Financial audit reports shall also meet the requirements of the OCI.

5. *Submission of the Audit Reports*

The audit report should be submitted electronically in PDF format to [DHSLTCFiscalOversight@dhs.wisconsin.gov](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov).



If the PO is unable to submit the report electronically, then two complete paper copies must be mailed to:

Director  
Department of Health Services  
Bureau of Rate Setting  
1 West Wilson Street, Room 472  
P.O. Box 309  
Madison, WI 53707-0309

6. *Access to Financial Auditor's Work Papers*

When contracting with an audit firm, the PO shall authorize its auditor to provide access to work papers, reports, and other materials generated during the audit to the appropriate representatives of the Department and/or the Office of the Commissioner of Insurance. Such access shall include the right to obtain photocopies of the work papers and computer disks, or other electronic media, upon which records/working papers are stored.

7. *Failure to Comply with the Requirements of this Section*

In the event that the PO fails to have an appropriate financial audit performed or fails to provide a complete audit report to the Department within the specified timeframes, in addition to applying one or more of the remedies available under this contract, the Department may:

- a. Conduct an audit or arrange for an independent audit of the PO and charge the cost of completing the audit to the PO; and/or
- b. Charge the PO for all loss of federal or state aid or for penalties assessed to the Department because the PO did not submit a complete financial audit report within the required timeframe.

**F. Other Regulatory Reviews and Identified Irregularities**

The PO will notify the Department within ten (10) business days of notice of any reviews, investigations, decisions and requirements for corrective action from other state and federal regulatory agencies including but not limited to the Office of the Commissioner of Insurance, Internal Revenue Service, Department of Workforce Development, State Department of Revenue, or the Department of Labor.

The PO will notify the Department within ten (10) business days of any identified irregularities involving financial fraud from internal or contracted operations. See Article XIII, Section K. for additional information.

**G. Reporting on Savings Initiatives**

1. As a part of the business plan submitted by the PO, the PO shall report on regional or PO wide efforts to control costs in one or more service cost categories. The reporting shall include expected annual savings from these efforts.



2. During the contract year, the PO shall report quarterly on savings associated with the efforts identified in the business plan, using a method identified by the Department.
3. Notwithstanding XVII.G.2. of this contract PO under heightened financial monitoring shall report savings efforts as directed by the Department.

#### **H. Medical Loss Ratio (MLR)**

##### *1. MLR Requirement*

The PO is required to calculate and report a Medical Loss Ratio (MLR) each year consistent with MLR standards as specified by the Department and described in 42 C.F.R. § 438.8. The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)). The MLR calculation for the PACE programs includes care management service expenses in the service cost component of the calculation. The PO must submit the MLR on June 1 of the following year with the annual financial reporting submission in the designated worksheet within the MCO Financial Reporting Template. The PO must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting MLR reports in the required Financial Statement Certification submitted with the required audit submissions. If the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the PO must re-calculate the MLR for all MLR reporting years affected by the change. It must then submit a new MLR report meeting the applicable requirements in the designated worksheet within the MCO Financial Reporting Template in the next scheduled quarterly financial reporting submission based on the DHS reporting due dates.

##### *2. MLR Reporting Requirements*

- a. Each PO expense must be included under only one type of expense category defined for MLR reporting, unless a proration between expense categories is required to reflect accuracy and a description of the allocation is provided.
- b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.
- c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.
- d. Shared expenses, including the expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
- e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with adjusting and paying of claims, must be



- borne solely by the reporting entity and are not to be apportioned to the other entities.
- f. The PO may add a credibility adjustment, which are published annually by CMS, to a calculated MLR if the MLR reporting year experience is partially credible.
  - g. The PO may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. Any PO with enrollment greater than the minimum number of member months set by CMS will be determined to be fully credible.
  - h. If a PO's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.
  - i. The PO will aggregate data for all Medicaid eligibility groups covered under the contract with the Department for the long-term care programs.
  - j. The PO's MLR report must include the following:
    - i. Total incurred claims including care management expenses
    - ii. Expenditures on quality improving activities
    - iii. Expenditures related to activities compliant with program integrity requirements
    - iv. Non-claims costs
    - v. Premium/capitation revenue
    - vi. Taxes
    - vii. Licensing fees
    - viii. Regulatory fees
    - ix. Methodology(ies) for allocation of expenditures
    - x. Any credibility adjustment applied
    - xi. The calculated MLR
    - xii. Any remittance owed to the state, if applicable
    - xiii. A reconciliation of the information reported to the annual financial report
    - xiv. A description of the aggregation method used to calculate total incurred claims
    - xv. The number of member months
    - xvi. Additional description and guidelines for the MLR report are located in the MLR worksheet within the DHS MCO Financial Reporting Template.



The PO must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the PO within 180 days of the end of the MLR reporting year or within 30 days of being requested by the PO, whichever comes sooner, regardless of current contractual limitations, in order to calculate and validate the accuracy of MLR reporting to meet the DHS MLR reporting due date.



## **XVIII. Payment to the PACE Organization**

### **A. Purpose**

The purpose of the payment to the PO is to cost-effectively fund the provision of Medicaid services, and the administration thereof, within the framework of a risk-based contract.

### **B. Medicaid Capitation Rates**

In full consideration of Medicaid services rendered by the PO for each enrolled member, the Department agrees to pay the PO a monthly capitation rate. The capitation rates shall be based on actuarial standards of practice.

The capitation rates shall include funding to support relocation of members from institutional settings into the most integrated community setting.

The capitation rate shall not include any amount for recoupment of losses incurred by the PO under previous contracts nor does it include services that are not covered under the State Plan.

When the rate cell used to process a member's capitation payment changes in the middle of a month, the Department will use a daily rate to calculate the capitation payment for the member. This daily rate is based on the annualized monthly capitation rate (i.e. monthly capitation rate times twelve months) divided by the number of days in the contracted calendar year and rounded to the fourth digit to the right of the decimal. Payment of the rate is based on the daily rate multiplied by the number of days the member was enrolled for the month and rounded to the nearest cent. Examples of mid-month changes that would require the use of a daily rate to calculate the capitation rate include enrollment and disenrollments between programs or MCOs or POs, and changes in the nursing home level of care

### **C. Actuarial Basis**

The capitation rate is calculated on an actuarial basis, recognizing the payment limits set forth in 42 C.F.R. § 460.182.

### **D. Annual Determination of Capitation Rates**

The monthly capitation rates are calculated on an annual basis. The capitation rates are not subject to renegotiation once they have been accepted, unless such renegotiation is required by changes in federal or state laws, rules, or regulations.

### **E. Retention of Risk**

The PO must remain substantially at risk for providing services under this contract. Risk is defined as the possibility of the PACE organization's monetary loss or gain resulting from costs exceeding or being less than capitation payments made to the PO by the Department.



**F. Payment Schedule**

Payment to the PO shall be based on the MCO Enrollment Reports which the Department will transmit to the PO. The Department will issue payments for each person listed as an ADD or CONTINUE in the MCO Enrollment Reports within sixty (60) calendar days of the date the report is generated. The PO shall accept payments under this contract as payment in full and shall not bill, charge, collect or receive any other form of payment from the Department or the member, except as provided for in the 1915(c) waiver's post-eligibility treatment of income and PACE premiums as described in 42 C.F.R. § 460.186.

**G. Payment Method**

All payments, recoupments, and debit adjustments for payments made in error by the Department to the PO will be made via Electronic Funds Transfer (EFT) via enrollment through the secure Forward Health Portal account.

POs are responsible for maintaining complete and accurate EFT information in order to receive payment. If a PO fails to maintain complete and accurate information and the Department makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment if it is unable to recoup payment from the incorrect account.

All arrangements between the financial institution specified for EFT and the PO must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the PO via their secure ForwardHealth Portal account constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of Wis. Stat. §§ 49.49(1) and (4m), and if any such information is false, criminal or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to PO in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

**H. Health Insurance Fee Reimbursement**

The Patient Protection and Affordable Care Act (PPACA) imposed an annual fee on health insurance providers based on their net written premiums ("Annual Fee"). The Department shall reimburse the PO for the Wisconsin-specific Medicaid amount of the Annual Fee. The Department shall add an adjustment for the non-deductibility of the Annual Fee for Federal and State tax purposes (the "gross-up").





1. *Health Insurance Fee (HIF) Reimbursement Methodology Guide and WI HIF MA Calculation Template*

The guide and template outlining the reporting requirements necessary to receive reimbursement can be found on the ForwardHealth Portal in the Managed Care Organization section. The website is below:

<https://www.forwardhealth.wi.gov/WIPortal/Home/Managed%20Care%20Login/tabid/38/Default.aspx>

2. *Reporting Timeframes*

The PO shall submit the following reports to the Department each calendar year in order to receive reimbursement for HIF for the prior year. The schedule below outlines several key dates associated with HIF. Only the dates in bold require the PO to submit reports to the Department:

<i>Date</i>	<i>Explanation</i>
April 1	PO submit the NAIC MA filing for the prior year with OCI
April 15	IRS Form 8963 is filed with the IRS
July 15	Corrections to the April 15 filing sent to the IRS
<b>July 31</b>	<b>The NAIC Exhibits, WI HIF MA Calculation Template (based on 5066C), final IRS Form 8963 and the entire IRS Letter 5066C are sent to DHS</b>
August 31	IRS will issue the tax bill to the POs
<b>September 10</b>	<b>MCOs will send DHS the NAIC Exhibits, the entire IRS Letter 5066C, IRS Letter 5067C, final IRS Form 8963 and complete WI HIF MA Calculation Template (based on 5067C) and Signed Attestation</b>
September 30	PO tax payment is due to the IRS
October 10	DHS will determine final reimbursement associated with the HIF
December 31	By this date, the State will issue a retroactive capitation rate and contract amendment based on the reimbursement

The non-bolded dates are provided for reference only. The PO is responsible to inform the Department within 5 business days of the due date if an extension is necessary beyond the required dates.

Failure to submit any document, including the attestation form, that the Department finds necessary to calculate and verify the requested Medicaid reimbursement will forfeit the PO's right to reimbursement. Failure to submit all of the requested documents by the due dates may result in the reimbursement being delayed.



3. *Capitation Rate Report Adjustment*

The Department will provide reimbursement for the Annual Fee and the gross-up to the POs by approximately December 31, of each calendar year. The Department will issue a retroactive capitation rate amendment for the PO's signature incorporating the PO specific HIF reimbursement by approximately December 31, of each calendar year. The Department will adjust the acute and primary portion of the PO capitation rate. The rate will be based on the annualized enrollment from the current calendar year. The HIF capitation rate amendment will not be subject to retroactive enrollment adjustments as the PO's reimbursement and member months will be fixed at the time of the rate report adjustment.

4. *POs Participating in a Wisconsin Medicaid Program Other Than, Or In Addition To PACE Program*

The PO must clearly separate the premiums associated with each contract in a separate exhibit as well as apply all appropriate deductions. The template should include a breakout of the premiums associated with each program.

5. *Noncompliance*

The Department shall have the right to audit any records of the PO and to request any information to determine if the PO has complied with the requirements in this section. If at any time the Department determines that the PO has not complied with any requirement in this section, the Department will issue an order to the PO to comply. The PO shall comply within 15 calendar days after the Department's determination of noncompliance. If the PO fails to comply after an order, the Department may pursue action against the PO as provided under Article XVI. Additionally, action may include forfeiture of the reimbursement.

6. *Payment Disputes*

The Department shall have the right to adjust the reimbursement outside the information provided by the PO in the guide or template.

The PO may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the PO waives the right to dispute the reimbursement amount.

7. *Resolution of Reporting Errors*

If the PO discovers a reporting error, the Bureau of Rate Setting in the Division of Medicaid Services must be contacted in writing within 15 days of the discovery.

Errors discovered after the retroactive capitation rate amendment is issued will be applied to the following year's reimbursement.

POs will be responsible for using the most updated version of the guide posted to the website. Questions should be directed by email to: [DHSDMSBRS@dhs.wisconsin.gov](mailto:DHSDMSBRS@dhs.wisconsin.gov)



**I. Coordination of Benefits (COB)**

1. *General Requirement*

The PO shall ensure the pursuit and collection of monies from primary third party payers for covered services to members under this contract is completed by service providers prior to the PACE payment of claims for contracted services in accordance with 42 C.F.R. §433.138 except where the amount of reimbursement the PO can reasonably expect to receive is less than the estimated cost of recovery. Pursuit of collections will include third party liability primary insurers and casualty collections such as private health insurance, Medicare, employer-sponsored health insurance, settlements from a liability insurer, workers' compensation, long-term care insurance, and other State and Federal programs. If determined that a potentially liable third party exists, the PO must ensure that the provider bills the third party first before sending the claim to the PO. If the PO has paid claims and subsequently discovers the existence of a liable third party it must attempt to recover the money from the liable third party.

a. *Cost Effectiveness of Recovery*

"Cost effectiveness" is determined by, but not limited to, time, effort, and capital outlay required to perform the recovery activity. Upon the Department's request, the PO must establish the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe and explain the process by which the PO determines that seeking reimbursement would not be cost effective. Recovery activities include post-payment billing (i.e. pay and chase), and pursuit of the PO's subrogation rights under Wis. Stat. § 49.89. According to Wis. Stat. § 49.89 and Wis. Adm. Code ch. DHS 106, the PO has the same COB and collection rights as does the Department, and may require providers to code claims for liability in order to assist with recovery efforts.

b. *Section 1912(b) of the Social Security Act.*

Section 1912(b) of the Social Security Act is construed in a beneficiary-specific manner. The purpose of the distribution provision is to permit the beneficiary to retain third party liability benefits to which he or she is entitled, except to the extent that PACE (or the PO on behalf of PACE) is reimbursed for its costs.

The PO is required, within the constraints of state law and this Contract, to recover the costs it incurred on behalf of its members and is free to make whatever case it can to recover these costs. The PO may use the maximum fee schedule, an estimate of what a provider would charge on a FFS basis, the value of the care provided in the market place or some other acceptable proxy as the basis of recovery. But, any excess recovery, over and above the cost of care must be returned to the beneficiary.



- c. Types of Collections/Recoveries
- i. The PO must attempt to coordinate benefits with other available resources before claiming reimbursement from the Department for all services meeting the cost effectiveness threshold and all services to:
  - ii. Other available resources for benefit coordination and recovery may include, but are not limited to, all other state or federal medical care programs that are primary to Family Care, Family Care Partnership, or PACE, group or individual health insurance, ERISAs, service benefit plans, disability insurance policy, the insurance of absent parents who may have insurance to pay medical care for spouses, subrogation/worker's compensation collections, and any other available medical payments coverage that is issued without regard to liability (even if contained within a liability insurance policy). To the extent payments coverage has been issued directly to a member instead of the PO or provider for reimbursement of specific claims, the PO may require such claims to be paid by the member out of these funds.
  - iii. Subrogation collections are any recoverable amounts arising out of the settlement or other resolution of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to the PO under Wis. Stat. § 49.89(9). After attorneys' fees and expenses have been paid, the PO will collect the full amount paid on behalf of the member (subject to applicable law). Similarly, the PO shall have the right to require a full accounting of claims already paid by a liability insurer under medical payments coverage prior to its payment to verify that the PO is not issuing payment on a claim that has already been paid by an alternate funding source. To the extent a claim is undisputed (for example, worker's compensation or personal injury) and the third party insurer is covering related medical expenses, such insurance shall be considered primary to Medicaid for such claims and should make payment on any related claim(s) prior to payment by the PO.
  - iv. In accordance with federal law, certain prenatal care may only be recovered through post-payment billing (pay and chase).
  - v. Payment of coinsurance or copayment for service under Part B of Medicare may not exceed the PO's payment rate for the service minus the Medicare payment.
- d. Responsibility of Network Providers
- COB collections are the responsibility of the PO or its providers. Providers must report COB information to the PO. The PO and provider shall not



pursue collection from the enrollee, but directly from the third party payer. Access to services will not be restricted due to COB collection.

e. Reporting Requirements

To assure compliance, records shall be maintained by the PO of COB policies, procedures and resulting collections. Reporting shall be made through the Department LTCare IES reporting system consistent with established protocols and reporting requirements.

The PO must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for enrollees. The PO must seek information on other available resources from all enrollees.

2. *PACE Organization that is a Licensed HMO*

The following requirement shall apply if the PO (or the PO's parent firm and/or any subdivision or subsidiary of either the PO's parent firm or of the PO) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organizations(s), and/or employer self-insurer health plan(s):

a. Throughout the contract term, these insurers and third-party administrators shall comply in full with the provision of Wis. Stat. § 49.475. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.

b. Throughout the contract term, these insurers and third-party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin Medicaid enrollees.

c. Long-Term Care Insurance

Section 9.2 of the Wisconsin Medicaid Eligibility Handbook instructs that payments from a long-term care insurance policy should be sent to the State of Wisconsin. The State of Wisconsin will provide a payment to PO for long-term care insurance payouts it receives for a member of the PO. These payments from the State of Wisconsin may be applied to service costs incurred for the member. Service expenditures used in future year capitation rate development will be expenditures net of revenue received by the PO. If the long-term care insurance payment exceeds the cost of services for the member, then the PO should forward any remaining amount to the State of Wisconsin through the contact information identified in Section 9.2 of the Wisconsin Medicaid Eligibility Handbook.



If a PO receives a long-term care insurance payment from any source other than the State of Wisconsin, it should forward the payment to the State of Wisconsin in accordance with the policies identified in Section 9.2 of the Wisconsin Medicaid Eligibility Handbook.

**J. Suspension of Payment Based on Credible Allegation of Fraud**

1. *Requirement*

The Department shall suspend the capitation payment to the PO if it determines that there is a credible allegation of fraud by the PO, unless the Department determines there is good cause for not suspending payments or for only suspending them in part, pursuant to the requirements of 42 C.F.R. § 455.23.

2. *Credible Allegation of Fraud*

A credible allegation of fraud is, as defined in 42 C.F.R. § 455.2, one considered by the Department to have indicia of reliability based on a careful and judicious review by the Department of all assertions, facts and evidence on a case-by-case basis.

3. *Good Cause to Not Suspend Payments*

The Department shall determine whether good cause exists to not suspend payments, to suspend them only in part, or to lift a payment suspension based on the criteria under 42 C.F.R. § 455.23 (e) or (f). Good Cause shall exist if any of the following apply:

- a. Law enforcement officials request that a payment suspension not be imposed because of a possible negative affect on an investigation;
- b. Other available remedies more effectively or quickly protect Medicaid funds;
- c. The Department determines based on written evidence submitted by the PO that the suspension should be removed;
- d. Member access to items or services would be jeopardized by a payment suspension because:
  - i. The PO or a provider is the sole source of essential specialized services in a community; or
  - ii. The PO or a provider serves a large number of members within an HRSA-designated medically underserved area;
- e. Law enforcement declines to certify that a matter continues to be under investigation; or
- f. The Department determines that payment suspension is not in the best interests of the Medicaid program.



4. *Notice Requirements*

The Department shall send the PO written notice of any suspension of capitation payments:

- a. Timeframes
  - i. Within five (5) business days after taking such action unless requested by a law enforcement agency to temporarily withhold such notice; or
  - ii. Within five (5) business days after taking such action if requested in writing by law enforcement to delay the notice, which request for delay may be renewed in writing up to twice but may not exceed ninety (90) days.
- b. Content – The notice shall include the following:
  - i. A statement that payments are being suspended in accordance with 42 C.F.R. § 455.23.
  - ii. The general allegations as to the reason for the suspension.
  - iii. A statement that the suspension is temporary and the circumstances under which it will be ended.
  - iv. If the suspension is partial, the types of services or business units to which it applies.
  - v. The PO's right to submit written evidence for consideration by the Department.
  - vi. The authority for the PO to appeal the suspension and the procedures for doing so is Wis. Stats. ch. 277.

5. *Duration of Suspension*

A suspension of payment will end when:

- a. The Department or a prosecuting authority determines there is insufficient evidence of fraud;
- b. Legal proceedings related to the alleged fraud are completed; or
- c. The Department determines there is good cause to terminate the suspension.

**K. Recoupments**

The Department will not normally recoup the PO's capitation payments when the PO has actually provided services. However, the Department may recoup the PO's capitation payments in the following situations:





1. *Loss of Eligibility*

The Department will recoup capitation payments made to the PO on a pro rata basis when a member's eligibility status has changed because:

- a. The member voluntarily disenrolls;
- b. The member fails to meet functional or financial eligibility and the member has exhausted his/her grievances processes including a fair hearing which the member has requested;
- c. The member initiates a move out of the PACE service area;
- d. The member fails to pay, or to make satisfactory arrangements to pay, any cost share amount due the PO after a thirty (30) calendar day grace period;
- e. The member dies; or,
- f. The member is ineligible for Medicaid as an Institutionalized Individual consistent with 42 C.F.R. § 435.1009 and as defined in 42 C.F.R. § 435.1010.

No recoupment under this section will occur unless the PO knew, or should have known, of such status change.

2. *Other Reasons for Recoupment*

The Department will recoup the PO's capitation payments for the following situations:

- a. Correction of a computer or human error; and
- b. Disenrollment of members.

3. *Disputed Membership*

When membership is disputed, the Department shall be the final arbitrator of membership and reserves the right to recoup capitation payments that were inappropriately made.

4. *Contract Termination*

If a contract is terminated, recoupments will be accomplished through a payment by the PO within thirty (30) business days of contract termination.



**XIX. PACE Specific Contract Terms**

**A. Program**

This contract covers the PACE Program.

**B. Contracting Contingencies:**

Contracting is contingent upon:

1. The contractor being certified by the Department to provide the PACE services to the projected enrollment.
2. The PO filing a business plan amendment with OCI in accordance with s. Ins 9.06, Wis. Adm. Code.
3. The PO being approved by CMS to expand its service area.. The PO must seek Department approval of a planned service area expansion prior to submitting a service area expansion application to CMS. The PO must also notify the Department as soon as it receives approval from CMS for a service area expansion.

**C. Maximum Enrollment Level**

The Department does not guarantee any minimum enrollment level.

Expansion Areas: Enrollment of current waiver participants and persons on waiting lists in expansion areas will be limited by a transition enrollment plan approved by the Department.

**D. Target Group**

This contract covers:

1. Adults with physical disabilities, including persons with Alzheimer’s disease or terminal illness;
2. Adults with developmental disabilities; and
3. Frail elders, including persons with Alzheimer’s disease or terminal illness.

**E. Capitation Rate**

Waukesha County, Milwaukee County, Racine County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			



**F. Signatures**

In WITNESS WHEREOF, the State of Wisconsin and the PACE Organization have executed this agreement:

Executed on behalf of  
<<PO>>

Executed on behalf of  
Department of Health Services

\_\_\_\_\_  
<<name>>  
Chief Executive Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## ADDENDUM

### I. Actuarial Basis

#### A. Actuarial Capitation Rate Report

Upon completion, the 2020 actuarial rate report for the PACE contract will be posted to:  
<https://www.dhs.wisconsin.gov/familycare/mcos/capitationrates.htm>.



## ADDENDUM

### II. Requirements for Memoranda of Understanding

The PO is required to negotiate, or make a “good faith” effort to negotiate to have the following Memoranda of Understanding (MOU). The PO shall submit MOUs referred to in this contract to the Department upon the Department’s request. The PO shall submit copies of changes in MOUs to the Department within fifteen (15) business days of the effective date of the MOU.

Title	Purpose	Party	Contract Provisions
Aging & Disability Resource Center	The PO will cooperate fully in executing a memorandum of understanding or other written agreement with each ADRC within its service area that describes the circumstances in which the PO will provide services to an individual who is functionally eligible but whose financial eligibility is pending.	All ADRCs within the PACE service areas	Article IV.A.3.
Adult Protective Services MOU	The PO will cooperate fully in executing memoranda of understanding with all county agencies in its service area that are responsible for adult protective services. The memoranda will define the roles and relationships of the county EA/AAR/APS agencies and the PO as they work together to assure the care and safety of adults at risk who have been abused, neglected or financially exploited.	The county agencies that are responsible for Adult Protective Services in the PACE service area	Article VII.N, Elder Adults/Adults at Risk Agencies and Adult Protective Services,
MOU on Institute for Mental Disease (IMD) Discharge Planning	The expectation for discharge planning when the member, someone who was a member prior to losing eligibility due to institutional status, or someone who is eligible to enroll upon discharge, who is currently a resident of an IMD. The purpose of this discharge planning will be to return the individual to the most integrated setting appropriate to his/her needs.	All counties within the PACE service areas	Article VII.P, MOU on Institute for Mental Disease (IMD) Discharge Planning,
Disaster Planning and Emergency Response MOU	The PO will be familiar with, and have involvement in, the emergency government plan of the counties in which they are providing services. The MOU will address the PO’s role in emergency response.	Each county in the PACE service area	Article XIII.L, Business Continuity,
General MOU	A PO may enter into an MOU with a business, provider or similar entity. Such an	A business, provider or	Article XIII.E

Addendum II,



**Contract for the PACE Program between the  
Wisconsin Department of Health Services, Division of Medicaid Services  
and PO**

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<b>Title</b>	<b>Purpose</b>	<b>Party</b>	<b>Contract Provisions</b>
	MOU may not violate any of the requirements found in this contract concerning contracts, subcontracts, or agreements between the PO and a business, provider or similar entity	similar entity	

Addendum II,



## ADDENDUM

### III. PACE Quality Indicators

This addendum lists the quality indicators the PO will report directly to the Department.

#### A. Quality Indicators

PACE must report to the Department all quality indicators and supporting information that are reported to CMS and any other entity which has quality oversight authority over the PACE program. Quality indicators will include any available measures of members' outcomes (clinical, functional and personal experience outcomes). Reports must be submitted to the Department within ten (10) business days of being reported to the other entities. Reports should exclude member-specific identifying information, unless otherwise requested by the Department.

- a. Care management (IDT staff) turnover
- b. Influenza vaccinations
- c. Pneumococcal (Pneumovax vaccinations)
- e. Dental visits – this data will be compiled by the Department.

The Department will issue a technical assistance memo providing instructions for each of the quality indicators and definitions to be utilized by September 30 of the previous year (e.g., September 30, 2013 for 2014 quality indicators).





## ADDENDUM

### IV. Data Certification

#### A. Encounter Data Certification

This certification requires the responsible party to attest that the submitted Encounter Data is accurate, complete and truthful to the best of his/her knowledge. This is required by the managed long-term care contract. **It is the responsibility of the certifying party to assure the necessary internal checks, audits, and testing procedures have been conducted to ensure the integrity of the data.**

After the PO receives the **submission status report** indicating that the PACE organization's data has been **accepted and free of batch reject errors**, certification shall be made via the automated data certification method or, when the automated function is not available, via the Data Certification Form. The form is provided by DHS. If it is necessary to use the form, it shall be emailed to the Department ([DHSBMC@wisconsin.gov](mailto:DHSBMC@wisconsin.gov)).

#### B. Financial Certification

This certification requires the responsible party to attest that the submitted financial statement is accurate, complete and truthful to the best of his/her knowledge. **It is the responsibility of the responsible party to develop the necessary internal checks, audits, and testing procedures to assure the integrity of the financial statement.**

Certification must be included with submission of the financial statement to the State. Email the completed form to the Department ([DHSLTCFiscalOversight@dhs.wisconsin.gov](mailto:DHSLTCFiscalOversight@dhs.wisconsin.gov)).



Form should be created on PACE organization letterhead

ENCOUNTER DATA CERTIFICATION

Pursuant to the PACE contract(s) between the State of Wisconsin, Department of Health Services, Division of Long-Term Care, and the \_\_\_\_\_ PACE Organization.. The PO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as a PO. The PO acknowledges that the data submitted must be certified by a Chief Financial officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The PO hereby requests payment from the Wisconsin Medicaid program based on encounter data submitted and in so doing makes the following certification to the State of Wisconsin. as described in Federal Code 42 C.F.R. § 438.600 (e.g.).

The PO has reported to the State of Wisconsin for the month/year of \_\_\_\_\_ all new encounters included in batch ID# \_\_\_\_\_. The PO has reviewed the encounter data for the period and batch listed above and I, \_\_\_\_\_ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, \_\_\_\_\_ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the PO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

\_\_\_\_\_  
SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE

\_\_\_\_\_  
DATE SIGNED



*Form should be created on PACE organization letterhead.*

### FINANCIAL STATEMENT CERTIFICATION

Pursuant to the PACE contract(s) between the State of Wisconsin, Department of Health Services, Division of Long-Term Care, and the \_\_\_\_\_  
\_\_\_\_\_ PACE Organization.. The PO certifies that: The business entity named on this form is a qualified provider enrolled with and authorized to participate in the Wisconsin Medicaid program as a PO.

The PO acknowledges that if payment is based on any information required by the State and contained in financial statements the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The PO hereby requests payment from the Wisconsin Medicaid program based on any information required by the State and contained in financial statements submitted and in so doing makes the following certification to the State of Wisconsin.

The PO has reported to the State of Wisconsin for the period of \_\_\_\_\_  
(indicate dates) all information required by the State and contained in financial statements. The PO has reviewed the information submitted for the period listed above and I, \_\_\_\_\_  
\_\_\_\_\_ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to the State of Wisconsin in this batch is accurate, complete, and truthful. No material fact has been omitted from this form.

I, \_\_\_\_\_ (enter Name of Chief Financial Officer, Chief Executive Officer or Name of person who reports directly to and who is authorized to sign for Chief Financial Officer, Chief Executive Officer) **acknowledge that the information described above may directly affect the calculation of payments to the PO. I understand that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact.**

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SIGNATURE - NAME AND TITLE OF CFO, CEO OR DELEGATE

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DATE SIGNED



## ADDENDUM

### V. Personal Experience Outcomes In Long-Term Care

Assisting people to achieve their desired individual quality-of-life outcomes is one of the primary goals of managed long-term care. The following personal experience outcome domains are the areas of life that people in long-term care programs have identified as being important to their quality of life. They provide a framework for learning about and understanding the individual's needs, values, preferences, and priorities in the assessment and care planning process and in monitoring the quality of our long-term care programs. It is expected that each of these domains will be assessed during the member-centered planning process.

Choice – choosing:

- Where and with whom to live
- Supports and services
- Daily routines

Personal Experience – having:

- Interaction with family and friends
- Work or other meaningful activities
- Community involvement
- Stability
- Respect and fairness
- Privacy

Health and Safety – being:

- Healthy
- Safe
- Free from abuse and neglect



## ADDENDUM

### VI. Service Definitions

#### A. Home and Community-Based Waiver Services

Services under a waiver service category may not duplicate any service provided under another waiver service category or through the Medicaid State Plan.

The following services, defined in Wisconsin's s. 1915 (c) home and community-based waiver services waiver #0367.90 are included in the PACE program benefits:

1. **Adaptive aids** are controls or appliances that enable members to increase their abilities to perform ADLs and IADLs or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable members to access, participate and function in their community and competitive integrated employment. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications, etc. that allow the vehicle to be used by the member to access the community) or those costs associated with the maintenance of these items. The adaptive aids service includes the evaluation of the adaptive aids needs of a member, including a functional evaluation of the impact of the provision of appropriate adaptive aids in the customary environment of the member.

The adaptive aids service also includes (1) the purchase of a fully trained service dog from a reputable provider with experience providing structured training for service dogs; (2) the post-purchase training with a reputable provider with experience providing structured training for service dogs necessary to partner a fully trained service dog with its owner (i.e. enable the fully trained service dog and the member to work together); and (3) the ongoing maintenance costs of a fully trained service dog obtained from a reputable provider with experience providing structured training for service dogs based on DHS guidelines. For the purpose of coverage as an adaptive aid benefit, a service dog is a dog that has been individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability. Excludes costs related to a dog that does not meet the definition of a service dog for the purposes of coverage as an adaptive aid benefit (i.e. emotional support dog, therapy dog, dog training to become a service dog, household pet).

Providers of adaptive aids must be Medicaid certified providers (excluding service dog providers). Electronic devices must meet UL or FCC standards. For service dogs, provider must be a reputable provider with experience providing structured training for service dogs.

2. **Adult day care services** are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-



supportive experience or who need assistance with activities of daily living, supervision, and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the member's place of residence and the adult day care center may be provided as a component of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day). The PO may only enter a provider agreement with adult day care centers that have been certified by the Department, under Wis. Stat. § 49.45(2)(a)(11), to provide adult day care services.

3. **Assistive technology/communication aid** is an item, piece of equipment or product system whether acquired commercially, modified, or customized that enables members to (1) increase their ability to perform ADLs and IADLs or control the environment in which they live and (2) access, participate, and function in their community and in competitive integrated employment. Assistive technology service is a service that directly assists a member in the selection, acquisition, or use of an assistive technology device. Assistive technology includes the following:
  - a. Evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services in the customary environment of the member;
  - b. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the member;
  - c. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
  - d. Coordination and use of necessary therapies, interventions or services with assistive technology devices, such as therapies, interventions or service, associated with other services in the service plan;
  - e. Training or technical assistance for the member or, where appropriate, family members, advocates, legal decision makers, or other persons designated by the member; and
  - f. Training or technical assistance for professionals or other individuals who provide services to, employ or are otherwise substantially involved in the major life functions of members.

Assistive technology includes communication, which are devices or services needed to assist members with hearing, speech, communication or vision impairments. These items or services assist the individual to effectively communicate with; others, decrease reliance on paid staff, increase personal safety, enhance independence, and improve social and emotional well-being.



Communication aids include any device that addresses these objectives such as augmentative and alternative communication systems, hearing or speech amplification devices, aids and assistive devices, interpreters, cognitive retraining aids and the repair and/or servicing of such systems. Communication aids also include electronic technology, such as tablets, mobile devices, and related software that assists with communication, when the use provides assistance to a person who needs such assistance due to his or her disabilities. Applications for mobile devices or other technology also are covered under this service, when the use is primarily medical in nature or provides assistance to a member who needs such assistance due to his or her disabilities. This list is intended to be illustrative and is not exhaustive. Excludes interpreter services that are otherwise available, including for communication with the managed care organization, its contractors or other health care professionals, which are required to provide interpreter services as part of their rate.

Individual interpreters must be on the state or national interpreter registry. Communication aids vendors must be Medicaid certified providers. Electronic devices must meet UL or FCC standards.

4. **Care management** (sometimes called support and service coordination) is provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports requested by the member. The IDT initiates and oversees the initial comprehensive assessment of needs and reassessment process, the results of which are used in developing the individual's member-centered plan (MCP). The IDT identifies the member's preferred outcomes and the services needed to achieve those outcomes and monitors the member's health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help members and their families to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

Care management is always provided by individuals employed by the managed care organization or by a subcontracted agency of the managed care organization. Care management services are provided by the case manager with the member and other participants of the interdisciplinary team and include:

- a. A comprehensive assessment of the member's strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices;
- b. Development of the MCP;
- c. Authorization for the purchase of paid services identified in the MCP;
- d. Monitoring of the delivery and quality of the paid services identified in the MCP;





- e. Monitoring of the member's circumstances and ongoing health and well-being; and
- f. Maintenance of the member record and all documentation associated with the delivery of services and any required waiver procedures; and
- g. Development of a plan to assure continuity of the member's independence, care, living arrangements and preferences in the face of changes in circumstances.

For providers of this service: Wis. Stats. Ch. 441 applies to Registered Nurses and Wis. Stats. Chapter 457 applies to Social Workers.

5. **Consultative clinical and therapeutic services for caregivers.** The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions.

Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the member's treatment/support plans, are not covered by the Medicaid State Plan and are necessary to improve the member's independence and inclusion in their community.

The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans and monitoring of the member and the caregiver/staff in the implementation of the plans.

This service includes the provision of training for caregivers/staff that are or will be serving members with complex needs (beyond routine care). For example, when an individual with complex needs is relocating from one of the State Centers for the Intellectually Disabled, this service could be used to train caregivers/staff on the behavioral support plans necessary for community integration.

This service may also include consultation with service providers and potential providers to identify providers that can meet the unique needs of the member and to identify additional supports necessary for caregivers to perform therapeutic interventions.

Excludes training in member self-advocacy or caregiver advocacy on behalf of a member, which are covered under consumer education and training.

Individual counselors must have current state licensure or certification in their field of practice. Counseling agencies must comply with Wis. Admin. Code DHS § 61.35.

6. **Consumer directed supports (self-directed supports) broker** is an individual who assists a member in planning, securing and directing self-directed supports. The services of a support broker are paid for from the member's self-directed supports budget authority. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support



broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the member. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the member's target group. The member and interdisciplinary team staff are responsible to assure that a support broker selected by the member has the appropriate knowledge.

Excludes the cost of any direct services authorized and obtained by a consumer through an SDS plan, which is paid for and reported under the appropriate service definition. Excludes the cost of fiscal agent services, which is paid for and reported as financial management services.

7. **Consumer education and training** is designed to help members develop self-advocacy skills, support self-determination, exercise civil rights and acquire skills needed to exercise control and responsibility over other support services. Self-advocacy skills enable members to communicate wants and needs, make informed decisions, voice their choices, and develop trusted supports with whomever they can share concerns. The consumer education and training service includes education and training for members, their caregivers, and legal decision makers that is directly related to developing such skills. Managed care organizations assure that information about educational and/or training opportunities is available to members, and their caregivers, and legal decision makers. Covered expenses may include enrollment fees, books and other educational materials, and transportation related to participation in training courses, conferences and other similar events. Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq) or other relevant funding sources. Excludes education/training costs exceeding \$2500 per participant annually. Excludes payment for hotel and meal expenses while members or their legal decision makers attend allowable training/education events.

Providers must have expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management and decision-making.

8. **Counseling and therapeutic resources** are professional, treatment-oriented services that address a member's identified needs for personal, social, physical, medical, behavioral, emotional, cognitive, mental, or substance abuse disorders.

Counseling and therapeutic services may include assistance in adjusting to aging and/or disabilities including understanding capabilities and limitations. Services may also include assistance with interpersonal relationships, recreational therapies, music therapy, art therapy, nutritional counseling, medical counseling, weight counseling, and grief counseling.

Counseling and therapeutic services must meet clearly defined outcomes, be proven effective for the member's condition or outcome, and be cost-effective. Any alternative therapies and treatments must meet DHS requirements. Excludes



inpatient services, services provided by a physician and services covered by the Medicare program (except for payment of any Medicare cost share).

Counseling agencies must comply with Wis. Admin.Code DHS § 61.35. All providers must have current state licensure or certification in their field of practice.

9. **Environmental accessibility adaptations (home modifications)** are the provision of services and items to assess the need for, arrange for, and provide modifications and/or improvements to a member's living quarters in order to increase accessibility or safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, enable members to increase their abilities to perform ADLs or IADLs, and decrease reliance on paid providers. Home modifications may include materials and services such as ramps, stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen and/or bathroom modifications; specialized accessibility/safety adaptations; and voice-activated, light-activated, motion-activated, and other electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety, or independence of the person; prevent institutionalization; and are the most cost effective means of meeting the accessibility or safety need. Contractors must comply with local and/or state housing and building codes.
10. **Financial management services** assist members and their families to manage service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member or legal decision maker authorizes payment to be made for services included in the member's approved self-directed supports plan. Financial management services providers, sometimes referred to as fiscal intermediaries or fiscal agents, are organizations or individuals who pay personnel costs, tax withholding, worker's compensation, health insurance premiums, and other taxes and benefits as indicated in the individual's self-directed supports plan and budget for services. Financial management services are purchased directly by the PO and made available to the member/family to ensure that appropriate compensation is paid to providers. Additionally, this service includes the provision of assistance to members who are unable to manage their own personal funds. This service includes assistance to the member to effectively budget personal funds to ensure sufficient resources are available for housing, board and other essential costs. This service includes paying bills authorized by the member or his or her legal decision maker and keeping an account of disbursements. Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions. Excludes payment for the cost of room and board.



A PO must have standards in place that ensure at minimum that a financial management services provider: 1) is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the participant or legal decision maker, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal decision maker.

11. **Habilitation Services**

- a. **Daily living skills training** is the provision of education and skill development to teach members the skills involved in performing activities of daily living, including skills intended to increase the member's independence and participation in community life. This service may include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources. Daily living skills training may involve training the member or the natural support person to assist the member.

For daily living skills training agencies, the PO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

For individual daily living skills trainers, the PO shall assure that the provider has the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PO and member must ensure that the individual provider receives member-specific training sufficient to enable the individual to competently provide the daily living skills training services to the member consistent with the care plan. If personal care or housekeeping services are provided



along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

Relatives and legal guardians meeting the requirements under Article VIII.N.2 may be paid to provide daily living skills training.

- b. **Day habilitation services** are the provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and full community citizenship. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

Day habilitation services focus on enabling the member to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the - member-centered plan, such as physical, occupational, or speech therapy. For members with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Day habilitation services may also be used to provide retirement activities. As some members get older, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities.

Day habilitation may be furnished in a variety of settings in the community except for the member's residence. Day habilitation services are not limited to fixed-site facilities but may take place in stores, restaurants, libraries, parks, recreational facilities, community centers, or any other place in the community.

Transportation may be provided between a member's place of residence and the site of day habilitation activities or between habilitation activities sites (in cases where the member receives habilitation services in more than one place) as a component of day habilitation activities. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Personal care/assistance may be a component of day habilitation services as necessary to meet the need of members, but may not comprise the entirety of the service. Members who receive day habilitation services may also receive educational, supported employment, and prevocational services. Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).



For day habilitation providers, the PO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

12. **Home delivered meals** are meals provided to recipients who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home-delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor, and transportation to deliver one or two meals a day.

Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

This service does not include payment for meals at federally subsidized nutrition sites.

Hospitals and nursing homes must comply with Wis. Admin. Code Ch. DHS 124, DHS 132, and DHS 134; aging network agencies must comply with Wis. Stat. § 46.82(3); and restaurants must comply with Wis. Admin. Code Ch. ATCP 75.

13. **Housing counseling** provides assistance to a member who is acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of housing counseling is to promote consumer choice and control, increase access to affordable housing, and promote community inclusion. Housing counseling includes exploring home ownership and rental options and individual and shared housing options, including options where the member lives with his or her family. Services include counseling and assistance in identifying housing options; identifying financial resources and determining affordability; identifying preferences of location and type of housing; identifying accessibility and modification needs; locating available housing; identifying and assisting in access to financing; explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint; and planning for ongoing management and maintenance. Housing counseling is not a one-time service and may be accessed by a member at any time. A qualified provider must be an agency, or unit of an agency, that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling providers must have specialized training and experience in housing issues. This service is excluded if it is otherwise provided free to the general public. This service may not be provided by an agency that also provides residential support services or





support/service coordination to the member. Providers must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant.

14. **Personal emergency response system (PERS)** provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional, or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate. Electronic devices must meet UL Standards. Telephonic devices must meet FCC regulations.
15. **Prevocational services** are designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services allow the member to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the member and his or her care planning team. Services are expected to specifically involve strategies that enhance a member's employability in integrated, community settings.

Prevocational services should enable each member to attain the highest possible wage and work in the most integrated setting that is matched to the member's interests, strengths, priorities, and abilities.. Services intend to develop general skills that lead to employment, including :the ability to communicate effectively and establish appropriate boundaries with supervisors, co-workers and customers; express and understand expectations; engage in generally accepted community workplace conduct and adopt appropriate workplace dress; follow directions; attend to tasks; workplace problem solve; manage conflicts; and adhere to general workplace safety. Services may include mobility training.

Prevocational services may be delivered in a variety of locations in the community and are not limited to fixed-site facilities. Some examples of community sites include the library, job center, banks or businesses.

Prevocational services, regardless of how and where they are delivered, are expected to help people make reasonable and continued progress toward participation in at least part-time, integrated employment. Prevocational services are not considered outcomes; competitive employment and supported employment are considered successful outcomes of prevocational services. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

Prevocational services may not duplicate services that are provided as part of an Individualized Plan for Employment (IPE) under the Rehabilitation Act of 1973,





as amended, or as part of an approved Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA).

The contracted provider of pre-vocational services must complete a six month progress report and service plan document for the interdisciplinary care management team (IDT). The purpose is to ensure and document that prevocational services are assisting the member in progressing toward a goal of at least part-time, integrated employment. Timely completion of this document is required for the IDT to consider reauthorization of prevocational services.

Participation in prevocational services is not a pre-requisite for individual or small group supported employment services. Members who receive prevocational services may also receive educational, supported employment and/or day services. A member centered plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed for the same period of time.

Members participating in prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations, Transportation may be provided between the member's residence and the site of the prevocational services or between prevocational service sites (in cases where the member receives prevocational services in more than one place) as a component part of prevocational services or under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met. If the transportation is provided by the prevocational services provider, the cost of this transportation is included in the rate paid to the provider.

Personal care provided to a member during the receipt of prevocational services may be included in the reimbursement paid to the prevocational services provider, or it may be covered and reimbursed under another waiver service so long as there is no duplication of payment.

Prevocational services may be provided to supplement, but may not duplicate services provided under supported employment or vocational futures planning and support services provided under the waiver.

The PO shall assure the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing employment-related services that have a goal of integrated employment in the community at minimum wage or above.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration



(OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

16. **Relocation services** are services and essential items needed to establish a community living arrangement for members who are relocating from an institution, a family home, to an independent living arrangement. This service includes person-specific services, supports, or goods that are put in place to prepare for the member's relocation to a safe, accessible and affordable community living arrangement. Services or items covered by this service may not be purchased more than 180 days prior to the date that the member relocates to the new community living arrangement. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings, and kitchen appliances that are not otherwise included in a rental arrangement if applicable. Relocation services may include the payment of a security deposit, utility connection costs, and telephone installation charges. This service includes payment for moving the member's personal belongings to the new community living arrangement, general cleaning, and household organization needed to prepare the selected community living arrangement for occupancy. Relocation services exclude home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided as the waiver service home modifications. Excludes housekeeping services provided after occupancy which are considered the waiver service supportive home care. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.). Providers must be reputable contractors or companies.

17. **Residential care**

Residential care services may be authorized only:

- When members' long-term care outcomes cannot be cost-effectively supported in the member's home, or when members' health and safety cannot be adequately safe-guarded in the member's home; or
- When residential care services are a cost-effective option for meeting that member's long-term care needs.

Types of residential care:

- a. **Adult residential care – 1-2 bed adult family homes** are places in which the operator provides care, treatment, support, or services above the level of room and board to up to two adults. Services typically include supportive home care, personal care, and supervision. Services may also include recreational/social activities, behavior and social supports, daily living skills training, and transportation if provided by the operator or designee of the operator. The service includes homes that are the primary domicile of the operator and homes that are controlled and operated by a third party that hires staff to provide support and services.



Adult family home services also include coordination with other services and providers, including health care, vocational, or day services. Services may also include the provision of other waiver services as specified in the contract between the PO and residential provider. Waiver funds may not be used to pay for the cost of room and board.

Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide adult residential care in a 1-2 bed adult family home.

An adult family home sponsor must comply with WI Medicaid Waiver Standards for Certified 1-2 Bed AFH and Wis. Admin. Code Ch. DHS 82 for Barrett Homes.

- b. **Adult residential care – 3-4 bed adult family homes** are licensed under Wis. Admin. Code Ch. DHS 88 and are places where 3-4 adults, who are not related to the licensee reside, receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care, and supervision. Other services provided may include behavior and social supports, daily living skills training, and transportation performed by the operator or designee of the operator. This service type also includes homes of 3-4 beds, specified under Wis. Stat. § 50.01- (1)(a), which are licensed as a foster home under Wis. Stat. § 48.62 and certified by a certifying agency as defined under Wis. Admin. Code Ch. DHS 82. The latter are owner-occupied homes for persons with intellectual disabilities who are aging out of foster care. This category of homes permits such persons to remain in the same home, promoting continuity of care. Waiver funds may not be used to pay for the cost of room and board. A licensed adult family home must comply with Wis. Admin. Code Ch. DHS 88.
- c. **Adult residential care community-based residential facilities (CBRF)** are a residences where five (5) or more adults not related to the operator or administrator of the facility, reside and receive care, treatment, support, supervision and training. An individual with an intellectual disability may only reside in a CBRF that is licensed for eight (8) or fewer residents, unless that person has been determined to require No Active Treatment (NAT) for his or her intellectual disability. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to three hours per week of nursing care per resident. Waiver funds may not be used to pay for the cost of room and board. A licensed CBRF must comply with Wis. Admin. Code Ch. DHS 83.
- d. **Adult residential care residential care apartment complexes (RCAC)** are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct



from each other. Persons who reside in the facility also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g., personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response). Waiver funds may not be used to pay for the cost of room and board. A certified RCAC must comply with Wis. Admin. Code DHS Ch. 89.

18. **Respite** is provided for a member on a short-term basis to ease the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the member's own home or the home of a respite care provider.

For providers of this service: supportive home care agencies, individual respite providers and personal care agencies must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care; 1-2 bed adult family homes must comply with WI Medicaid Waiver Standards for 1-2 bed adult family homes and Wis. Admin. Code Ch. DHS 82 for Barrett Homes; residential care apartment complexes must comply with Wis. Admin. Code Ch. DHS 89; and hospital, nursing homes, community-based residential facilities and 3-4 bed adult family homes must comply with DHS 124, DHS 132, DHS 134, DHS 83, and DHS 88 as applicable.

Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide respite.

19. **Self-directed personal care** consists of activities that assist a member with activities of daily living, instrumental activities of daily living, and housekeeping services directly related to the care of the member to maintain the member in his or her place of residence and to assist the member to access the community. Services may include the following:

- a. Assistance with activities of daily living (ADLs): bathing; getting in and out of bed; oral, hair, and skin care excluding skilled wound care; help with toileting; simple transfers; assistance with mobility and ambulation; assistance with eating; and assistance with dressing and undressing.
- b. Assistance with instrumental activities of daily living (IADLs): managing medications and treatments normally self-administered, care of eyeglasses and hearing aids, meal preparation and serving, bill paying and other aspects of money management, using the telephone or other forms of communication, arranging and using transportation, and physical assistance to function at a job site.
- c. Housekeeping services related to the care of the person: cleaning in essential areas of the home used when assisting with ADLs and IADLs,



- laundry of the member's clothes and bedding and changing of bedding, and shopping for the member's food.
- d. Accompanying and assisting the member to access the community for medical care, employment, recreation, shopping and other purposes, as long as the provision of assistance with ADLs and IADLs is required during such trips.
  - e. Medically-oriented tasks delegated by a registered nurse pursuant to an agreement between the member and the interdisciplinary care team (IDT) staff.

Services are provided by either an individual or agency selected by the member, pursuant to a physician's order (a state law requirement) and following a member-centered plan (MCP) developed jointly by the member and IDT staff including a registered nurse. The MCP shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check and is not barred from participating in the Medicaid or Medicare program, including, relatives and legal guardian meeting the requirements under Article VIII.N.2. The member may also use an agency that is not barred from participating in the Medicaid or Medicare program. The MCP, including self-directed personal care and all other services received, is reviewed by the member and care team staff at least every six months or more often as needed. Visits by the consulting RN, who may be a member of the IDT or other nurse consultant, to the member's residence will occur at least once a year unless the member and RN agree on a more frequent visits or the RN determines that delegated nursing tasks need to be reviewed more often. The member and IDT staff will determine any training needed by selected providers and how it will be obtained. The member shall be the common law employer of individual providers; if the member selects an agency, the member shall be a managing, co-employer of the worker and the agency shall hire any worker referred by the member who passes the background check and is, or can become competent in required tasks. Services may be provided both in the member's residence and outside the residence in other community settings.

Members must have budget authority over an allocation of waiver funding through the Self-Directed Services option to receive personal care through this service and must function themselves or through a representative as either the common law employer of an individual worker or the managing, co-employer of an agency-provided worker. Members without budget authority who are authorized by PACE to receive personal care services would receive them through the State Plan personal care benefit instead.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency,



would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

- f. Medically-Related
  - i. Hospitalization;
  - ii. Nursing home or ICF/IID admission;
  - iii. Receipt of medical or rehabilitative care entailing at least an overnight absence; or
  - iv. Participation in a therapeutic rehabilitative program as defined in Wis. Admin. § DHS 101.03(175).

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

- g. Non-Medically Related
  - i. Planned vacation entailing at least an overnight absence and unaccompanied by the worker;
  - ii. Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;
  - iii. Obtaining education, employment or job, habilitative, or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or
  - iv. Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

The PO shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

Agency-employed, member-directed workers must comply with Wis. Admin. Ch. DHS 105.17. Member-employed individual workers must comply with Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.

- 20. **Skilled nursing services RN/LPN** is “professional nursing” as defined in Wisconsin’s Nurse Practice Act, Wis. Stat., Ch. 441. Nursing services are medically necessary, skilled nursing services that may only be provided safely and effectively by an advanced practice nurse, a registered nurse or a licensed practical nurse who is working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act, consistent with the member centered plan, authorized by the PO and





not otherwise available to the member under the Medicaid State Plan or through Medicare. However, the lack of coverage under the State Plan or through Medicare does not preclude the coverage of skilled nursing as a waiver service when services are within the scope of the Wisconsin Nurse Practice Act.

Under the Wisconsin Nurse Practice Act, professional nursing includes any of the following:

Professional skilled nursing means the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others that requires substantial nursing skill, knowledge, training, or application of nursing principles based on biological, physical and social sciences. Professional skilled nursing includes any of the following:

- a. The observation and recording of symptoms and reactions;
- b. The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under Wis. Stat. Ch. 448, dentist licensed under Wis. Stat. Ch. 447, or optometrist licensed under Wis. Stat. Ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state;
- c. The execution of general nursing procedures and techniques; or
- d. The supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants in accordance with Wis. Stat. Ch. 441.

Nursing services may include periodic assessment of the member's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a member's fragile or complex medical condition, as well as the monitoring of a member who has a history of non-adherence with medication or other medical treatment needs.

Delegation of nursing tasks to less skilled personnel shall be in accordance with Wis. Stat. Ch. 441 and Wis. Admin. Code Ch. N6, and the Wisconsin Nurses Association's Guidelines for Registered Nurse Delegation to Unlicensed Assistive Personnel.

These services are provided when nursing services identified as needed in a plan of care and furnished under the approved State plan limits are exhausted or when the nursing services are not covered under the Medicaid State Plan. For members enrolled in Medicare, this excludes services that are available through the Medicare program except for payment of Medicare cost share. RNs and LPNs must comply with Wis. Stat. Ch. 441.





Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide skilled nursing services.

21. **Specialized medical equipment and supplies.** Specialized medical equipment, items, devices and supplies are those items necessary to maintain the member's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided must be of direct medical or remedial benefit to the member. Allowable items, devices or supplies may include: incontinence supplies; wound dressings; IV or life support equipment; orthotics; enteral nutrition products and associated supplies and equipment not covered under the Medicaid State Plan but needed for the member to obtain adequate nutrition; over the counter medications with a National Drug Code (NDC) if not covered under the State Plan drug benefit and when prescribed by any licensed and authorized prescriber; medically necessary prescribed skin conditioning lotions/lubricants; and prescribed Vitamin D, a prescribed multivitamin and prescribed calcium supplements. (The Department of Health Services may add other prescribed vitamins or nutritional supplements in the future based on clear and convincing evidence substantiating their safety and effectiveness in maintaining health or treating or managing a medical condition.) Additionally, allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers and water treatment systems may be allowable when needed to support a member's health and safety outcomes.

Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid State Plan when coverage of the additional items or devices has been denied.

Excludes items considered as and regulated by the federal Food and Drug Administration (FDA) as nutritional supplements unless specifically covered under this definition or under the Medicaid State Plan.

Authorized DME vendors and licensed pharmacies must comply with Wis. Admin. Code Ch. DHS 105.40 or Wis. Stat. Ch. 450.

22. **Supported employment – individual employment support** is the ongoing support provided to members who, because of their disabilities, need intensive ongoing support to obtain and maintain competitive, customized, or self-employment, in an integrated work setting, in the general workforce. A member receiving this service shall be compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage, in an integrated setting in the general workforce, and in a job that meets personal and career goals.

Individual employment support services are individualized and may include any combination of the following activities: vocational/job-related discovery or



assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, job supports, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Additional services include those that are not specifically related to job skill training that enable the member to be successfully integrate into the job setting.

Individual employment supports may include support to maintain self-employment, including home-based self-employment. This service may also include services and supports that assist the member in achieving self-employment; however, Medicaid funds may not be used to defray the expenses associated with starting or operating a business. Assistance for self-employment may include the following: assistance in identifying potential business opportunities; assistance developing a business plan, including identifying potential sources of business financing and developing and launching a business; identification of the supports that are necessary in order for the member to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

Individual employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers in similar positions in the business. Individual employment support services may be provided by a co-worker or other job site personnel when (a) the services are not part of the normal duties of the co-worker, supervisor or other personnel; and (b) the individual meets the established qualifications for individual providers of this service. Employers may be reimbursed for supported employment services provided by co-workers.

Supported employment services do not include vocational services that are provided in facility based work settings and not in general community work places. Supported employment services may not include volunteer work.

Members receiving individual employment supports may also receive educational, pre-vocational and/or day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the §110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq).

Coverage does not include incentive payments, subsidies or unrelated vocational training expenses, such as:

- a. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or



- b. Wages or other payments that are passed through to users of supported employment services.

Payment for individual employment support services may be based on different methods, including, but not limited to, co-worker support models, payments for work milestones, such as length of time on the job, or number of hours the member works.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider or may be reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but it may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under the supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

When personal care/assistance or transportation or both are a component of this service, payment may not be made for such assistance or transport under another waiver service for the same period of time.

For the individual on the job support person, the PO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PO and member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

For the supported employment agency, the PO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:



- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide individual employment support.

23. **Supported employment - small group employment support** consists of services and training activities that are provided in a regular business, industry or community setting for groups of two to eight workers with disabilities. Examples include mobile crews and other business-based workgroups who employ small groups of workers with disabilities in a community setting. Small group employment support must be provided in a manner that promotes integration into the workplace and integration between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment, work experiences that leads to further career development, and individual integrated community-based employment for which a member is compensated at or above the minimum wage, but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. This service also includes other workplace support services that are not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support does not include payment for supervision, training, support, or adaptations that are typically available to workers without disabilities who fill similar positions in the business. Employers may be reimbursed for supported employment services provided by co-workers or other job site personnel, when the services that are furnished are not part of the normal



duties of the co-worker or other personnel, and when these individuals meet the qualifications established below for individual providers of service.

Supported employment services do not include vocational services provided in facility-based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places.

Supported employment services may not include volunteer work.

Members receiving small group employment support may also receive educational, pre-vocational, career planning, and day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded by § 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 et seq).

Coverage does not include incentive payments, subsidies or unrelated vocational training expenses, like the following:

- a. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- b. Wages or other payments that are passed through to users of supported employment services.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but it may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

When personal care/assistance or transportation or both are a component of supported employment services, payment may not be made for such assistance or transport under another waiver service for the same period of time.

The PO shall assure that supported employment agencies have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.



- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

The PO shall assure that the individual on the job support person has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide individual employment support.

24. **Supportive home care (SHC)** is the provision of services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include the following:
- a. Hands-on assistance with activities of daily living such as dressing/undressing; bathing; feeding; managing medications and treatments that are normally self-administered; toileting; assistance with ambulation (including the use of a walker, cane, etc.); carrying out professional therapeutic treatment plans; and grooming, such as care of hair, teeth or dentures. This may also include preparation and cleaning of areas that are used during provision of personal assistance such as the bathroom and kitchen.





- b. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member, to ensure that the member safely and appropriately completes activities of daily living and instrumental activities of daily living.
- c. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, and arrangement and usage of transportation and personal assistance at a job site and in non-employment related community activities.
- d. Routine housekeeping and cleaning activities performed for a member consisting of tasks that take place on a daily, weekly or other regular basis. These tasks may include: washing dishes, doing laundry, dusting, vacuuming, cooking, shopping and similar activities that do not involve hands-on care of the member.
- e. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the member's continued community living. These tasks may include outdoor activities, such as yard work and snow removal; indoor activities, such as window washing; cleaning of attics and basements; cleaning of carpets, rugs, and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs and other adaptive equipment; bed bug inspection and extermination; and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Relatives and legal guardians (live-in or otherwise) meeting the requirements under Article VIII.N.2. may be paid to provide any or all of the types of supportive home care. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.

Excludes training provided to a member intended to improve the member's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days when there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer





payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

Medically Related

- i. Hospitalization;
- ii. Nursing home or ICF-IID admission ;
- iii. Receipt of medical or rehabilitative care entailing at least an overnight absence; or
- iv. Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175).

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

Non-Medically Related

- i. Planned vacation entailing at least an overnight absence and unaccompanied by the worker;
- ii. Visit to relatives or friends entailing at least an overnight absence and unaccompanied by the worker;
- iii. Obtaining education, employment or job, habilitative, or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or
- iv. Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

The PO shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

All workers must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.

25. **Training services for unpaid caregivers** is the provision of training services for individuals who provide uncompensated care, training, companionship, supervision, or other supports to members.

Training includes instruction about treatment regimens and other services that are included in the member's care plan, use of equipment specified in the service plan and guidance to safely maintain the member in the community. Training must be aimed at assisting the unpaid caregiver in meeting the needs of the member. All training for individuals who provide unpaid support to the member must be included in the member's care plan and must directly relate to the individual's role in supporting the member.



This service includes, but is not limited to, on-line or in-person training; conferences; or resource materials on the specific disabilities, illnesses, or conditions that affect the member. The purpose of the training is for the caregiver to learn more about member's condition, what to expect, and how to provide the best care for someone with that specific condition. For example, training could be provided how to on effectively care for a member with dementia.

Training includes registration costs and fees associated with formal instruction in areas that are relevant to the needs identified in the member's care plan.

This service may not be provided in order to train paid caregivers. This service excludes payment for lodging and meal expenses incurred while attending a training event or conference. This service does not cover teaching self-advocacy which is covered under consumer education and training services.

This service must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

26. **Transportation (specialized transportation) – community transportation** is the provision of transportation services or items that enable a member to gain access to waiver and other community services, activities and resources, as specified in the member's care plan. This service may consist of items such as tickets, fare cards or other fare media, or services where the common carrier, specialized medical vehicle or other provider directly conveys a member and her or his attendant, if any, to destinations. Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.

Excludes transportation to receive non-emergency medical services which are covered under the Medicaid State Plan transportation benefit, or in the case of a self-directing member with budget authority to purchase such services, under the Other Transportation service. Excludes emergency (ambulance) medical transportation covered under the Medicaid State Plan service.

Taxis or common carriers must comply with Wis. Stat. Ch. 194. Public mass transit must comply with Wis. Stat. Ch. § 85.20. Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide specialized transportation (community transportation)

27. **Transportation (specialized transportation) - other transportation** consists of transportation to receive non-emergency, Medicaid-covered medical services. This service may include items such as tickets, fare cards or other fare media, reimbursement of mileage expenses, or payment for services where the provider directly conveys the member and her or his attendant, if any, by common carrier or specialized medical vehicle (SMV) as appropriate to and from receiving Medicaid-covered medical services.



Members eligible for this service must have decision-making authority over a budget for the purchase of such services. Such members (1) are not limited to providers in the PACE network, although the PO must verify credentials of specialized medical vehicle providers, (2) are not required to obtain prior authorization to purchase any transportation service from a qualified provider to any Medicaid-covered medical service if the member's budget is sufficient to pay for the service, and (3) are not required to schedule routine trips if the member can obtain transport. Legally responsible persons, relatives, or legal guardians may be paid for providing this service if they meet the conditions under Article VIII.N.2.

Excludes ambulance transportation, which is available through the Medicaid State plan. Excludes non-emergency medical transportation when authorized by PACE as a State Plan service for members without budget authority. Excludes non-medical transportation which is provided under the sub-service of Community Transportation; however the same ride may be used to provide transport to medical appointments and community activities as long as there is not duplication of payment.

Specialized transportation agencies must comply with Wis. Stat. § 85.21 and Wis. Admin. Code DHS § 61.45. Individual providers must have a valid driver's license and liability insurance. Relatives and legal guardians meeting the requirements under Article VIII.N.2. may be paid to provide specialized transportation (other transportation).

28. **Vocational futures planning and support (VFPS)** is a person-centered, team-based comprehensive employment planning and support service that provides assistance for members to obtain, maintain or advance in employment or self-employment/microenterprise. The agency providing VFPS services will ensure that the following service strategies are available as needed to the member:
- a. Development of an employment plan based on an individualized determination of the member's strengths, needs, and interests; the barriers to work, including an assistive technology pre-screen or in-depth assessment; and identification of the assets that a member brings to employment;
  - b. Work Incentive Benefits analysis and support;
  - c. Resource team coordination;
  - d. Career exploration and employment goal validation;
  - e. Job seeking support; and
  - f. Job follow-up and long-term support.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefit specialist, and an assistive technology consultant. When this service is provided, the member record must contain activity reports,



completed by the appropriate VFPS team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the ongoing support.

VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver. VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17)).

All providers shall have skills and knowledge typically acquired through completion of an advanced degree in human services, or an equivalent combination of education and experience, with ongoing training and technical assistance appropriate to their specific specialty.

**B. Medicaid State Plan Services –**

The PO must provide for the provision of all services required under Attachment 3.1-A, Supplement 1, Services provided to the categorically needy  
<<https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/3-1a-supplement1.pdf>>  
as applicable to the particular member. .

In addition to the services required under Attachment 3.1-A, Supplement 1, the PO must also provide:

Ambulatory surgical center services (Wis. Admin. Code § DHS 107.30);

Anesthesiology services (Wis. Admin. Code § DHS 107.065);

Blood services (Wis. Admin. Code § DHS 107.27);

Dialysis services (Wis. Admin Code § DHS 107.26); and

Medicare deductible and coinsurance (Wis. Admin. Code § DHS 107.02(1)(b)).

The PO will determine which services require prior authorization and use the member-centered planning process to define the service limitations. Information about specific services is found in the BadgerCare Plus and Medicaid handbooks.

The PO must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid, as set forth in 42 CFR § 438.210(a)(2), 42 CFR § 440.230, and 42 CFR part 441, subpart B.



**ADDENDUM**

**VII. Materials Cited in This Contract & Other Related Communications**

<b>Title</b>	<b>URL</b>
1. Appeal Log for Family Care, Partnership, and PACE	<a href="http://www.dhs.wisconsin.gov/library/f-02466.htm">www.dhs.wisconsin.gov/library/f-02466.htm</a>
2. Authorizing Supported Employment Job Coaching for Family Care, Partnership and PACE Members, RS memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/rs12-02.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/rs12-02.pdf</a>
3. Civil Rights Compliance Information	<a href="http://www.dhs.wisconsin.gov/civil-rights">www.dhs.wisconsin.gov/civil-rights</a>
4. Claims Audit Report for Long-Term Care MCOs, F-02022	<a href="http://www.dhs.wisconsin.gov/forms/f02022.docx">www.dhs.wisconsin.gov/forms/f02022.docx</a>
5. Community Support Program (CSP) Coverage and Billing, TA memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-03.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-03.pdf</a>
6. Community Support Program (CSP), Medicaid Maximum Allowable Fee Schedule	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-03maxfeecsp.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-03maxfeecsp.pdf</a>
7. Cost Share Cap Memo	<a href="http://www.dhs.wisconsin.gov/dltc/memos/2019-01.pdf">www.dhs.wisconsin.gov/dltc/memos/2019-01.pdf</a>
8. Cost Share Reduction Application, F-01827	<a href="http://www.dhs.wisconsin.gov/library/f-01827.htm">www.dhs.wisconsin.gov/library/f-01827.htm</a>
9. Data Security Staff User Agreement	<a href="http://www.dhs.wisconsin.gov/forms/f0/f00639.docx">www.dhs.wisconsin.gov/forms/f0/f00639.docx</a>
10. Electronic Visit Verification (EVV)	<a href="http://www.dhs.wisconsin.gov/evv">www.dhs.wisconsin.gov/evv</a>
11. Encounter Data Reporting	<a href="http://www.dhs.wisconsin.gov/ies">www.dhs.wisconsin.gov/ies</a>
12. Enrollment Discrepancy Resolution, TA memo	<a href="http://www.dhs.wisconsin.gov/publications/p01048-15-02.pdf">www.dhs.wisconsin.gov/publications/p01048-15-02.pdf</a>
13. Enrollment Discrepancy Report, F-01655	<a href="http://www.dhs.wisconsin.gov/forms/f01655.xlsx">www.dhs.wisconsin.gov/forms/f01655.xlsx</a>



14. Estate Recovery Program Handbook	<a href="http://www.dhs.wisconsin.gov/library/P-13032.htm">www.dhs.wisconsin.gov/library/P-13032.htm</a>
15. Financial Reporting Template, F-01284	<a href="http://www.dhs.wisconsin.gov/forms/f0/f01284.xlsx">www.dhs.wisconsin.gov/forms/f0/f01284.xlsx</a>
16. ForwardHealth	<a href="http://www.forwardhealth.wi.gov/WIPortal/Default.aspx">www.forwardhealth.wi.gov/WIPortal/Default.aspx</a>
17. ForwardHealth Community Partners	<a href="http://www.dhs.wisconsin.gov/forwardhealth/partners.htm">www.dhs.wisconsin.gov/forwardhealth/partners.htm</a>
18. ForwardHealth Enrollment and Benefits Handbook, P-00079	<a href="http://www.dhs.wisconsin.gov/library/p-00079.htm">www.dhs.wisconsin.gov/library/p-00079.htm</a>
19. ForwardHealth Family Care Pricing Administration Guide	<a href="http://www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Managed%20Care%20Organization/reports_data/FH_FC_Pricing_Administration_Guide.pdf.spage">www.forwardhealth.wi.gov/WIPortal/Subsystem/SW/StaticContent/Managed%20Care%20Organization/reports_data/FH_FC_Pricing_Administration_Guide.pdf.spage</a>
20. ForwardHealth Online Provider Handbooks	<a href="http://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx">www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx</a>
21. ForwardHealth Report Matrix	<a href="http://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmatrix.htm.spage">www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmatrix.htm.spage</a>
22. Fraud Reporting System	<a href="https://www.reportfraud.wisconsin.gov/RptFrd/">https://www.reportfraud.wisconsin.gov/RptFrd/</a>
23. Home and Community-Based Services (HCBS) Settings Rule	<a href="http://www.dhs.wisconsin.gov/hcbs">www.dhs.wisconsin.gov/hcbs</a>
24. Long Term Care Functional Screen	<a href="http://www.dhs.wisconsin.gov/functionalscreen">www.dhs.wisconsin.gov/functionalscreen</a>
25. Managed Long-Term Care Audit Guide, P-00466	<a href="http://www.dhs.wisconsin.gov/publications/p0/p00466.pdf">www.dhs.wisconsin.gov/publications/p0/p00466.pdf</a>
26. Medicaid Change Report, F-10137	<a href="http://www.dhs.wisconsin.gov/forms/fl/f10137.pdf">www.dhs.wisconsin.gov/forms/fl/f10137.pdf</a>
27. Medicaid Eligibility Handbook	<a href="http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm">www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm</a>
28. Medical and Remedial Expenses in Family Care, Partnership, PACE, and IRIS, DMS Memo 2017-03	<a href="http://www.dhs.wisconsin.gov/dltc/memos/2017-03.pdf">www.dhs.wisconsin.gov/dltc/memos/2017-03.pdf</a>
29. Medical and Remedial Expenses FAQs	<a href="http://www.dhs.wisconsin.gov/publications/p02006.pdf">www.dhs.wisconsin.gov/publications/p02006.pdf</a>



30. Medical and Remedial Expense Checklist, F-00295	<a href="http://www.dhs.wisconsin.gov/forms/f0/f00295.docx">www.dhs.wisconsin.gov/forms/f0/f00295.docx</a>
31. Nursing Home Commissions formed under Wis. Stat. § 49.49(7): MCO Access and Contracts, TA memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta11-02.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta11-02.pdf</a>
32. Nursing Home Commissions: Fiscal Year Rates	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/nh-rates.htm">www.dhs.wisconsin.gov/familycare/mcos/nh-rates.htm</a>
33. Out-of-County Notification Form, F-02558	<a href="http://www.dhs.wisconsin.gov/forms/f02558.docx">www.dhs.wisconsin.gov/forms/f02558.docx</a>
34. Pay Over Medicaid Fee-For-Service Rate, F-00152	<a href="http://www.dhs.wisconsin.gov/forms/f0/f00152.docx">www.dhs.wisconsin.gov/forms/f0/f00152.docx</a>
35. Prohibited Restrictive Measures in Community-Based Programs and Facilities, DMS Memo 2017-01	<a href="http://www.dhs.wisconsin.gov/dltc/memos/2017-01.pdf">www.dhs.wisconsin.gov/dltc/memos/2017-01.pdf</a>
36. Promoting Integrated Community Living in Family Care, Partnership, and PACE, TA Memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-01.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-01.pdf</a>
37. RAD guidelines, TA Memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-02.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta13-02.pdf</a>
38. Resident Relocation Manual	<a href="http://www.dhs.wisconsin.gov/relocation">www.dhs.wisconsin.gov/relocation</a>
39. Residential Provider Rate Results, TA Memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta10-06.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta10-06.pdf</a>
40. Restrictive Measures Guidelines and Procedures	<a href="http://www.dhs.wisconsin.gov/publications/p027572.pdf">www.dhs.wisconsin.gov/publications/p027572.pdf</a>
41. Restrictive Measures: Request for Use of Medical Restraints, F-62608	<a href="http://www.dhs.wisconsin.gov/library/f-62608.htm">www.dhs.wisconsin.gov/library/f-62608.htm</a>
42. Restrictive Measures: Request for Use of Restraints, Isolation, or Protective Equipment as Part of a Behavior Support Plan, F-62607	<a href="http://www.dhs.wisconsin.gov/library/f-62607.htm">www.dhs.wisconsin.gov/library/f-62607.htm</a>





43. Service Guide Dog, TA memo	<a href="http://www.dhs.wisconsin.gov/publications/p01048-15-01.pdf">www.dhs.wisconsin.gov/publications/p01048-15-01.pdf</a>
44. Six-Month and Ongoing Member Reassessment Guideline	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/rs13-03.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/rs13-03.pdf</a>
45. SSI-E Policy Handbook	<a href="http://www.emhandbooks.wisconsin.gov/ssi-e/ssi-e.htm">www.emhandbooks.wisconsin.gov/ssi-e/ssi-e.htm</a>
46. Standard Definitions of Managed Care Terminology	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/standard-terminology.htm">www.dhs.wisconsin.gov/familycare/mcos/standard-terminology.htm</a>
47. Standards for Certified 1-2 Bed AFHs	<a href="http://www.dhs.wisconsin.gov/regulations/afh/1-2bed">www.dhs.wisconsin.gov/regulations/afh/1-2bed</a>
48. Statements of Deficiency (SODs), TA Memo	<a href="http://www.dhs.wisconsin.gov/familycare/mcos/communication/ta12-01.pdf">www.dhs.wisconsin.gov/familycare/mcos/communication/ta12-01.pdf</a>
49. Supportive Home Care (SHC) Training and Documentation Standards	<a href="http://www.dhs.wisconsin.gov/publications/p01602.pdf">www.dhs.wisconsin.gov/publications/p01602.pdf</a>
50. Transition of Care Between Medicaid Programs or Between Agencies Within a Medicaid Program	<a href="http://www.dhs.wisconsin.gov/publications/p02364.pdf">www.dhs.wisconsin.gov/publications/p02364.pdf</a>
51. Undue Hardship Waiver Request, F-10193	<a href="http://www.dhs.wisconsin.gov/forms/f10193.docx">www.dhs.wisconsin.gov/forms/f10193.docx</a>
<b>Enrollment and Disenrollment Forms</b>	
52. Change Routing Form, F-02404	<a href="http://www.dhs.wisconsin.gov/forms/f0/f02404.docx">www.dhs.wisconsin.gov/forms/f0/f02404.docx</a>
PACE Enrollment Form, F-02483	<a href="https://www.dhs.wisconsin.gov/forms/f02483.docx">https://www.dhs.wisconsin.gov/forms/f02483.docx</a>
PACE Member requested Disenrollment or Transfer Form, F-02484	<a href="https://www.dhs.wisconsin.gov/forms/f02484.docx">https://www.dhs.wisconsin.gov/forms/f02484.docx</a>
53. Program-Requested Disenrollment Form, F-02403	<a href="http://www.dhs.wisconsin.gov/forms/f02403.docx">www.dhs.wisconsin.gov/forms/f02403.docx</a>
<b>Grievance and Appeals Forms</b>	
54. Adverse Benefit Determination Notice, F-00950a	<a href="https://www.dhs.wisconsin.gov/forms/f00950a.docx">https://www.dhs.wisconsin.gov/forms/f00950a.docx</a>



55. Appeal Request Forms	<a href="http://www.dhs.wisconsin.gov/familycare/mcoappeal.htm">www.dhs.wisconsin.gov/familycare/mcoappeal.htm</a>
56. Change in Level of Care Notice, F-01590	<a href="http://www.dhs.wisconsin.gov/library/f-01590.htm">www.dhs.wisconsin.gov/library/f-01590.htm</a>
57. Decision Letter: Decision Reversed, F-00232D	<a href="http://www.dhs.wisconsin.gov/library/f-00232d.htm">www.dhs.wisconsin.gov/library/f-00232d.htm</a>
58. Decision Letter: Decision Upheld, F-00232E	<a href="http://www.dhs.wisconsin.gov/library/f-00232e.htm">www.dhs.wisconsin.gov/library/f-00232e.htm</a>
59. Decision Letter: Notice of Extension for a Decision Request, F-00232B	<a href="http://www.dhs.wisconsin.gov/library/f-00232b.htm">www.dhs.wisconsin.gov/library/f-00232b.htm</a>
60. Fair Hearing Request Form, F-00236	<a href="http://www.dhs.wisconsin.gov/library/f-00236.htm">www.dhs.wisconsin.gov/library/f-00236.htm</a>
61. Fair Hearing Voluntary Withdrawal	<a href="https://doa.wi.gov/DHA/WFSVW.pdf">https://doa.wi.gov/DHA/WFSVW.pdf</a>
62. Non-Covered Benefit Notice, F-01283	<a href="http://www.dhs.wisconsin.gov/library/f-01283.htm">www.dhs.wisconsin.gov/library/f-01283.htm</a>