



**XXX Amendment to the 2018 Family Care/Partnership/PACE Contract**

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

**Article III, Eligibility, Section D.5 is amended to read:**

5. *Medicare Coverage Elections - Partnership and PACE programs*

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 from the Partnership or PACE program.

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

- iii. The system logic that determines a member's patient liability amount can offset either a MCO capitation payment or a Nursing Home Fee-for-Service (NH FFS) claim, but not both. The system will offset whichever of the two transactions that process first.

Generally, when members residing in a NH are enrolled into a MCO 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 MCOs 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 MCO should collect the liability amount.

**Article IV, Enrollment and Disenrollment, Section A.1 is amended to read:**

1. *Open Enrollment*

Conduct enrollment consistent with the resource center enrollment plan approved by the Department. All applicants shall be enrolled provided the individual meets eligibility requirements as defined in Article III.A., Eligibility Requirements, page 27. Practices that are discriminatory or that could reasonably be expected to have the effect of denying or discouraging enrollment are prohibited.

**Article IV, Enrollment and Disenrollment, Section C.3 is added:**

3. *Transition of Care*

The MCO shall comply with the Department's transition of care policy to ensure that members transitioning to the MCO from FFS Medicaid or transitioning from one MCO 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.



**Article V, Care Management, Section K.8.g.i is amended to read:**

- i. Within the timeframes identified in paragraph 9 below, if the service or item requested is in the benefit package, 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. The adverse benefit determination notice must meet the requirements of Article XI, Grievances and Appeals, page 176.

**Article V, Care Management, Section K.8.g.iv is amended to read:**

- iv. Although the MCO may cover alternative services (i.e., services outside the benefit package) as described in Article VII, Section A.7., an MCO is not required to provide a notice of adverse benefit determination when it denies a member's request for alternate service. However, the MCO is required to inform the member in writing within 14 (fourteen) days when a request for an alternative service is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template (<https://www.dhs.wisconsin.gov/library/f-01283.htm>). The IDT staff will continue to ensure that the member's health and long-term care outcomes are supported.

**Article V, Care Management, Section K.9.c is amended to read:**

- c. 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. The adverse benefit determination notice must meet the requirements of Article XI, Grievances and Appeals, page 176.

**Article V, Care Management, Section K.10 is amended to read:**

10. *Notice of Adverse Benefit Determination*  
In accordance with Article XI, Section D.1., page 182, the MCO shall provide written notice of an adverse benefit determination to the member when a decision is made to:

**Article V, Care Management, Section O.1.d is amended to read:**

- 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.

**Article VII, Services, Section A.8.a is amended to read:**

8. *In Lieu of Services*
  - a. Definition  
In lieu of services are a subset of alternate services that the Department has determined are medically appropriate and cost-effective substitutes for covered



services or settings in Addendum VIII.B for Family Care or Addendum VIII.C for Partnership and PACE; and:

- i. Are offered to a member at the discretion of the MCO; and
- ii. The member is not required by the MCO to use the alternative service or setting; and
- iii. Utilization and cost are taken into account in setting capitation rates, unless a statute or regulation explicitly requires otherwise.

**Article VII, Services, Section B.2.c is amended to read:**

- c. If a member at the non-nursing home level of care enrolls when residing in a nursing facility or ICF-IID, the LTC Functional Screen must be updated by a certified screener within three (3) business days of enrollment to determine the appropriate level of care. If the re-screening result continues to indicate a non-nursing home level of care, before notifying the member and nursing facility that nursing home services are not coverable for the member, the MCO shall follow the steps and requirements under b. i.-iii above

If the member remains at the non-nursing home level of care and the most recent MDS assessment indicates that the member's nursing home services are not Medicaid reimbursable, the MCO shall notify the member and nursing facility that this service is not in the member's benefit package and the member must be referred to the ADRC. If the MCO will terminate the nursing home service, it must provide appropriate notice in accordance with Article XI.D., Notice of Adverse Benefit Determination, page 182.

**Article VII, Services, Section K.3.a is amended to read:**

- 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.

**Article VIII, Provider Network, Section D.13 is amended to read:**

13. *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.

**Article VIII, Provider Network, Section D.26.e is amended to read:**

- e. The member's right to request the continuation of his or her benefits throughout the appeal and fair hearing process when the MCO is seeking to reduce or terminate those benefits and, if the MCO's adverse benefit determination is upheld in a hearing, the member may be liable for the cost of any continued benefits; and



**Article VIII, Provider Network, Section D.27.c is added:**

- c. Marketing/outreach activities as described in Article IX.A.5.a.-g., page 161, are prohibited.

**Article VIII, Provider Network, Section D.32 is added:**

32. *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.”

**Article VIII, Provider Network, Section G.1 is amended to read:**

1. *Wisconsin Provider Standards*

The MCO 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 newly licensed or certified as a residential provider\*, 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 must be in compliance with 42 C.F.R. § 441.301(c)(4) before the MCO can use the setting; or
- b. For State Plan services in Addendum VIII.B and C:
  - 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 MCO’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 MCO member transition plan.

**Article VIII, Provider Network, Section H.1 is amended to read:**

1. *Cultural Competency and Values*

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

The MCO 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.

**Article VIII, Provider Network, Section I is amended to read:**

I. Access to Providers

1. *Access Standards*

The MCO shall demonstrate to the Department that all services and all service providers comply with access standards provided in Article VII, Services, page 96 and the access standards in this article.

2. *Assuring Member Access To Care and Services*

The MCO 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 benefit package 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 Adequate Network Capacity*

The MCO 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 services in the benefit package 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 MCO;
  - 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 Adequate Network Capacity*
- a. The MCO 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 MCO's operations that would affect the adequacy of capacity and services, including:
      - a) Changes in MCO services, benefits, geographic service area, composition of or payments to its provider network; or
      - b) Enrollment of new population in the MCO.
  - b. The MCO 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. *Verification of MCO Network Adequacy and Access*
- The MCO 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 MCO;
  - b. A description of how the MCO 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 MCO;
  - iii. Services being provided (e.g. home health or respite);
  - iv. For Partnership and PACE programs, whether or not physicians and hospitals are accepting new MCO members;
  - v. Whether or not other network providers are accepting new MCO 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. As applicable, evidence of compliance with the Mental Health Parity and Addiction Equity Act.
  - f. DHS approved policies with supporting procedures for travel and distance times or service delivery timeframes for the providers of the services listed in the benefit package;
  - g. Current policies with supporting procedures for provider selection and retention; and
  - h. Other information the Department determines to be necessary for certification of the MCO provider network.
6. *Monitoring Access to Services*
- The MCO 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 MCO or the Department discovers deficiencies in its capacity to meet the requirements of Article VII, Services, page 96. This shall include MCO policies and procedures for interdisciplinary teams to notify the MCO network developers when they experience problems in accessing services for members.
7. *Full Enrollment*
- Any MCO that will, at any time during the term of this contract, operate the MCO in a service area where the Family Care 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 the MCO. The entitlement period is specified in Wis. Stat. § 46.286(3)(c).





**Article VIII, Provider Network, Section L.7 is amended to read:**

7. *Medicaid Rates*

a. Negotiated Rates

Except as provided in sub.b., if the MCO can negotiate such agreements with providers, the MCO 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 MCO must employ the Medicaid fee-for-service nursing home rate methodology applied solely to the MCO's residents in that nursing facility. MCOs may use either the acuity of the MCO'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. MCOs must apply nursing home retroactive rate adjustments within 90 days of DHS posting an updated rate for the nursing home.

**Article IX, Marketing and Member Materials, Section E.1.c is amended to read:**

- 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 MCO's service area.

**Article XI, Grievances and Appeals is amended to read:**

**A. Purpose and Philosophy**

Members have the right to grieve or appeal any action or inaction of an MCO that the member perceives as negatively impacting the member. The overall system for dealing with grievances and appeals has been developed in cooperation with members and other stakeholders. It is intentionally designed to offer members different options for attempting to resolve differences.

While multiple options are available to resolve grievances and appeals, members are encouraged, and usually best served, to seek to directly resolve most concerns.

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 MCO 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 MCO's grievance and appeal process is the next most direct source for resolving differences. It is described in more detail in Section 0 of this article.





3. The Department reviews grievances and appeals primarily to assure that MCOs follow their own internal grievance and appeal policies and procedures and comply with the requirements of this contract in handling any disputes with members. For more information about the Department review process see Section 0 of this article.
4. The State Fair Hearing process is the final administrative decision-making process for the Department in resolving members' appeals. It is described more fully in Section 0 of this article.
5. Other remedies available to members 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 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 that falls within the benefit package specified in Addendum VIII, 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.
    - iv. The denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VIII.
    - v. The failure to provide services and support items included in the member's MCP in a timely manner, as defined by the Department.
    - vi. The failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals.
    - vii. 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.
- viii. The involuntary disenrollment of the member from the MCO at the MCO's request.
- ix. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
- b. An "adverse benefit determination" is not:
  - i. A change in provider;
  - ii. A change in the rate the MCO 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., page 82; 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.
  - v. The denial of authorization or payment for a service or item that is not inside of the benefit package specified in Addendum VIII.

## 2. *Appeal*

An "appeal" is a request for MCO review of an "adverse benefit determination."

## 3. *Grievance*

"Grievance" is an expression of a member's dissatisfaction about any matter other than an "adverse benefit determination."

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 MCO 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 an MCO.

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

1. *General MCO Requirement*

The governing board of the MCO is responsible to assure that the MCO has a grievance and appeal system that is responsive to concerns raised by members. This function may be delegated in writing to a grievance and appeal committee.

The MCO 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 MCO adverse benefit determinations set forth in Article XI.B.1.a.ii-ix. can be reviewed by the internal MCO grievance and appeal process. Functional and financial eligibility decisions and cost share calculations cannot be reviewed by the MCO’s internal grievance and 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 MCO to resolve grievances and appeals shall be approved by the Department in initial certification and when any significant change in the MCO’s policies and procedures is made.

2. *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 an MCO grievance, MCO appeal, or State Fair Hearing. In an expedited review, the MCO 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.

3. *Provision of Case File*

The MCO 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 MCO’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 MCO in setting coverage limits and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) 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.



4. *Cooperation with Advocates*

MCOs 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.

5. *Reversed Appeal Decisions*

If the MCO appeal process or the Department review process or State Fair Hearing process reverses a decision to deny, limit, or delay services that were not furnished during the appeal, the MCO 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 MCO appeal process, the Department review process, or a State Fair Hearing process reverses a decision to deny authorization of services, and the member received the disputed services during the appeal, the MCO must pay for those services.

6. *Continuation of Benefits While an MCO Appeal or State Fair Hearing are pending*

- a. Services shall be continued by the MCO throughout the local MCO 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 0.0.0 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 MCO appeal decision. If the member makes a



timely request for continuation of benefits, the MCO 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 MCO 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 MCO 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 MCO'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 MCO's 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 is adverse to the member (i.e. upholds the MCO's adverse benefit determination) the MCO may recover the cost of services continued solely because of the requirements of this section unless the Department or the MCO determines that the person would incur a significant and substantial financial hardship as a result of repaying the cost of the services provided, in which case the Department or the MCO may waive or reduce the member's liability.

7. *Information to Providers*

In its subcontracts with providers, the MCO shall furnish providers with information regarding the grievance and appeal processes as specified in this article and require subcontractors to cooperate in grievance and appeal investigations.

**D. Notice of Adverse Benefit Determination**

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

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



The MCO must use the Department and/or CMS issued notice of adverse benefit determination form for the Family Care, Partnership and PACE Programs: <https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm>. 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 MCO must mail or hand deliver written notice of adverse benefit determination <https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm> to an affected member when the MCO intends to deny in whole or in part a request for a service included in the benefit package.

Although the MCO may cover a service that is outside of the benefit package under the circumstances set forth in Article VII, Section A.5., an MCO is not required to provide a notice of adverse benefit determination when it denies a member's request for such a service. The MCO is however required to inform members in writing when a request for a service outside the benefit package is denied. The MCO must utilize DHS' Notification of Non Covered Benefit template (<https://www.dhs.wisconsin.gov/library/f-01283.htm>) 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.86) or medical supplies (Article I.87) shall be treated by the MCO as a denial of a benefit package 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 MCO.

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

The MCO must mail or hand deliver advance written notice of adverse benefit determination <https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm> to an affected member when the MCO intends to reduce, suspend or terminate any service regardless of whether that service is included in the benefit package.

c. Denial of Payment for a Service

The MCO must mail or hand deliver written notice of adverse benefit determination <https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm> to an affected member when the MCO intends to deny a member's request for payment of a service included in the benefit package.

Although the MCO may pay for a service that is outside of the benefit package under the circumstances set forth in Article VII, Section A.5., an MCO is not required to provide a notice of adverse benefit determination



when it denies a member's request for payment of such a service. The MCO is however required to inform members in writing when a request for payment of a service outside of the benefit package is denied. The MCO 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.86) or medical supplies (Article I.87) shall be treated by the MCO as a denial of a benefit package 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 MCO.

2. *Documentation of Notice of Adverse Benefit Determination*

The MCO 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 MCO will use the DHS issued notice of adverse benefit determination form (<https://www.dhs.wisconsin.gov/familycare/mcos/noa.htm>) 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 MCO 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 MCO of the adverse benefit determination.





- e. The right of the member or any other legal decision maker to request Department review and/or request a State Fair Hearing in regard to the adverse benefit determination.
- 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 MCO 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 MCO grievance or appeal, Department 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 MCO 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 included in the benefit package, the MCO must mail or hand deliver a notice of adverse benefit determination within fourteen (14) calendar days of the request unless the MCO extends the timeframe. The MCO may extend the timeframe by up to fourteen (14) additional calendar days (for a total timeframe of twenty-eight (28) calendar days) if the member or provider requests the extension or the MCO 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 MCO must mail or hand deliver a written notification of extension to the member no later than the



fourteenth calendar day 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.

If the MCO denies a member's request for an alternate service, as described in Article VII. Section A.5., the MCO must mail or hand deliver a Notification of Non Covered Benefit (<https://www.dhs.wisconsin.gov/library/f-01283.htm>) within fourteen (14) calendar days of the request.

- ii. Expedited Service Authorizations: A member or provider may request an expedited service authorization decision. For cases in which an expedited decision is needed because a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or physical or mental health or ability to attain, maintain, or regain maximum function, the MCO must make the service authorization decision and mail or hand deliver notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after the request unless the timeframe has been extended.

In the case of an expedited decision, the timeline for a decision may be extended by an additional fourteen (14) calendar days up to a total of seventeen (17) calendar days if the member or provider requests the extension or the MCO 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 MCO must:

- a) Mail or hand deliver to the member 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
  - b) 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. A standard or expedited service authorization decision that is not reached within the timeframes specified in paragraphs i. or ii. constitutes a denial. In such situations, the MCO must send a notice of adverse benefit determination as soon as the timeframes have expired.



b. Termination, Suspension Or Reduction of Services

For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCO must mail or hand deliver a notice of adverse benefit determination

<https://www.dhs.wisconsin.gov/familycare/mcos/noa.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 MCO may take action to immediately reduce or terminate a member's service. The MCO 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 MCO 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 MCO 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 MCO 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 and their appeals rights. The MCO 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 MCO 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 MCO does not need to provide notification of change in level of care if the member is found to no longer meet any level of care because the income maintenance agency will send a Notice of Decision.

b. Adverse MCO Grievance or Appeal Decision

When the MCO 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 MCO shall use the following Department mandated templates:

i. MCO decision is upheld:

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

ii. MCO decision is reversed:

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

iii. MCO decision is upheld with respect to a service or support that was originally authorized on a temporary (episodic) or trial basis:

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

iv. MCO notification of extension for decision:

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

c. Other Adverse Benefit Determinations

A member has the right to appeal the other adverse benefit determinations identified in Article XI.B.1.a.v.-ix. The MCO shall mail or hand deliver to the member a written notification of the right to appeal these adverse benefit determinations.



2. *Documentation of Notification of Appeal Rights*

The MCO 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 in a loss or change in functional eligibility under Wis. Stat. § 46.286(1)(a), the screener shall verify the results and then immediately transfer the screen results to CARES. The screen results will also be automatically updated in ForwardHealth interChange. In addition:

- i. For Family Care, Partnership and PACE, if the functional screen results in a complete loss of functional eligibility for the program, 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 MCO must continue to provide services until the date of disenrollment.
- ii. For Family Care only, if the functional screen results in a change in level of care from the nursing home level of care to the non-nursing home level of care, the MCO shall verify the result and mail or hand deliver a notice of change in level of care which includes notification of appeal rights informing the member of the change in level of care. The effective date included in the notification shall be not less than fifteen (15) calendar days from the date the screen is calculated, and the notification shall be mailed or hand delivered to the member on the date the screen is calculated.

If the member remains enrolled at the non-nursing home level of care and the MCO will reduce or terminate any service as a result of the change in level of care, the MCO must provide an additional notice of adverse benefit determination in accordance with Article XI.D.5.b.

b. **Adverse MCO Grievance or Appeal Decision**

i. **Grievances**

The MCO 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 MCO's decision is entirely or partially adverse to the member, the decision must include the reason for the decision and any further rights to review.



ii. Appeals

The MCO 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 MCO's decision is entirely or partially adverse to the member, the decision must include notification of any further appeal rights. 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.

iii. Other adverse benefit determinations

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

**F. MCO Grievance and Appeal Process**

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

1. *Assistance in Filing a Grievance or Appeal*

The MCO must designate a "Member Rights Specialist" (see Article X.E.) who is responsible for assisting members when they are dissatisfied. The MCO Member Rights Specialist must offer assistance to members in submitting grievances or appeals.

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 MCO grievance and appeal committee that considers that specific circumstance. The Member Rights Specialist may not represent the MCO at a hearing of the MCO grievance and appeal committee, in a Department Review or at a State Fair Hearing.

The MCO should attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the interdisciplinary team and the Member Rights Specialist must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.

- 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 Member Rights Specialist will assist the member or legal decision maker to understand the grievance or appeal options and help to complete any required paperwork to file the grievance or appeal. At the same time, unless contrary to the expressed desire of the member, the Member Rights Specialist will attempt to resolve issues through internal review, negotiation, or mediation.
- c. The MCO 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).
- d. The MCO 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 MCO must ensure that the MCO 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 MCO 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 MCO. 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 MCO 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 and;
- 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. *MCO 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 MCO.

b. Timing of Filing

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

c. Acknowledgement of Grievance Receipt

The MCO must acknowledge in writing receipt of each grievance. 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 MCO. In order to establish the earliest possible filing date for the grievance, the MCO must document all grievances whether received orally or in writing.
- ii. Unless contrary to the expressed desire of the member, the MCO 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 MCO grievance and appeal committee.
- iv. A member who files a grievance must be given the right to appear in person before the MCO grievance and appeal committee or its designee.



e. Grievance Resolution Timeframe

- i. The MCO 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 MCO 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 MCO 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 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.

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. *MCO Process for Medicaid 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 MCO regarding any MCO adverse benefit determination, with the exception of the adverse benefit determinations specified in Article XI.F.5.a.ii. or iii.
- ii. There is no MCO level appeal of loss of functional eligibility, or loss of financial eligibility under Wis. Stat. § 46.286(1)(a). The MCO 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.

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 reduction of level of care, loss of functional eligibility, or loss of financial eligibility.

- iii. There is no right to an MCO level appeal of a decision that has been issued by the MCO 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 MCO must acknowledge in writing receipt of each appeal. 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 MCO. 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 MCO must document all appeals whether received orally or in writing. The MCO 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 MCO 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 MCO 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 MCO 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, **Error! Reference source not found.** Definitions.



- vi. The MCO grievance and appeal committee must make a decision on an appeal as expeditiously as the member's situation and health condition requires. The MCO 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, for Family Care and Partnership the MCO 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) If the MCO 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 MCO 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 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.
- 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 MCO 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 MCO 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 MCO's decision. When the MCO



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 MCO 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 MCO 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 MCO 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 MCO 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 MCO 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 MCO 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 MCO's decision is upheld in the State Fair Hearing.

6. *Parties to the Appeal*

The parties to the MCO 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 MCO will participate in the Department Review Process.

1. *General Review Process*

- a. A member may not request a Department review, as defined in Wis. Admin. Code § DHS 10.54 of loss of functional eligibility or reduction of functional level of care
- b. For all other member concerns, the Department shall complete a timely review, investigation and analysis of the facts surrounding member grievances and appeals in an attempt to resolve concerns and problems through internal review, negotiation, or mediation, whenever a member or a member's legal decision maker:
  - i. Requests a Department review directly; or
  - ii. Requests a Department review of a decision arrived at through a county agency, resource center or MCO grievance and appeal process.
- c. 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 resolve the member's concern or problem through internal review, negotiation, or mediation.
- d. If, during the course of its review, the Department determines that the MCO failed to act within the requirements of this contract, the Department may order the MCO to take corrective action. The MCO shall comply with any corrective action required within the timeframes established by the Department.
- e. The MCO 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.

2. *Timing of Request for Department Review*

The member must file the request for Department Review within forty-five (45) calendar days of the action that is the subject of the member's grievance or appeal.



3. *Concurrent Review Process*

Whenever the Department receives notice from the Department of Administration's Division of Hearings and Appeals that it has received a fair hearing request, the Department shall use the general review process described above to conduct a concurrent review in accordance with Wis. Admin. Code § DHS 10.55(4).

4. *Member Notification*

The Department will mail or hand deliver to the member in writing of the result of the Department review within five (5) business days of the completion of the review.

**H. The State Fair Hearing Process**

The MCO will participate in the State Fair Hearing Process.

1. *Request for 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 fair hearing regarding any of the actions listed in paragraphs (0) through (0) below.

A member may submit a fair hearing request regarding the actions listed in paragraphs (0) through (0) below instead of or after using the MCO appeal process, MCO grievance process, or Department review process. However, once a member files a request for a Fair Hearing decision, s/he may not file an MCO appeal or grievance or DHS review unless there is a significant change in circumstances relevant to the appealed issue.

A State Fair Hearing is the only process available to appeal the action described in paragraphs (0) and (0) below.

- a. Denial of functional eligibility under Wis. Stat. § 46.286(1)(a) as a result of administration of the long-term care functional screen.
- b. Reduction of level of care from nursing home to non-nursing home under Wis. Stat. §§ 46.286(a) 1m. and 2m., as a result of administration of the long-term care functional screen.
- c. Denial or limited authorization of a requested service that falls within the benefit package specified in Addendum VIII, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- d. Reduction, suspension or termination of services or support items in the member's member-centered plan, except in accordance with a change agreed to by the member;
- e. Denial, in whole or in part, of payment for a service that falls within the benefit package specified in Addendum VIII.





- f. Failure to provide timely services and items that are included in the member's member-centered plan;
- g. Failure of the MCO to act within the timeframes of this article for resolution of grievances or appeals.
- h. A member-centered plan that is unacceptable to the member because any of the following apply:
  - i. 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.
  - ii. The plan does not provide sufficient care, treatment or support to meet the member's needs and identified outcomes.
  - iii. The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member.
- i. Involuntary disenrollment of a member from the MCO at the MCO's request;
- j. The MCO makes a decision on a grievance or appeal that is entirely or partially adverse to the member; or
- k. The member disagrees with the conclusion following a Department investigation of a grievance or appeal.
- l. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

2. *Time Limits for Requesting a Fair Hearing*

The member must file the request for a fair hearing within forty-five (45) calendar days of one of the types of incidences noted above, or from the date of receipt of written notice from the MCO.

3. *MCO 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 MCO 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 MCO Representative at State Fair Hearing*

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

- a. Any MCO adverse benefit determination described in Article XI.B.1. is being appealed; or



- b. The MCO has knowledge that the issue being appealed concerns the member's cost share and the MCO has relevant information likely to help the Administrative Law Judge reach a decision.
- c. The MCO representative will be prepared to
  - i. Represent the MCO's position;
  - ii. Explain the rationale and authority for the MCO 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 MCO policies and procedures related to the adverse benefit determination that is being appealed.

5. *Timeline for Resolution of Fair Hearing*

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

6. *Parties to the Fair Hearing*

The parties to the 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 MCO.

7. *Fair Hearing Decision*

Any formal decision made through the fair hearing process under this section, shall be subject to member appeal rights as provided by State and federal laws and rules. The fair hearing process will include receiving input from the member and the MCO in considering the appeal.

8. *Access to Services*

If the MCO's decision to deny or limit a service is reversed through the fair hearing process, the MCO 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 fair hearing decision reversing the determination.

**L. Documentation and Reporting**

The MCO 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 MCO and the Department. The MCO 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 MCO;
- d. The date receipt of the appeal or grievance was acknowledged by the MCO;
- 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 MCO 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 MCO shall keep grievance and appeal records confidential in accordance with Article XIII.A., Member Records, page 216.

3. *Retention of Grievance and Appeal Records*

The MCO shall retain the documents related to each grievance and appeal in accordance with Article XIV.F., Records Retention, page 252.

4. *Notice of Adverse Decisions to the Department*

a. *Applicability*

The notice of adverse decision requirements described in paragraph 0. apply only to the following MCOs:

- i. Any MCO that is in its first year of operation.



- ii. Any MCO, after the first year of operation, that has been identified by the Department as needing to comply with the requirements described in paragraph 0. The Department will make this determination based on the MCO's quality review, quarterly reports, and other factors.
- iii. Any MCO operating a PACE program limited to reporting for that PACE program.

b. Required Submission

If the MCO makes a decision on a grievance or appeal that is entirely or partially adverse to the member, the MCO shall submit the decision to the Department no later than twenty (20) business days after the MCO mails or hand-delivers the written decision. Supporting documentation shall include:

- i. Any transcript and minutes of the MCO 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 MCO shall submit to the Department a quarterly grievance and appeal report as specified in Article XIV.C.3., page 244 consisting of a summary and a log, as follows:

a. Summary

The summary shall be an analysis of the trends the MCO has experienced regarding types of issues appealed and grieved through the local MCO 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 MCO shall conduct an in-depth review, report the results to DHS, and take appropriate corrective action.



b. Log

MCOs will use a standard appeal log developed by the Department. The log shall include the information described under Article XI.I.1.a-i about with respect to each grievance and appeal received through the local process.

**Article XIV, Reports and Data, Section C.4 is amended to read:**

4. *Quarterly Employment Data Report*

The MCO shall report employment data quarterly for members who do and do not have a vocational service provider for the months of March, June, September, and December of each year for pre-populated lists of members provided by DHS. The MCO may choose to require employment services providers to report employment data to them; however, the MCO will be responsible for the uploading and certification of the employment data sent to DHS. The tool the MCO will use for employment data collection and submission of these reports will be Integrated Exchange System (IES) through Business Objects.

**Article XVI, Contractual Relationship, Section E.2.c is added:**

c. Sanctions When an IHCP is Providing Care Management to the MCO's Members

The Department will not sanction the MCO for failing to meet a performance expectation under Article XVI.E.2.a that the Department determines is the responsibility of an IHCP.

**Article XVIII, Payment to the Managed Care Organization, Section E is amended to read:**

**E. Pay for Performance**

For Family Care and Partnership, the Department will implement a pay for performance mechanism in 2019. This incentive applies only to CY 2019 and will not be renewed automatically. The pay for performance withhold payments, as described in Article XVIII.E.1.c and 2.a, will be based on results from the member satisfaction survey and competitive integrated employment plan. MCOs may additionally be eligible for an incentive payment based on results from the member satisfaction survey, competitive integrated employment actions, and assisted living quality improvement incentive. The following three programs and any payments thereunder are expressly contingent upon receiving federal approval for the programs.

The withhold and incentive percentages will be applied to the MCO's capitation rate before reductions for the high cost risk pool and member cost share. The payment amounts will be calculated based on the Long Term Care Functional Screen and enrollment data used to develop capitation rates for the next contract year. The payment amounts will reflect the Target Group Mix and Long-Term Care Functional Status retrospective adjustments.



1. *Member Satisfaction Survey*

a. Criteria

The Department will conduct a member satisfaction survey that will be sent to a sample of each MCO's members in the 3rd quarter of 2019. The pay for performance criteria will be based on four questions that are part of the complete survey. The four questions will assess:

- i. Member access to services
- ii. Member participation in the care planning process
- iii. Member satisfaction with care plan/team
- iv. Member satisfaction with services

The Department will establish benchmarks for each of the four questions based on previous member satisfaction surveys. The MCOs will be notified of what the benchmarks are prior to survey distribution. If the responses and results of the survey show an MCO has met the minimum performance standard for a survey question, the portion of the capitated rate withheld for that question will be returned to the MCO. If an MCO meets the minimum performance standards for all four questions and meets or exceeds the targeted performance benchmark for one or more questions, the MCO will receive the entire amount withheld from the capitation rate and will receive an incentive payment to their capitated rate.

b. Notification of Survey Results

The Department shall notify each MCO of their survey results upon compilation.

c. Methodology

All MCOs will have 0.25% of their calendar year 2019 capitation rate withheld to be returned based on the MCO's performance on the member satisfaction survey. The MCO will receive one fourth of the 0.25% withheld from the capitation rate for each survey question in which they meet the minimum performance standard set by the Department. MCOs that meet the minimum performance standards for all four questions will earn back all of the 0.25% withheld from the rate. MCOs will earn a 0.05% performance enhancement to their rate for each targeted performance benchmark they meet. The survey results used to make payments will be based on a statistically significant sample at the MCO level. Payments under this section will be made by December 31, 2020.



Survey Question	Meets Minimum Performance Standard	Meets Targeted Performance Benchmark
	MCO will earn 0.0625% withhold for each survey question for which it meets the minimum performance standard up to a total of 0.25%.	The MCO must meet the minimum performance standards for all 4 survey questions to qualify for an enhanced performance payment for meeting any one of the target performance benchmarks for the 4 survey questions. The MCO will earn 0.05% incentive payment for each survey question for which it meets the targeted performance benchmark up to a total of 0.20%.
1. Member access to services	0.0625% withhold returned	0.05% incentive payment
2. Member participation in the care planning process	0.0625% withhold returned	0.05% incentive payment
3. Member satisfaction with care plan/team	0.0625% withhold returned	0.05% incentive payment
4. Member satisfaction with services	0.0625% withhold returned	0.05% incentive payment

2. *Competitive Integrated Employment*

Competitive integrated employment is work performed on a full-time or part-time basis, compensated not less than the applicable state or local minimum wage law (or the customary wage), or if self-employed, yields income comparable to persons without disabilities doing similar tasks. The worker should be eligible for the level of benefits provided to other employees and the job should present opportunities for advancement. The work should be at a location typically found in the community where the employee with a disability interacts with other persons who do not have disabilities and are not in a supervisory role.

a. *Withhold Criteria*

All MCOs will have 0.25% of their calendar year 2019 capitation rate withheld to be returned based on approval by the Department of the MCO’s Competitive Integrated Employment Plan (“CIE Plan”). The Department will only approve plans that satisfy all of the requirements listed in section v.

- i. An MCO must submit its CIE Plan to [DHSLTCEmployment@dhs.wisconsin.gov](mailto:DHSLTCEmployment@dhs.wisconsin.gov) between January 1, 2019 and January 4, 2019.
- ii. CIE Plans that satisfy six of the eight requirements listed in sub v., will receive written feedback from the Department and the MCO





will be eligible to resubmit these plans to meet the remaining requirements. The MCO must resubmit its CIE Plan to the Department within two weeks of receiving written feedback from the Department.

- iii. If the MCO does not satisfy at least six of the requirements, the MCO will not be eligible to resubmit its CIE Plan and will not be eligible for reimbursement of the CIE withhold or incentive payments.
- iv. The Department will notify the MCO regarding approval of its CIE Plan by January 31, 2019.
- v. CIE Plans must satisfy the following requirements in order to be approved by the Department:
  - a) State the purpose of CIE Plan;
  - b) Describe ways in which the CIE Plan will increase CIE;
  - c) Identify the following:
    - 1) Executive sponsor;
    - 2) Contact person for CIE within MCO;
    - 3) MCO staff involved in planning and execution of CIE Plan;
    - 4) External stakeholders involved in execution of CIE Plan;
    - 5) Sustainability of the CIE plan for increasing CIE over the next 5 years; and
    - 6) Templates, graphs and charts to demonstrate how the MCO will measure CIE outcomes;
  - d) Describe how the MCO will execute the CIE Plan;
  - e) Identify evidence-based practices that will be utilized to increase CIE for members;
  - f) Describe barriers to implementation of the CIE Plan and how they will be addressed;
  - g) List, if applicable, any and all data collection and reports the MCO will utilize to measure identified outcomes other than DHS mandated data collection and reports. If the MCO does include additional data collection and reports in the CIE Plan, the Plan must also include:
    - 1) Frequency of data collection,
    - 2) Reporting mechanisms;



- h) Describe training and technical assistance offered by the MCO to IDT staff in order to increase CIE.

b. Incentive Criteria

To be eligible for the incentive payment, an MCO must have a Department approved CIE Plan.

- i. An MCO will receive 0.08% of its 2019 capitation rate as an incentive payment if the MCO documents employment interest of 90% of its members aged 18-45 years old. The Department will provide a list of the MCO members aged 18-45 years old.

The MCO must identify members as fitting into one of the following categories using a template provided by the Department:

- a) Currently working in CIE;
- b) Interested in working in CIE and either
  - 1) Know their desired career path; or
  - 2) Unsure of desired career path;
- c) May be interested in working in CIE;
- d) Not interested in working in CIE; or
- e) Exempt from CIE population for health reasons.

The MCO must submit the completed template to [DHSLTCEmployment@dhs.wisconsin.gov](mailto:DHSLTCEmployment@dhs.wisconsin.gov) by September 30, 2019.

- ii. An MCO will receive 0.12% of its 2019 capitation rate as an incentive payment if the MCO documents a Department-approved employment activity with 90% of members who are currently enrolled in the MCO and identified to be:

- a) Currently working in CIE;
- b) Interested in working in CIE; or
- c) May be interested in CIE.

The MCO must use the template provided by the Department and submit the completed template to [DHSLTCEmployment@dhs.wisconsin.gov](mailto:DHSLTCEmployment@dhs.wisconsin.gov) by December 31, 2019.

3. *Assisted Living Quality Improvement Incentive*

a. Criteria

MCOs may receive an incentive payment for each member residing in an assisted living facility if the assisted living facility falls within one of the two qualifying categories:



- i. Qualifies for the abbreviated Division of Quality Assurance survey and is compliant with Home and Community-Based Services settings rule; or
- ii. Qualifies for the abbreviated Division of Quality Assurance survey, is compliant with the Home and Community-Based Services settings rule, and is a member in good standing with Wisconsin Coalition for Collaborative Excellence in Assisted Living.

**b. Methodology**

The Department will provide a template to each MCO on July 1, 2019 that provides the name of the assisted living facilities that satisfy either of the qualifying categories for the incentive payment. The MCO must submit the completed template to the Department by July 31, 2019.

**c. Amount of Incentive Payment**

The amount of the per member incentive payment will be determined by the Department in the third quarter of 2019. The total amount to be distributed for the assisted living quality improvement incentive is \$2 million. One million dollars will be allocated to each incentive category (3.a.1. and 3.a.2.). MCOs will only receive one payment per member living in an eligible assisted living facility. For members that reside in an assisted living facility that meets the criteria under 3.a.2., the MCO will receive a payment only from the funding allocated to 3.a.2. but not the funding allocated to 3.a.1.

MCOs, if eligible, will receive the assisted living quality improvement incentive payment in the third quarter of 2019. MCOs receiving the assisted living quality improvement incentive payment must report to DHS how they spent, or intend to spend, the incentive funds received by December 31, 2019.

**Article XIX, MCO Specific Contract Terms, Section B is amended to read:**

**B. Geographic Coverage Where Enrollment is Accepted**

The MCO will provide services in the following counties:

<b>County</b>	<b>RFP Number</b>	<b>Contract Term</b>
<b>Geographic Service Region 1</b>		
1. Chippewa	S-0505 DLTC-17	01/01/19-12/31/20
2. Dunn	S-0505 DLTC-17	01/01/19-12/31/20
3. Eau Claire	S-0505 DLTC-17	01/01/19-12/31/20
4. Pierce	S-0505 DLTC-17	01/01/19-12/31/20
5. St. Croix	S-0505 DLTC-17	01/01/19-12/31/20
6. Taylor	S-0505 DLTC-17	01/01/19-12/31/20



Contract for the **Family Care/Partnership/PACE** Program between the  
Wisconsin Department of Health Services, Division of Medicaid Services  
And << **MCO** >>

<b>County</b>	<b>RFP Number</b>	<b>Contract Term</b>
<b>Geographic Service Region 2</b>		
7. Buffalo	S-0647 DMS-17	01/01/18-12/31/19
8. Clark	S-0647 DMS-17	01/01/18-12/31/19
9. Jackson	S-0647 DMS-17	01/01/18-12/31/19
10. La Crosse	S-0647 DMS-17	01/01/18-12/31/19
11. Monroe	S-0647 DMS-17	01/01/18-12/31/19
12. Pepin	S-0647 DMS-17	01/01/18-12/31/19
13. Trempealeau	S-0647 DMS-17	01/01/18-12/31/19
14. Vernon	S-0647 DMS-17	01/01/18-12/31/19
<b>Geographic Service Region 3</b>		
15. Crawford	S-0647 DMS-17	01/01/18-12/31/19
16. Grant	S-0647 DMS-17	01/01/18-12/31/19
17. Green	S-0647 DMS-17	01/01/18-12/31/19
18. Iowa	S-0647 DMS-17	01/01/18-12/31/19
19. Juneau	S-0647 DMS-17	01/01/18-12/31/19
20. Lafayette	S-0647 DMS-17	01/01/18-12/31/19
21. Richland	S-0647 DMS-17	01/01/18-12/31/19
22. Sauk	S-0647 DMS-17	01/01/18-12/31/19
<b>Geographic Service Region 4</b>		
23. Florence	S-0505 DLTC-17	01/01/19-12/31/20
24. Forest	S-0505 DLTC-17	01/01/19-12/31/20
25. Langlade	S-0505 DLTC-17	01/01/19-12/31/20
26. Lincoln	S-0505 DLTC-17	01/01/19-12/31/20
27. Marathon	S-0505 DLTC-17	01/01/19-12/31/20
28. Oneida	S-0505 DLTC-17	01/01/19-12/31/20
29. Portage	S-0505 DLTC-17	01/01/19-12/31/20
30. Vilas	S-0505 DLTC-17	01/01/19-12/31/20
31. Wood	S-0505 DLTC-17	01/01/19-12/31/20
<b>Geographic Service Region 5</b>		
32. Columbia	1737 DLTC-JB	01/01/19-06/30/19
33. Dodge	1737 DLTC-JB	01/01/19-06/30/19
34. Green Lake	1737 DLTC-JB	01/01/19-06/30/19
35. Jefferson	1737 DLTC-JB	01/01/19-06/30/19
36. Marquette	1737 DLTC-JB	01/01/19-06/30/19
37. Waushara	1737 DLTC-JB	01/01/19-06/30/19
<b>Geographic Service Region 6</b>		
38. Washington	1737 DLTC-JB	01/01/19-06/30/19
39. Waukesha	1737 DLTC-JB	01/01/19-06/30/19
<b>Geographic Service Region 7</b>		
40. Ashland	S-0707 DMS-18	01/01/18-12/31/18
41. Barron	S-0707 DMS-18	01/01/18-12/31/18
42. Bayfield	S-0707 DMS-18	01/01/18-12/31/18
43. Burnett	S-0707 DMS-18	01/01/18-12/31/18



<b>County</b>	<b>RFP Number</b>	<b>Contract Term</b>
44. Douglas	S-0707 DMS-18	01/01/18-12/31/18
45. Iron	S-0707 DMS-18	01/01/18-12/31/18
46. Polk	S-0707 DMS-18	01/01/18-12/31/18
47. Price	S-0707 DMS-18	01/01/18-12/31/18
48. Rusk	S-0707 DMS-18	01/01/18-12/31/18
49. Sawyer	S-0707 DMS-18	01/01/18-12/31/18
50. Washburn	S-0707 DMS-18	01/01/18-12/31/18
<b>Geographic Service Region 14</b>		
51. Rock	Not applicable	01/01/19-12/31/19

The MCO is permitted to phase in operations in the following counties as long as the MCO services are fully implemented by December 31, 2019:

- a. Not applicable

**Article XIX, MCO Specific Contract Terms, Section G is amended to read:**

**G. Capitation Rate**

GSR 1 – Chippewa County, Dunn County, Eau Claire County, Pierce County, St. Croix County, Taylor County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

GSR 2 – Buffalo County, Clark County, Jackson County, La Crosse County, Monroe County, Pepin County, Trempealeau County, Vernon County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

GSR 3 – Crawford County, Grant County, Green County, Iowa County, Juneau County, Lafayette County, Richland County, Sauk County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			



GSR 4 – Florence County, Forest County, Langlade County, Lincoln County, Marathon County, Oneida County, Portage County, Vilas County, Wood County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

GSR 5 – Columbia County, Dodge County, Green Lake County, Jefferson County, Marquette County, Waushara County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

GSR 5 & 6 – Washington County and Waukesha County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

GSR 7 – Ashland County, Barron County, Bayfield County, Burnett County, Douglas County, Iron County, Polk County, Price County, Rusk County, Sawyer County, Washburn County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			

GSR 14 – Rock County

Level of Care	Administrative	Long Term Care	Medical
Nursing Home - Monthly			
Non-Nursing Home - Monthly			



**Addendum I, Actuarial Basis, Section B.1 is amended to read:**

1. *HIV/AIDS and Vent Dependent Acute and Primary Retrospective Adjustment – Partnership program*

For Partnership enrollees who meet the criteria in this section, the MCO is not at financial risk for changes in utilization or for Medicaid state plan acute and primary costs incurred that do not exceed the upper payment limits specified in 42 C.F.R. § 447.362.

**Addendum I, Actuarial Basis, Section B.2 is amended to read:**

2. *Vent Dependent Long Term Care Retrospective Adjustment – Family Care and Partnership programs*

**Addendum I, Actuarial Basis, Section B.3 is amended to read:**

3. *Nursing Home Closures – Family Care and Partnership programs*

**Addendum I, Actuarial Basis, Section B.4 is amended to read:**

4. *Money Follows the Person Relocation Incentive Payment- Family Care and Partnership programs*

**Addendum I, Actuarial Basis, Section B.5 is amended to read:**

5. *Dual Eligibility Status – Partnership program*

**Addendum I, Actuarial Basis, Section B.6 is amended to read:**

6. *Target Group Mix – Family Care and Partnership programs*

**Addendum I, Actuarial Basis, Section B.7 is amended to read:**

7. *Long-Term Care Functional Status - Family Care and Partnership programs*

**Addendum I, Actuarial Basis, Section B.8 is amended to read:**

8. *High Cost Risk Pool – Family Care and Partnership programs*





**Addendum II, State Reporting Requirements, Section A.7 is amended to read:**

7. Employment Data Report	03/01/19-03/31/19	1 <sup>st</sup> week of July	Integrated Exchange System (IES) through Business Objects	Article XIV.C.4 (page 249)
	06/01/19-06/30/19	1 <sup>st</sup> week of October		
	09/01/19-09/30/19	1 <sup>st</sup> week of January		
	12/01/19-12/31/19	1 <sup>st</sup> week of April		

**Addendum VIII, Benefit Package Service Definitions, Section B.10 is amended to read:**

- Nursing home** services as defined in Wis. Admin. Code § DHS 107.09 including ICF-IID and IMD. Inpatient services are only covered for IMD nursing home residents under the age of 21 years or age 65 or older, except that services may be provided to a 21 year old resident of an IMD if the person was a resident immediately prior to turning 21 and continues to be a resident after turning 21. This exception only applies until the person’s 22<sup>nd</sup> birthday.

THIS CONTRACT AMENDMENT SHALL BECOME EFFECTIVE UPON SIGNING.

In WITNESS WHEREOF, the State of Wisconsin and the managed care organization have executed this agreement:

Executed on behalf of  
<< MCO >>

Executed on behalf of  
Department of Health Services

\_\_\_\_\_  
<< CEO >>  
Chief Executive Officer

\_\_\_\_\_  
Heather K Smith, Medicaid Director  
Division of Medicaid Services

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date