1. DEFINITIONS

Cost Sharing means any copayment, coinsurance, deductible, or other similar charge. Cost sharing does not include post-eligibility treatment of income, which is also referred to as "cost share" in Wisconsin.

Dual Eligible means an individual who has established eligibility for Medicare as their primary coverage and Medicaid as their secondary coverage.

Dual Special Needs Plan means a specialized Medicare Advantage plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Act that coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services.

Exclusively Aligned Enrollment means State policy limits a D-SNP's membership to individuals whose Medicaid benefits are covered under a Medicaid managed care organization contract under section 1903(m) of the Act between the applicable State and: the dual eligible special needs plan's (D-SNP's) MA organization, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.

Family Care Partnership Program is a capitated integrated Medicaid managed care program that provides both managed Medicaid long-term care and health care benefits. Members enrolled in Partnership must have a Wisconsin Medicaid nursing home-certifiable level of care.

MA Plan means health benefits coverage offered under a policy or contract by an MA organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan.

State Plan means the State of Wisconsin's plan for the Medical Assistance Program as submitted by the Department and approved by the Secretary of the U.S. Department of Health and Human Services under Title XIX of the Social Security Act, as modified or amended.

2. MA PLAN Introduction

The MA Plan has entered into a contract with the Centers for Medicare & Medicaid Services ("CMS") to provide a Dual Eligible Special Needs Plan (D-SNP). The MA Plan and the Department enter into this agreement to outline each party's obligations to provide or arrange for benefits for Dual Eligible Members enrolled in the MA Plan's D-SNP.

The legal entity offering the D-SNP receives direct capitation from the Department to provide coverage of Medicaid benefits referenced in the DHS-MCO Contract Addenda VIII. A and C., and further referenced in Appendix B of this contract. The DHS-MCO Contract is the capitated contract between the MA Plan and the Department for the MA Plan to provide Medicaid benefits.

The requirements to operate a Family Care Partnership plan are contained in the DHS-MCO Contract. The MA Plan is required to follow all requirements in the DHS-MCO Contract in addition to the requirements contained in this contract.

As required in its DHS-MCO Contract, each Family Care Partnership plan is required to also operate a MA Plan offering a D-SNP product(s) in all Service Areas in which it holds a Partnership contract. The Department shall execute an Agreement only when an MA Plan holds a Partnership contract that covers the same service areas as the Partnership plan.

Each contracted Family Care Partnership plan shall have, and assure the Department it does have, the legal and actual authority to direct, manage, and control the operations of both the corporation operating its Family Care Partnership contract and its companion MA Plan to the extent necessary to ensure integration of Medicare and Medicaid services for individuals enrolled for both programs.

3. MA PLAN Eligibility and Enrollment

3.1 *Eligibility*

a) The MA Plan must only enroll full-benefit dually eligible beneficiaries who:
   i. Are enrolled in the Family Care Partnership program with the MA Plan's organization; and
   ii. Reside in a Wisconsin county where the MA Plan is offered as listed in Appendix A.

b) To be eligible for Family Care Partnership, the individual must:
   i. Satisfy requirements to be in the target group of person with a physical disability, person with a development disability, or frail elder;
   ii. Reside in a county where Family Care Partnership is offered;
   iii. Be eligible for a full benefit Medicaid program;
   iv. Have a nursing home level of care as determined by the long-term care functional screen; and
   v. Be 18 years of age or older.

3.2 *Enrollment*

a) The MA Plan agrees to conduct enrollment of eligible persons in accordance with this agreement and must maintain exclusively aligned enrollment for the duration of the contract period.
b) The MA Plan must confirm an applicant's enrollment in Family Care Partnership prior to enrollment.

4. MA PLAN SERVICES

4.1 Services

a) The DHS-MCO Contract is the capitated Medicaid contract with the MA organization offering the MA Health Plan, the MA organization's parent organization, or another entity that is owned and controlled by the SNP's parent organization. In accordance with the DHS-MCO Contract, the MA Health Plan receives a capitated payment for Medicaid payment of Medicare cost sharing, Medicaid primary and acute care, nursing facility services for a period of at least 180 days during the plan year, behavioral health and long term services and supports that beneficiaries are entitled to receive under Family Care Partnership, subject to any limitations and/or excluded services as specified in Addenda VII.A and C of the DHS-MCO Contract.

b) Provision of these services shall be equal in amount, duration, and scope as established by Family Care Partnership, in accordance with medical necessity and without any predetermined limits, unless specifically stated, and shall be provided as set forth in 42 C.F.R. Parts 440; 434, and 438; the Medicaid State Plan; and all applicable federal and State statutes, rules, and regulations.

c) Medicaid benefits that are not covered by this Contract are listed in **Appendix B.** These benefits are not included in the capitated rate paid to the MA Plan by the Department. The MA Plan is not required to provide these services, but is responsible for ensuring coordination of these services, per the federal regulations described at 42 CFR §422.107(c)(1).

d) The MA Plan is responsible for the coordination of both Medicare and Medicaid integrated benefits within a single managed care organization. The MA Plan shall be responsible for coordinating all services required by the enrollee, including any Medicaid benefits that are carved out of the capitated contract but provided under the Medicaid State Plan, Waiver Programs, Medicare Part C, Medicare Part D, or other medically or socially necessary community services, as identified in the enrollee's Plan of Care. The MA Plan shall utilize Medicare Parts A, B and D data, and Partnership health care and other data received from the Department, to coordinate all aspects of the enrollee's integrated benefits, including, but not limited to discharge planning, disease management, and care management.

    i. The MA Plan shall assign appropriate staff who are responsible for ensuring integrated Medicare-Medicaid benefits are coordinated. Coordination of Medicare and/or Medicaid benefits is not the enrollee's responsibility.

    ii. The MA Plan shall have a process to share Health Risk Assessment or other key data with the enrollee's primary care or specialty providers and with relevant Partnership case managers, contractors, or providers where information can inform shared care plan development.

iii. The MA Plan shall ensure care coordination works to support seamless care transitions, integrated care planning, and strategies to reduce unnecessary hospitalizations.

4.2 Authorization of Services

a) The MA Plan shall coordinate and authorize the delivery of covered services using aligned care management.

b) All covered services, except for 1915(c) waiver services and services mandated by state or federal law, are subject to determination of medical necessity by the MA Plan, as defined in Wis. Admin. Code DHS §101.03(96m). Medical necessity for 1915(c) waiver services is defined as: the service is reasonable, appropriate and cost-effectively addresses a member's assessed long-term care need or outcome related to any of the following purposes:

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

c) The MA Plan shall not deny 1915(c) waiver services that are reasonable and necessary to cost-effectively support the member's long term care outcomes identified in the comprehensive assessment as well as those necessary to assist the member to be as self-reliant and autonomous as possible. The MA Plan will either provide, or coordinate and authorize delivery of, covered 1915(c) waiver services to members in an amount, duration and scope that will support member outcomes and are no less effective than would be achieved through the amount, duration and scope of services that would otherwise be furnished to fee-for-service Medicaid recipients, as set forth in 42 CFR § 440.230 and, for members under the age of 21, as additionally set forth in 42 CFR §§ 441.50 – 441.62 (EPSDT).

d) Consistent with 42 CFR §438.206(b)(4), if the MA Plan's provider network is unable to provide necessary medical services covered under the Contract to a particular enrollee, the Contractor must adequately and timely cover these services out of network for the enrollee.

e) The MA Plan must ensure access to the appropriate range of providers, including specialists, to provide all medically necessary services to the members. Due to the high

level of functional need experienced by members, all members are considered to be potentially high risk and have access to the full range of providers, including specialists.

5. ENROLLEE INFORMATION

5.1 Enrollee Materials

a) The MA Plan agrees to employ policies and procedures approved by CMS and the State to coordinate and integrate enrollee communication materials, including enrollment communications, grievance and appeals, and quality assurance, including but not limited to:

   i. Facilitating Medicaid eligibility redeterminations, including assisting with applications for medical assistance and conducting member education regarding Medicaid eligibility, as described in Article III.C;

   ii. Performing integrated Medicare and Medicaid Health Risk Assessments upon enrollment and annually thereafter; and

   iii. Integrating member facing materials wherever possible, including integrated enrollment communications and a single member identification card for Medicare and Medicaid.

b) Summary of Benefits, Annual Notice of Change, and Evidence of Coverage:

   i. The MA Plan will identify in the MA Plan's Summary of Benefits those benefits in **Appendix B** the member may be eligible for under the State Plan that are not covered services under the Member's MA Plan.

   ii. The MA Plan will provide a copy of the Summary of Benefits, Annual Notice of Change, and Evidence of Coverage to the Department prior to CMS approval so that the Department may review the Medicaid benefit information in the documents.

5.2 Enrollee Grievance and Appeal System

a) The MA Plan shall implement a grievance and appeal system and process grievances and appeals in compliance with 42 CFR §§ 422.629 – 422.634, 438.210, 438.400, and 438.402. This includes:

   i. Grievances and appeals systems that meet the standards described in §422.629;

   ii. An integrated grievance process that complies with §422.630;

   iii. A process for making integrated organization determinations consistent with §422.631;

   iv. Continuation of benefits while an integrated reconsideration is pending consistent with §422.632;

v. A process for making integrated reconsiderations consistent with §422.633; and

vi. A process for effectuation of decisions consistent with §422.634.

5.3 Enrollee Liability for Payment.

a) The MA Plan shall communicate fully integrated Medicare-Medicaid coverage to all members, providers, MA Plan staff, and other stakeholders, including guarantee of complete member protection from financial liability – meaning all deductibles, premiums, coinsurance, copayments, and cost sharing of any kind, with exception for member post-eligibility treatment of income payment, if applicable.

b) The MA Plan shall include information and require providers to acknowledge and agree that they shall not bill or charge members the balance of a bill ("balance bill") and that members are not liable for cost-sharing obligations.

c) As a general rule, if a participating or non-participating provider renders a covered service to an enrollee, the Provider's sole recourse for payment, other than collection of any third party liability, is the MA Plan, not the enrollee.

d) Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for enhanced services as described in the DHS-MCO Contract Art. VII.K.

5.4 Third Party Liability & Coordination of Benefits.

a) The MA Health Plan will be the payer of all Medicare cost sharing that the Department would otherwise pay.

b) The Department may have financial responsibility for Medicare Part A and/or Part B premiums for certain Dual Eligible Members as described in the State Plan. The Department shall identify and pay those premiums for Dual Eligible Members.

6. DEPARTMENT OBLIGATIONS

6.1 Eligibility Verification.

a) The Department agrees to provide the MA Plan with real-time access to the state's eligibility system (ForwardHealth) to verify an applicant's Medicaid status or an enrollee's current Medicaid enrollment. Information obtained by the MA Plan from the Department's eligibility verification system shall not be used by the MA Plan for marketing purposes.

b) The Department shall notify the MA Plan two times per month of all members that are enrolled in the MA Plan's Partnership program and disenrolled from the program. Notification shall be effected through MCO Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final MCO Enrollment Reports are members

of the MCO during the enrollment month indicated in the report. All members listed as a Disenroll with an effective date on either the Initial or Final MCO Enrollment Reports are members no longer enrolled in the MCO. The reports are available to MCOs via the ForwardHealth MCO Portal and Trading Partner Portal accounts.

c) The MA Plan shall verify that the individual is enrolled in Medicare prior to enrolling the individual in the DSNP.

6.2 Sharing of Information.

a) The Department will provide the MA Plan with access to an electronic data file of participating Medicaid providers and access to the State Plan and ForwardHealth provider updates.

b) The Department shall provide access to the MA Plan with information about State Plan Medicaid provider participation in the MA Plan's service area. The Department shall give the MA Plan timely responses to requests for confirmation of particular providers' Medicaid certification status.

7. TERMINATION

7.1 Mutual Consent

This contract may be terminated at any time by mutual written consent of both the MA Plan and the Department.

7.2 Unilateral Termination

This contract may be unilaterally terminated only as follows:

a) Termination for Convenience: Either party may terminate this Contract at any time, without cause, by providing a written notice to the other party at least 90 days in advance of the intended date of termination.

b) Changes in Federal or State Law: This contract may be terminated at any time, by either party, due to modifications mandated by changes in federal or state law or regulations that materially affect either party's rights or responsibilities under this contract. In such case, the party initiating such termination procedures must notify the other party in writing, at least ninety (90) days prior to the proposed date of termination, of its intent to terminate this contract.

c) Termination for Cause: If either party fails to perform under the terms of this Contract, the other party may terminate this Contract by providing written notice of any defects or failures to the non-performing party. The non-performing party will have 30 calendar days from the date of receipt of notice to cure the failures or defects established within the notice sent by the other party. If the failures or defects are not cured within 30 days of the non-performing party receiving the notice, the other party may terminate the Contract.

d) Permanent Loss of Funding: This contract may be terminated by either party, in the event federal or state funding of contractual services rendered by the MA Plan becomes permanently unavailable and such lack of funding would preclude reimbursement for the performance of the MA Plan's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the MA Plan will become unavailable, the Department shall immediately notify the MA Plan, in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will end. In the event of termination, the contract will terminate without termination costs to either party.

e) Temporary Loss of Funding: In the event funding will become temporarily suspended or unavailable, the Department will suspend the MA Plan's performance of any or all of the MA Plan's obligations under this contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department shall attempt to give notice of suspension of performance of any or all of the MA Plan's obligations sixty (60) days prior to said suspension, if possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the MA Plan will resume the suspended services within thirty (30) days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

f) Contract Non-Renewal: The MA Plan or the Department may decide to not renew this contract. In the case of a non-renewal of this contract, the party deciding to not renew this contract must notify the other party in writing at least ninety (90) calendar days prior to the expiration date of this contract.

8. DISPUTE RESOLUTION

8.1 Agreement to Cooperate

The parties agree to fully cooperate with each other in connection with the performance of their respective obligations and covenants under this contract.

8.2 Contract Dispute Resolution

The parties shall use their best efforts to cooperatively resolve disputes and problems that arise in connection with this contract. When a dispute arises that the MA Plan and the Department have been unable to resolve, the Department reserves the right to final interpretation of contract language.

9. MISCELLANEOUS PROVISIONS

9.1 Choice of Law

This contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The MA Plan shall be required to bring all legal proceedings against the Department in the state courts in Dane County, Wisconsin.

9.2 Waiver

No delay or failure by the MA Plan or the Department to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

9.3 Severability

If any provision of this contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision; but if such provision does not relate to payments or services to members and if the remainder of this contract shall not be affected by such declaration or finding, then each provision not so affected shall be enforced to the fullest extent permitted by law.

9.4 Force Majeure

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9.5 Headings

The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Assignability

Except as allowed under subcontracting and entering into provider agreements, this contract is not assignable by the MA Plan either in whole or in part, without the prior written consent of the Department.

9.7 Right to Publish

The Department agrees to allow the MA Plan to write and have such writings published provided the MA Plan receives prior written approval from the Department before publishing writings on subjects associated with the work under this contract. The MA Plan agrees to protect the privacy of individual members, as required under 42 C.F.R. § 434.6(a)(8).

9.8 Survival

The terms and conditions contained in this contract that by their sense and context are intended to survive the performance by the parties shall so survive the completion of the performance, expiration or termination of the contract. This specifically includes, but is not limited to recoupments and confidentiality provisions. All rights and remedies of the parties provided under this contract, including but not limited to any and all sanctions for violation, breach or non-performance, survive from one contract year to the next, and survive the completion of the performance, expiration or termination of the contract.

9.9 Notices.

All notices, consents, requests, instructions, approvals or other communications provided for herein will be in writing and delivered by electronic mail addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

The DEPARTMENT: DHSDMSLTC@dhs.wisconsin.gov

MA PLAN:
NAME:
ADDRESS:
CITY, STATE, ZIP:
FAX:

A party may change the contact information set forth above by giving written notice to the other party.

9.10 Compliance with Federal and State Law.

The parties agree to comply with all relevant federal and state laws, including but not limited to the following: the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations and other applicable state or federal confidentiality laws; the Medicare Improvements for Patients and Providers Act of 2008 and its implementing regulations issued by CMS; 42 CFR Part 422; Title VI of the Civil Rights Act of 1964, as amended (42 USC § 2000d et seq.); Sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 USC §§ 793 and 794); Title IX of the Education Amendments of 1972, as amended (20 USC § 1681 et seq.); Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (41 USC § 9849); the Americans with Disabilities Act (42 USC § 12101 et seq); and the Age Discrimination Act of 1975, as amended (42 USC § 6101 et seq.).

10. Default Enrollment

10.1 *Eligible Population*

On behalf of currently enrolled Family Care Partnership categorically eligible members who receive full medical assistance benefits, and who become newly Medicare eligible either by age or disability, and that such Medicare eligibility results in Full Benefit Dual Eligible status for such members, MA Health Plan shall perform the default enrollment process as provided by 42 CFR §§ 422.66 and 422.68.

10.2 *Department Approval*

In conformance with 42 CFR §§ 422.66(c)(2)(i)(B) and 42 CFR§ 422.107, the Department approves the MA Health Plan's implementation of the default enrollment process subject to CMS' prior approval as per the requirements of 42 CFR §§ 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable.

10.3 *CMS Approval*

The MA Health Plan shall coordinate with the Department regarding those activities necessary to obtain such CMS approval. The MA Health Plan shall forward to the Department a copy of CMS' default enrollment process prior approval notification or correspondence to the MAO within 10 calendar days of receipt.

The MA Health Plan shall be responsible for coordinating those necessary activities to renew any existing default enrollment process approval(s) with CMS, as per the requirements of 42 CFR § 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved default enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. The MA Health Plan shall coordinate with the Department regarding those activities necessary to obtain such CMS renewal approval(s) of an existing default enrollment process. The MA Health Plan shall forward to the Department copies of its default enrollment process renewal notification and materials to CMS, and CMS' renewal approval(s) notification or correspondence to the MA Health Plan within 10 calendar days to **DHSDMSLTC@dhs.wisconsin.gov**.

10.4 *Department Obligation*

Through implementation of the default enrollment process, the Department shall provide the MA Health Plan with information necessary to prospectively identify those Medicaid categorically eligible members who are or will be in their Medicare Initial Coverage Election Period.

10.5 *Reporting Requirements*

The MA Health Plan shall report the following data quarterly to the Department of its default enrollment process activities and results:

a) Number of individuals (potential dually eligible members) identified by the MA Health Plan as eligible for default enrollment based on age or disability.

b) Number of beneficiaries (potential dually eligible members), separated by eligibility based on age or disability, that were noticed by the MA Health Plan at least 60 calendar days prior to the effective date of default enrollment.

c) Number of beneficiaries (potential dually eligible members) who opt out of (decline) default enrollment prior to the effective date. Differentiate between those who opt out by telephone or in writing, as well as eligibility based on age or disability.

d) At the end of the first month of enrollment, specify the number of rapid disenrollments (the number of dually eligible members who disenroll within their first month of default enrollment). Continue to track for rapid disenrollments within the first three months of a dually eligible member's default enrollment effective date.

The MA Health Plan shall submit reports to **DHSDMSLTC@dhs.wisconsin.gov**.

10.6 *Star Rating*

The MA Health Plan shall have a minimum overall quality rating from the most recently issued ratings, under the rating system described in §§ 422.160 through 422.166, of at least 3 stars or is a low enrollment contract or new MA plan as defined in § 422.252 in order to perform default enrollment.

APPENDIX A

MA PLAN
SERVICE AREAS

County	RFP Number	Contract Term

APPENDIX B

The MA Plan must provide for the provision of all services required under Attachment 3.1-A, Supplement 1 of the State Plan, Services provided to the categorically needy, https://www.dhs.wisconsin.gov/mandatoryreports/mastateplan/3-1a-supplement1.pdf, as applicable to the particular member; except those listed below.

The following Medicaid services are not covered by the MA Plan. These services are not included in the capitated rate paid to the MA Plan. The MA Plan is not required to provide these services, but is responsible for ensuring coordination of these services to members who want to access the following services on a fee-for-service basis:

1. Behavioral treatment services (Autism Services) as defined in ForwardHealth Online Handbook;
2. Comprehensive community services;
3. Community recovery services;
4. Prenatal care coordination;
5. School-based services;
6. Medication therapy management;
7. Tuberculosis-related services;
8. Covered outpatient drugs that are not reimbursable as part of the rate paid for a physician office visit or a stay in a hospital or nursing home;
9. Prescription drugs administered by a physician as part of a physician office visit or incident to a physician's service; and
10. Residential substance use disorder treatment.