First Amendment to the 2015 Family Care/Partnership/PACE Contract

The following changes are made to the contract through this amendment:

Article I, Definitions, is amended to include the following definitions (all other definitions are renumbered accordingly):

54. **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.

55. **Group B**: Persons age 18 or 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.

56. **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.

109. **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.

Article III, Eligibility, Section D.3.c is amended to read:

D. Eligibility Determination Process

3. *Assisting Members to Maintain Medicaid Eligibility*

c. Assisting members to understand any deductible, cost share or patient liability obligation they may need to meet to maintain Medicaid eligibility;

Article III, Eligibility, Section E.1 is amended to read:

E. 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.wi.gov/meh-ebd/). Such members are eligible in Group A without a cost share for the remainder of the deductible period. This will happen rarely in the Family Care Program, but can occur in the following situations:

a. Members who meet a nursing home level of care and who are newly enrolling in a home and community-based waiver program may have met a Medicaid deductible prior to enrollment and thereby become financially eligible for the remainder of the six-month deductible period (see MEH Ch. 24.3). Such persons have no cost share. At the end of the deductible

period, the income maintenance agency will re-determine the member's financial eligibility, which in almost all cases will be under the special HCBS waiver eligibility group (Group B or B+). The member will then not have to meet a deductible but may have to pay a cost share depending on income and allowable deductions. The MCO shall explain these circumstances to the member and assist the member with the financial eligibility re-determination by the income maintenance agency at the end of the deductible period.

b. Members who meet a non-nursing home level of care may have met a Medicaid deducible prior to enrollment and thereby become financially eligible for the remainder of the six-month deductible period. At the end of the deductible period, the income maintenance agency will re-determine the member's Medicaid eligibility.

i. Prior to the end of the deductible period, the MCO shall explain to the member that upon re-determination, unless the member will be eligible under a different Medicaid eligibility category or is able to prepay the deductible, the member will lose Medicaid eligibility and be disenrolled when the current deductible period ends until the member can meet the deductible in the next deductible period. The MCO shall review with the member how to meet the new deductible amount, including the option to prepay it in order to avoid a period of ineligibility.

ii. The income maintenance agency will determine if the person is eligible under a different category of full-benefit Medicaid. If not, the agency will determine the new deductible amount and monitor whether it's met, including explaining the option to prepay the deductible.

Article III, Eligibility, Section E.2 is amended to read:

E. Medicaid Deductibles or Cost Share

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.

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 cost, as determined by the Department, of waiver services in a given month for all MCO waiver participants.

c. The MCO is responsible for collection of the member's monthly cost share or patient liability. The MCO's collection of cost share or patient liability from members must be in accordance with the following Department policies and procedures:

i. The MCO 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.

ii. Cost share is not prorated for partial months.

iii. If a member fails to pay the cost share or patient liability as billed by the due date, the MCO 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 MCO is willing to waive some or the entire obligation.

c) Remind the member that non-payment may result in loss of eligibility and disenrollment.

d) Attempt to convince the member to make the 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 guardian 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.

Article III, Eligibility, Section E.3. is deleted from the contract (other sections of Article III, Section E are renumbered accordingly).

Article III, Eligibility, Section E.4. is amended to read:

E. Medicaid Deductibles or Cost Share

4. *Monitoring Cost Share or Patient Liability*

The MCO is responsible for the ongoing monitoring of the cost share or patient liability amounts of its members. The MCO is also responsible for knowing what the member's ongoing medical/remedial expenses are and reporting changes in those amounts to the income maintenance agency. The MCO is also responsible to report changes in other circumstances of members that may affect the amount of cost share or patient liability to the income maintenance agency within ten (10) calendar days of the MCO becoming aware of the change.

Article V, Care Management, Section M.2.a.ii is amended to read:

F. MCO Responsibilities When a Member Changes County of Residence

2. *MCO Responsibilities*

a. For Moves Within the Geographic Service Region

ii. Complete Section D of the Family Care /Partnership /PACE Change Routing Form per instructions. The form is available at Family Care/Partnership/PACE/IRIS - Change Routing Form (F-00221A). The instructions are at Family Care/Partnership/PACE/IRIS - Change Routing Instructions (F-00221AI). Do not disenroll the member; only a transfer of Medicaid eligibility between income maintenance consortia is necessary if applicable.

Article V, Care Management, Section M.2.a.iii is deleted from the contract.

Article V, Care Management, Section M.2.b.ii is amended to read:

M. MCO Responsibilities When a Member Changes County of Residence

2. *MCO Responsibilities*

b. For Moves to Another Geographic Service Region Served by the MCO:

ii. Complete Section D of the Family Care /Partnership /PACE Change Routing Form per instructions. The form is available at Family Care/Partnership/PACE/IRIS - Change Routing Form (F-00221A). The instructions are at Family Care/Partnership/PACE/IRIS - Change Routing Instructions (F-00221AI). Do not disenroll the member; only a transfer of Medicaid eligibility between income maintenance consortia is necessary if applicable.

Article V, Care Management, Section M.2.b.iii is deleted from the contract.

Article V, Care Management, Section M.2.c.ii is amended to read:

M. MCO Responsibilities When a Member Changes County of Residence

2. *MCO Responsibilities*

c. For Moves to Another Geographic Service Region Not Served by the MCO:

ii. Explain to the member that to assure uninterrupted services, and in the case of a member in the special home and community-based waiver eligibility group (Group B or B+) uninterrupted Medicaid eligibility, it is necessary to contact the ADRC in the new county of residence to enroll in another MCO or another long term care program, preferably with the same effective date as the disenrollment from the current MCO. The MCO should facilitate this contact and coordinate disenrollment/enrollment dates with the receiving ADRC.

Article V, Care Management, Section M.2.d.ii is amended to read:

2. *MCO Responsibilities*

d. For Moves to a County without the Family Care Benefit:

ii. Explain to the member that the Family Care benefit is not available in the county to which the member intends to move. Explain that this means services may not be available from the receiving county; if not available, she or he may be placed on a 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.

Article VII, Services, Section C.2.c is amended to include (other sections of C.2.c renumbered accordingly):

C. Provision of Services in the Partnership and PACE Benefit Packages

2. *Requirements Related to Delivery of Specific Services in PACE and Partnership*

c. Transplants

ii. In applying the procedure in Section F to determine coverage of transplants for persons not enrolled in Medicare, the MCO 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.

Article VII, Services, Section C.2.e is amended to include:

C. Provision of Services in the Partnership and PACE Benefit Packages

2. *Requirements Related to Delivery of Specific Services in PACE and Partnership*

e. Drug Rebates

Outpatient prescription drugs covered for members are subject to the same rebate requirements as the fee-for- service drug benefit is subject to under §1927 of the Social Security Act. The MCO shall take such actions as the Department may determine necessary to permit the Department to collect such rebates from manufacturers for outpatient prescription drugs the MCO covers as a Medicaid benefit for members.

Article VII, Services, Section J.2. is amended to read:

J. Department Policy for Member Use of Personal Resources

2. *Permitted Uses of Member Resources*

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

Article VII, Services, Section K.2.b. The first paragraph of this section is amended to read:

K. Prevention and Wellness

2. *Prevention and Wellness 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 MCO will review and update practice guidelines periodically as appropriate.

Article VII, Services, is amended to include a new Section D. (all other sections in Article VII re-lettered accordingly):

D. Prohibited Services

1. *Provider Preventable Conditions*

   a. For Partnership and PACE members the MCO is prohibited from making payment to a provider for any provider preventable condition as defined in Article I.

   b. For Family Care members the MCO is prohibited from making payment to a provider for any provider preventable condition as defined in Article I.

2. *Assisted Suicide*

   The MCO 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 MCO 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, except for coverage of alternate services under A.5.

Article VIII, Provider Network, Section D. is amended to include one new subcontract language requirement:

D. Subcontract Language

26. *Provider Preventable Conditions*

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

Article VIII, Provider Network, Section N.2.a is amended to read:

N. Payment

2. *Federally Qualified Health Centers*

   a. Payment

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

      i. Provide payment that is not less than the level and amount of payment which the MCO 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 MCO receives from the Department for any type of provider.

Article VIII, Provider Network, Section N is amended to include (all other subsections of Section N are renumbered accordingly):

3. *Rural Health Clinics (RHCs)*

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

Article XI, Grievances and Appeals, Section C.6.c is amended to include:

C. Overall Policies and Procedures for Grievances and Appeals

6. *Continuation of Benefits during an Appeal*

c. A member does not have a right to continuation of benefits:

v. After electing to withdraw an appeal.

Article XIII, MCO Administration, Section E.1.c is amended to include (all other sections renumbered accordingly):

E. Disclosure of Interest

1. *Disclosure of Interest*

c. Information to be Disclosed

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 MCO or in any subcontractor in which the MCO 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 MCO or in any subcontractor in which the MCO 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 of the MCO.

Article XIV, Reports and Data, Section C.3. is amended to include one new Quarterly Report component.

C. Reports: Regular Interval

3. Quarterly Report

f. Identified provider-preventable conditions, if any, as defined in Article I.

Addendum X, Benefit Package Service Definitions, Section B.6 is amended to read:

B. Medicaid State Plan Services – Family Care Benefit Package

6. **Home health** as defined in Wis. Admin. Code § DHS 107.11. The MCO shall only contract for home health care services with a licensed, Medicare certified home health agency that provides the Department with a surety bond as specified in § 1861(o) (7) of the Social Security Act.

THIS CONTRACT AMENDMENT SHALL BECOME EFFECTIVE ON JULY 1, 2015.

In WITNESS WHEREOF, the State of Wisconsin and Name of MCO have executed this agreement:

Executed on behalf of Name of MCO	Executed on behalf of Department of Health Services
_____	_____
Name Title	Brian Shoup, Administrator Division of Long Term Care
_____	_____
Date	Date