XXX Amendment to the 2017 Family Care/Partnership/PACE Contract

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

Article V, Care Management, Section K.1.b is amended to read:

K. Service Authorization
   1. Service Authorization Policies and Procedures
      b. Acute and Primary Care Services in the Partnership and PACE Benefit Packages

      The MCO shall have documented and Department-approved service authorization policies and procedures for services in the acute and primary care benefit package. The MCO’s service authorization policies and procedures must be applied no more stringently for mental health/substance abuse benefits than they are for medical/surgical benefits as required by the Mental Health Parity and Addiction Equity Act. The MCO’s policies and procedures may differ from the authorization policies and procedures for services in the long-term care benefit package, and may be based on accepted clinical practices. Decisions about the authorization of services in the acute and primary care benefit package may be made outside of the IDT by other clinical professionals with consideration for member preferences.

Article V, Care Management, Section K.7 is amended to read:

K. Service Authorization
   7. Communication of Guidelines

      Upon request, the MCO shall communicate to providers and members guidelines used for review and approval of requests for specific services. Additionally, the guidelines used for review and approval of mental health/substance abuse services must be made available by MCOs serving the PACE and Partnership programs to any potential member upon request as required by the Mental Health Parity and Addiction Equity Act.

Article VII, Services, Section C.2.f is added:

C. Provision of Services in the Partnership and PACE Benefit Packages
   2. Requirements Related to Delivery of Specific Services in PACE and Partnership
      f. Mental Health and Substance Abuse Services

      Effective October 2, 2017, the Partnership and PACE programs must comply with provisions of the Mental Health Parity and Addiction Equity Act (U.S. Public Law 110-343, section 512), as interpreted in 42 CFR Part 438 Subpart K, in the provision of all AODA and mental health services identified in Addendum VIII.C.
Article VIII, Provider Network, Section K.6.c. is added:

K. Access to Providers
   6. Evidence of Adequate Service Capacity
      c. Effective October 2, 2017, the Partnership and PACE programs must comply with provisions of the Mental Health Parity and Addiction Equity Act (U.S. Public Law 110-343, section 512), as interpreted in 42 CFR Part 438 Subpart K. Partnership and PACE MCOs must submit evidence of compliance with these requirements at the time of certification.

Article XIII, MCO Administration, Section F.1 is amended to read:

F. Ineligible Organizations and Individuals
   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 F.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.)

Article XIII, MCO Administration, Section F.4 is added:

F. Ineligible Organizations and Individuals

4. Foreign Entity Exclusion

a. Participation in Medicaid

Pursuant to 42 CFR § 438.602(i), the State is prohibited from contracting with an MCO located outside of the United States. In the event an MCO moves outside of the United States, this contract will be terminated.

b. Capitation rate development

Pursuant to 42 CFR § 438.602(i), no claims paid by an MCO 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.
Article XVI, Contractual Relationship, Section F.4 is inserted, with subsequent subsections renumbered accordingly:

F. Modification and Termination of the Contract

4. Automatic Termination of Foreign Entity

Pursuant to 42 CFR § 438.602(i), DHS is prohibited from contracting with an MCO located outside of the United States. In the event an MCO moves outside of the United States, this contract will be terminated.

Article XVII, Fiscal Components/Provisions, Section E.3 is amended to read:

E. Financial Audit

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:

Article XVIII, Payment to the Managed Care Organization, Section I.1. is amended to read:

I. Coordination of Benefits (COB)

1. General Requirement

The MCO 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 MCO payment of claims for contracted services in accordance with 42 CFR §433.138. Pursuit of collections will include Third Party Liability (TPL) 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 MCO must ensure that the provider bills the third party first before sending the claim to the MCO. If the MCO 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.

In addition, in accordance with 42 CFR §438.3(t), the MCO must enter into a Coordination of Benefits Agreement (COBA) with Medicare, participate in the automated claims crossover process, and execute all deliverables in the agreement.
Addendum VIII, Benefit Package Service Definitions, Section C. is amended to read:

C. Medicaid State Plan Services – Partnership and PACE Benefit Packages

The following Medicaid State Plan long-term care and health care services defined in Wis. Admin. Code § DHS 107 with specific service definitions as noted in the reference(s) following each service and Medicare Deductibles are included in the Partnership and PACE Benefit Packages. MCOs will determine which services require prior authorization and use the member-centered planning process to define the service limitations, rather than using the requirements in Wis. Admin. Code § DHS 107.

Effective October 2, 2017, all prior authorization and other determinations relating to service limits relating to mental health and substance abuse benefits must be in compliance with the Mental Health Parity and Addiction Equity Act, (U.S. Public Law 110-343, section 512), as interpreted in 42 CFR Part 438 Subpart K. For informational purposes, information about specific services is found in the BadgerCare Plus and Medicaid handbooks at: https://www.forwardhealth.wi.gov/WIPortal/OnlineHandbooks/Display/tabid/152/Default.aspx.

THIS CONTRACT AMENDMENT SHALL BECOME EFFECTIVE UPON SIGNING.

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

Executed on behalf of Executed on behalf of
<< MCO >> Department of Health Services

<<CEO / Director>> Curtis J. Cunningham, Assistant Administrator
Chief Executive Officer Long Term Care Benefits and Programs
Division of Medicaid Services

Date Date