Contract Amendment for BadgerCare Plus and/or Medicaid SSI Services

____
(HMO Name)

The agreement entered into for the period from February 1, 2008 through December 31, 2009 between the State of Wisconsin acting by or through the Department of Health and Family Services, hereinafter referred to as the "Department" and ___________________, an insurer with a certificate of authority to do business in Wisconsin for the BadgerCare Plus and/or Medicaid SSI Program is hereby amended as follows:

HealthCheck/Blood Lead/Immunizations

1. Article III, K, 1, d – HMO Responsibilities:

   Delete all of "d."

   Then amend to read:

   "The rate of Comprehensive HealthCheck screens will continue to be determined by the calculation in the HealthCheck Worksheet (Addendum IV, G). Comprehensive HealthCheck data provided by the HMO must agree with its medical record documentation. For the purpose of the HealthCheck recoupment process, the Department will not include any additional HealthCheck encounter records that are received after January 16 for the year under consideration. (Please note: This date marks the end of the twelve and one half month period of time from the end of the year under consideration. For example, for dates of service in 2008 the cut-off date will be January 16, 2010.)"

2. Article III, K, 2 – Department Responsibilities

   Add the following as a **new** second paragraph:

   "The HealthCheck, Blood Lead Test, and Childhood Immunization performance improvement incentive information is provided in Addendum VI and the methodology worksheets are provided in Addendum IV."

3. Article III, K, 2, - Department Responsibilities:

   Delete K, 2, a through d.

4. Article IV, J, 4 – Pay for Performance

   Amend the bullet listing to add the following as **new**:

   - HealthCheck (See Addendum VI, 3)
   - Blood Lead Test (See Addendum VI, 4)

- Childhood Immunizations (See Addendum VI, 5)

5. Addendum VI – Incentives

Add the following as **new**:

3. – HealthCheck Screen Incentive

a. The Department will provide a performance improvement incentive payment for each HealthCheck screen over 80%. The Department will track the number of screens performed in the contract year using HMO encounter data as of January 16, 2010 for the calendar year 2008 incentive payment and January 16, 2011 for the calendar year 2009 incentive payment.

b. The Department will allocate $1,000,000 to this incentive. Payments to each HMO will be $500 per screen for screens over 80% if the combined total incentive for all HMOs does not exceed $1,000,000 for HealthCheck. If $500 per screen for screens over 80% exceeds $1,000,000 for all HMOs, the per screen incentive amount will be reduced by a pro rata share to limit the total incentive payment to all HMOs to $1,000,000.

c. The Department will calculate the number of screens eligible for the incentive payment using the HealthCheck Worksheet, Addendum IV, G.

6. Addendum VI – Incentives

Add the following as **new:**

4. - Blood Lead Test Incentive

a. The Department will provide a performance improvement incentive payment for HMOs that increase the number of blood lead toxicity tests performed for one and two year old children compared to those performed in a base year. If the HMO reduces its base year performance gap by 10% or more, as calculated in the Blood Lead Test Worksheet, Addendum IV, K, the HMO will receive an incentive payment for each test it performs above the base year, up to a maximum. No incentive payment will be made for increases in the number of blood lead tests if the HMO fails to reduce its performance gap by at least 10 percent.

b. The Department will allocate $1,250,000 to this incentive. Payments to each HMO will be $500 per test for tests it performs above the base year if the 10% performance goal is met and if the combined total incentive for all HMOs does not exceed $1,250,000. If $500 per test for tests over the base year exceeds $1,250,000 for all HMOs, the per test incentive amount will be

reduced by a pro rata share to limit the total incentive payment to all HMOs to $1,250,000.

c. The HMO will be paid separately for tests for one and two year old children. This incentive payment will not become part of the HMO's base rate. The Department will use Wisconsin Childhood Lead Poisoning Prevention Program data (which includes HMO encounter data) to establish the base year. For an HMO certified after the 2007 base year, the Department will use the Milwaukee HMO average rate as the base year. Calendar year 2007 results will be used as the baseline to determine the 2008 incentive payment. Calendar year 2008 results will be used to determine the 2009 incentive payment.

d. The Department will calculate the number of tests eligible for the incentive payment using the Blood Lead Test Worksheet, Addendum IV, K. (A sample completed Blood Lead Test Worksheet is provided in Addendum IV, K, 1.)

7. Addendum VI – Incentives

Add the following as **new:**

5. Childhood Immunizations Incentive

a. The Department will provide a performance improvement incentive payment for HMOs that increase the number of two year old children that are fully immunized compared to those fully immunized in a base year. A fully immunized two year old is defined according to the recommendation of the CDC Advisory Committee on Immunization Practices (ACIP) as a child who has received four diphtheria, tetanus, and acellular pertussis (DTaP) immunizations; three polio (IPV) immunizations; one measles, mumps, and rubella (MMR) immunization; three H influenza type B (HIB) immunizations; three Hepatitis B immunizations; and one chicken pox (VZV) immunization. If the HMO reduces its base year performance gap by 10% or more, it will receive an incentive payment for each child fully immunized above the base year, up to a maximum. No incentive payment will be made for increases in the number of fully immunized two year olds if the HMO fails to reduce its performance gap by at least 10 percent.

b. The Department will allocate $1,500,000 to this incentive. Payments to each HMO will be $1,000 per fully immunized child above the base year if the 10% performance goal is met and if the combined total incentive for all HMOs does not exceed $1,500,000. If $1,000 per fully immunized child over the base year exceeds $1,500,000 for

all HMOs, the incentive per child will be reduced by a pro rata share to limit the total incentive payment to all HMOs to $1,500,000.

c. This incentive payment will not become part of the HMO's base rate. The Department will use data from the Wisconsin Immunization Registry (which includes HMO encounter data) to establish the base year. For the HMO certified after the 2007 base year, the Department will use the Milwaukee HMO average rate as the base year. Calendar year 2007 results will be used as the baseline to determine the 2008 incentive payment. Calendar year 2008 results will be used to determine the 2009 incentive payment.

d. The Department will calculate the incentive payment using the Childhood Immunization Worksheet, Addendum IV, L.

8. Addendum IV, G – HealthCheck Worksheet

Replace current HealthCheck Worksheet in Addendum IV, G with the new HealthCheck Worksheet (on following page).

G. HealthCheck Worksheet

HEALTHCHECK WORKSHEET

HMO: ___________

			Age Groups					
		Calculation	**< = 1**	**1 – 2**	**3 – 5**	**6 – 14**	**15 – 20**	**Total**
1	# of eligible months for enrollees under age 21	Entered (Total is sum of age groups)						
2	# of unduplicated enrollees under age 21	Entered						
3	Ratio of recommended screens per age group member	Given	5	1.5	1.0	0.56	0.5	
4	Average period of eligibility in years	Line 1 ÷ Line 2 ÷ 12						
5	Adjusted ratio of recommended screens per age group member	Line 3 x Line 4						
6	Expected # of screens (100% of required screens for ages and months of eligibility)	Line 2 x Line 5 (Total is sum of age groups)						
7	# of screens in 80% goal	Line 6 x 0.80 (Total is calculated by formula)						
8	Actual # of screens completed	Entered (Total is sum of age groups)						
9	Difference between goal and actual	Line 8 – Line 7 (If negative, goal was not met)						
10	% of HMO discount or premium if applicable							
11	Amount per screen to be recouped	FFS maximum allowable fee* x Line 10						
12	Total recoupment	Line 11 x Line 9						
13	Screens over 80%	Line 8 – Line 7						
14	Incentive $ over 80%	Entered						
15	Total Incentive Payment	Line 13 x Line 14						

9. Addendum IV, K

Add as **new** to this Addendum the Blood Lead Test Worksheet (on following page.)

K. Blood Lead Test Worksheet

BLOOD LEAD TEST WORKSHEET

Contract Year: ________________
HMO: ________________________

			Age Group	
	Description	Calculation	1[A]	2[B]
1	Base Year Total Eligible Children [C]	Entered		
2	Base Year Number of Children Tested	Entered		
3	Base Year Testing Rate	Line 2 ÷ Line 1 *100		
4	Performance Gap (Percent Untested)	100% - Line 3		
5	10% Reduction in Performance Gap	Line 4 x 0.1		
6	Contract Year Percent Performance Required	Line 3 + Line 5		
7	Contract Year Total # of Tests Needed to Meet Goal	Line 6 x Line 1		
8	Contract Year Incremental Number of Tests from Base Year Needed to meet Goal	Line 7 - Line 2		
9	Contract Year Total Eligible Children	Entered		
10	Contract Year/Base Year Enrollment Ratio	Line 9 ÷ Line 1		
11	Adjusted Contract Year Number of Children Tested Needed to Meet Goal	Line 10 x Line 7		
12	Adjusted Incremental Number of Contract Year Tested Children Needed to Meet Goal	Line 11 - (Line 10 x Line 2)		
13	Contract Number of Children Tested	Entered		
14	Target Met	Yes if Line 13 – Line 11 ≥ 0 No if Line 13 – Line 11 < 0		
15	Incentive Payment if Line 14 = Yes	(Line 12 + (Line 13- Line 11)) x $500		

Notes:

A Age one is between six and 16 months of age on date of service.

B Age two is between 17 and 28 months of age on date of service.

C Eligible children in each age category were enrolled in the HMO at the measure end date and had at least 304 days of continuous enrollment prior to the measure end date with no more than one break in enrollment of up to 45 days. Measure end date is the last date by which measured services can be rendered to be included in the numerator (number of children tested).

10. Addendum IV, K, 1

Add as **new** to this Addendum the completed Sample Blood Lead Test Worksheet (on following page.)

K. 1. Sample Blood Lead Test Worksheet

BLOOD LEAD TEST WORKSHEET - SAMPLE

Contract Year:_______________

HMO: ____________________

			Test 1	Test 2	Test 3
			Age Group		
	Description	Calculation	1[A]	2[B]	2[B]
1	Base Year Total Eligible Children [C]	Entered	178	250	250
2	Base Year Number of Children Tested	Entered	134	150	150
3	Base Year Testing Rate	Line 2 ÷ Line 1 *100	75.3%	60.0%	60.0%
4	Performance Gap (Percent Untested)	100% - Line 3	24.7%	40.0%	40.0%
5	10% Reduction in Performance Gap	Line 4 x 0.1	2.5%	4.0%	4.0%
6	Contract Year % Performance Required	Line 3 + Line 5	77.8%	64.0%	64.0%
7	Contract Year Total Number of Tests Needed to Meet Goal	Line 6 x Line 1	138	160	160
8	Contract Year Incremental # of Tests from Base Year Needed to meet Goal	Line 7 - Line 2	4	10	10
9	Contract Year Total Eligible Children	Entered	162	225	275
10	Contract Year/Base Year Enrollment Ratio	Line 9 ÷ Line 1	0.91	0.90	1.10
11	Adjusted Contract Year Number of Children Tested Needed to Meet Goal	Line 10 x Line 7	126	144	176
12	Adjusted Incremental Number of Contract Year Tested Children Needed to Meet Goal	Line 11 - (Line 10 x Line 2)	4	9	11
13	Contract Year Number of Children Tested	Entered	125	145	176
14	Target Met	Yes if Line 13 – Line 11 ≥0 No if Line 13 – Line 11 < 0	**N**	**Y**	**Y**
15	Incentive Payment if Line 14 = Yes	(Line 12 + (Line 13- Line 11)) x $500		$5,000	$5,500

Test 1: Example of Declining Enrollment in Contract Year, threshold Not Met
Test 2: Example of Declining Enrollment in Contract Year, Threshold Met and Exceeded
Test 3: Example of Increasing Enrollment in Contract Year, Threshold Met but Not Exceeded

Notes:
A Age one is between six and 16 months of age on date of service.
B Age two is between 17 and 28 months of age on date of service.
C Eligible children in each age category were enrolled in the HMO at the measure end date and had at least 304 days of continuous enrollment prior to the measure end date with no more than one break in enrollment of up to 45 days. Measure end date is the last date by which measured services can be rendered to be included in the numerator (number of children tested).

11. Addendum IV, L

Add as **new** to this Addendum the Childhood Immunization Worksheet (on the following page.)

L. Childhood Immunization Worksheet

CHILDHOOD IMMUNIZATION WORKSHEET

Contract Year: ____________
HMO: _____________

	Description	Calculation	2 Year Old Children
1	Base Year Total Eligible Children	Entered	
2	Base Year Number of Children Fully Immunized	Entered	
3	Base Year Testing Rate	Line 2 ÷ Line 1 *100	
4	Performance Gap (Percent Not Fully Immunized)	100% - Line 3	
5	10% Reduction in Performance Gap	Line 4 x 0.1	
6	Contract Year Percent Performance Required	Line 3 + Line 5	
7	Contract Year Total Number of Children Fully Immunized Needed to Meet Goal	Line 6 x Line 1	
8	Contract Year Incremental Number of Children Fully Immunized from Base Year Needed to meet Goal	Line 7 - Line 2	
9	Contract Year Total Eligible Children	Entered	
10	Contract Year/Base Year Enrollment Ratio	Line 9 ÷ Line 1	
11	Adjusted Contract # of Children Fully Immunized Needed to Meet Goal	Line 10 x Line 7	
12	Adjusted Incremental Number of Contract Year Fully Immunized Children Needed to Meet Goal	Line 11 - (Line 10 x Line 2)	
13	Contract Year Number of Children Fully Immunized	Entered	
14	Target Met	Yes if Line 13 – Line 11 ≥0 No if Line 13 – Line 11 < 0	
15	Incentive Payment if Line 14 = Yes	(Line 12 + (Line 13- Line 11)) x $1,000	

Notes:

- Eligible children turn two years of age during the measurement year with no more than one gap in enrollment of up to 45 days during the 12 months prior to the child's second birthday.
- Fully Immunized children have had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three H influenza B (HIB); three hepatitis B; and one chicken pox (VSV) by their second birthday.

WIC

12. Article III, H – Provider Network and Access Requirements

Add the following as **new** to read:

6. Use of Non-Medicaid Providers

"Effective February 1, 2008, the Department deems any WIC project that has a contract with the Department's Division of Public Health to be a certified provider for purposes of blood lead testing (and related services such as brief office visit, lab handling fee, etc.) only. The HMO may enter into a contract or MOU with such a WIC project and will directly reimburse the WIC project for those services."

Policy Clarification

13. Article III, C, 3 - Attestation

Amend to read: "The HMO's Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes encounter data, AIDS/Vent, and any other data regarding claims the HMO paid. The HMO must use the Department's encounter data attestation form in Addendum IV, I. The encounter data attestation form should be submitted quarterly to the HMO's Managed Care Analyst in the Bureau of Benefits Management according to the submission schedule in Article VII, I."

14. Article III, E, 7, a – BadgerCare Plus – Standard Plan and Medicaid SSI

Amend to read: "The HMO must provide or arrange for common carrier transportation, including HealthCheck screenings, in accordance with the BadgerCare Plus and/or Medicaid SSI transportation guidelines included in the Medicaid Enrollment Handbook (online at: http://emhandbooks.wi.gov/bcplus/plicyfiles/5_Coverage/38_Covered_Services/38.3.htm).

Common carrier transportation includes, but is not limited to, taxi, van, or bus as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and/or Medicaid SSI covered services, including those not covered by the HMO such as chiropractic and family planning services. Common carrier transportation also includes coverage of meals and lodging in accordance with the Medicaid Enrollment Handbook. The HMO must arrange for transportation for HealthCheck screenings."

15. Article III, E, 7, a, (1) – Enrollees Outside of Milwaukee County

Delete first sentence: "The HMO must arrange for transportation for HealthCheck screenings."

Amend to read:

- Directly provide non-emergency transportation by common carrier or private motor vehicle for covered services to the enrollee and the HMO will be reimbursed by the county; or

- The HMO may refer an enrollee directly to the local county Department of Health and Social Services for transportation services."

16. Article III, E, 7, a, (2) – Enrollees in Milwaukee County

Delete the following: "The HMO must provide or arrange for common carrier transportation in accordance with the BadgerCare Plus and/or Medicaid SSI transportation guidelines included in the Medicaid Enrollment Handbook. Common carrier transportation includes, but is not limited to, taxi, van, or bus as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and/or Medicaid SSI covered services, including those not covered by the HMO such as chiropractic and family planning services. Common carrier transportation also includes coverage of meals and lodging in accordance with the Medicaid Enrollment Handbook."

Amend the rest of this section to read:

"The Department will reimburse the HMO for Milwaukee County common carrier transportation for its members. Reimbursement will be subject to the HMO submitting a detailed report on CD ROM in an Excel file. The report must be submitted to the Bureau of Fiscal Management's Common Carrier Rate Analyst on a quarterly basis as specified in the submission schedule in Article VII, I and include all the data elements specified in Addendum IV, J. The Department will not reimburse the HMO for claims if data is not submitted according to these specifications. If the HMO is contracted to serve BadgerCare Plus and Medicaid SSI enrollees the reports must be submitted separately."

17. Article VI, A – Capitation Rates

Second bullet amend to read: "The Department will conduct an analysis comparing actual HMO enrollee's diagnosis and service usage intensity (utilization and costs) with the comparable FFS or HMO equivalent

population using the Chronic Illness and Disability Payment System (CDPS)."

Add a third bullet to read: "Phase-in of the rate realignment and CDPS adjusters will be 25% in 2008 and 50% in 2009."

18. Article VI, H, 3, a, 1) – Reporting Requirements

    Amend to read: "An interim report must be submitted to the Department on or before May 1 of the following year (i.e., an interim report for the period January 1, 2008 through December 31, 2008, must be submitted on or before May 1, 2009)."

19. Article VI, H, 3, a, 2) – Reporting Requirements

    Amend to read: "The final report must be submitted on or before May 1, one year after the submission of an interim report (i.e., a final report for the period January 1, 2008 through December 31, 2008, must be submitted on or before May 1, 2010)."

20. Article VI, I, 1, c, 2), b) – Criteria Requirement – Medicaid SSI

    Amend bullet three to read: "003/541"
    Amend bullet four to read: "004/542"

21. Article VI, I, 1, c, 4), b) – Documentation Requirements – Medicaid SSI

    Amend bullet three to read: "003/541"
    Amend bullet four to read: "004/542"

22. Article VII, I, entire report – Contract Specified Reports and Due Dates

    Amend chart: Add quarterly Encounter Data Attestation Form report dates to the schedule in the same location as the Formal/Informal Grievance Experience Summary Report on January 31, 2008, April 30, 2008, July 31, 2008, October 31, 2008, January 31, 2009, April 30, 2009, July 31, 2009, and October 31, 2009.

23. Addendum II – When You May Be Billed For Services

    Amend first paragraph to read: "It is very important to follow the rules when you get medical care so you are not billed for services. You must receive your care from (HMO NAME) providers and hospitals unless you have our approval. The only exception is for severe emergencies."

24. Addendum II – Billing Enrollees – Co-payments

Amend fourth bullet to read: "Members under 19 years of age who are members of a federally recognized tribe, and"

Amend fifth bullet to read: "Members under 19 years of age with incomes at or below 100% of the Federal Poverty Level (FPL)."

25. Addendum II - Dental Services

Add a second paragraph to #1 to read: "As a member of (HMO NAME), you have the right to a routine dental appointment within 90 days after your formal request."

26. Addendum II - Dental Emergency

Add the following as the last sentence to this section: "You have a right to obtain treatment for your dental emergency within 24 hours after receipt of your request."

27. Addendum II - Pharmacy Benefits

Add the following as **new** at the end of "Services Covered By (HMO Name) section, after Ambulance:"

"Your prescriptions and certain over-the-counter items are provided by the State, not (HMO Name).

You may receive a prescription from a (HMO Name) doctor, specialist, or dentist. You can fill your prescription at (HMO clinic pharmacy if the HMO has their own pharmacies) any pharmacy that is a provider for BadgerCare Plus and Medicaid SSI.

Please show your ForwardHealth or Forward ID card to the pharmacy when you get your prescriptions filled. Do not show your (HMO Name) ID card to the pharmacy."

28. Addendum VI – Incentives

Add the following as **new** under the title:

"The total incentive amounts in aggregate paid to the HMO under this contract per calendar year will not exceed total capitation revenues by more than 5%."

Technical Changes

29. Cover Page

    Amend to read: "Contract for BadgerCare Plus and/or Medicaid SSI HMO Services between the HMO and The Wisconsin Department of Health Services."

30. Table of Contents – Article V, J

    Amend to read: "Vaccines for Family (BadgerCare Plus Only)."

31. Table of Contents – Article VI - Payment To The HMO

    Add: J – "Expansion Incentive"

32. Table of Contents – Addendum IV, B

    Amend title to read: "HMO Report on Coordination of Benefits"

33. Table of Contents – Addendum IV, F

    Amend to read: "HMO Newborn Report (BadgerCare Plus Only)"

34. Article I – Title Page

    Amend to read: "Contract For Services Between the Wisconsin Department of Health Services."

35. Article I, First Paragraph

    Amend to line of first paragraph to read: "The Wisconsin Department of Health Services (the Department) and the HMO…"

36. Article I – Definitions

    Amend "Department" definition to read: "The Wisconsin Department of Health Services (formerly known as the Wisconsin Department of Health and Family Services."

    Amend "Formerly Enrolled with a Continuing Care Provider" to read: "A member, member's guardian, or authorized representative agrees to use one continuing care provider as the regular source of a described set of services for a stated period of time."

    Amend "Medicaid" definition to read: The BadgerCare Plus and Medicaid SSI Program operated by the Wisconsin Department of Health

Services under Title XIX of the Federal Social Security Act, Wis. Stats., Ch. 49, and related state and federal rules and regulations."

37. Article III, B – Compliance with Applicable Laws

    Amend last sentence to read: "Specifically and as applicable, the Contractor agrees to abide by the Copeland-Anti Kickback Act, the Davis-Bacon Act, federal contract work hours and safety standard requirements, the federal Clean Air Act and the federal Water Pollution Control Act."

38. Article III, C, 1, a, 1), d) – Organizational Responsibilities and Duties

    Capitalize the "S" in the word Subsections.

39. Article III, C, 4 – Affirmative Action (AA) and Equal Opportunity, and Civil Rights Compliance (CRC)

    Amend the second to last line to read: "…with Wis. Stats., s. 16.765, and Adm. Code 50."

40. Article III, C, 4, a, 3) and 4) – Civil Rights Compliance

    Amend address at top of the page to read: "The Department of Health Services."

    In same Article change telephone number to read: "(608) 266-9372"

41. Article III, C, 5 – Non-Discrimination in Employment

    Amend last sentence of last paragraph to read: "This shall not be construed to prohibit the HMO…"

42. Article III, C, 10, d – Prenatal Care Coordination (PNCC) Agencies

    Amend, second paragraph, first line to read: "In addition, the HMO must assign the HMO…"

43. Article III, D, 6 – Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

    Amend first line to read: "If the HMO contracts with a BadgerCare Plus…"

    Amend last sentence to read: "The HMO that contracts…"

44. Article III, D, 8, c – Transplants

Amend to read: "As a general principle, the BadgerCare Plus and/or Medicaid SSI Program does not pay for transplants that it determines to be experimental in nature."

45. Article III, D, 8, last paragraph – Transplants

Amend to read: "Enrollees who have had one or more of the transplant surgeries referenced in 8,b, above will be permanently exempted from HMO enrollment."

46. Article III, D, 9, c)

Amend to read: "Disenrollment is due to a medical status code change which includes:"

47. Article III, D, 9, c), second bullet

Amend to read: "503 case (503 cases are SSI cases that continue Medicaid SSI eligibility when Social Security cost of living increases cause an SSI member to lose SSI eligibility)."

48. Article III, E, 1, k – Provision of Contract Services

Add a period after the word Coverage.

49. Article III, E, 5, a – Ambulance Services

Amend to read: "Pay a service fee for an ambulance response…"

50. Article III, E, 8, a – Dental Services

Amend to read: "Dental Services Covered by the HMO."

51. Article III, E, 8, b

Amend to read: "Dental Services Covered by the HMO Contracted to Provide Dental Care"

52. Article III, Dental Chart, - Footnote

Amend to read: "Orthodontic treatment is only covered by BadgerCare Plus and/or Medicaid SSI for children under 21 as a result of a HealthCheck referral (HFS 107.07(3))."

53. Article III, H, 1 – Use of BadgerCare Plus and/or Medicaid SSI Certified Providers

    Amend last line to read: "The HMO must require every physician providing…"

54. Article III, I, 9, b, 2), first bullet

    Amend to read: "Be based upon known facts and recent information and evaluations and include assessment for mental health disorders, substance abuse disorders, physical or mental impairments and medical problems."

55. Article III, I, 9, c

    Amend second sentence to read: "The HMO shall submit a monthly detailed report of assessments to the Department, for SSI only, electronically (as provided by the Department)."

56. Article III, I, 9, e

    Amend first sentence to read: "The care plan must be developed in consultation with the enrollee and/or the enrollee's legal guardian…"

57. Article III, N – HMO Card

    Change: "Forward Health to ForwardHealth."

58. Article IV, J, 1

    Delete the colon at the end of "10 Steps for Completing a Performance Improvement Project."

59. Article IV, J, 1, h, 10)

    Add an "s" to the word "table" to read "tables."

60. Article IV, J, 2

    Delete the 3 at the end of the paragraph.

61. Article IV, J, 3, last paragraph – Priority Areas

    Amend to read: "In addition, the HMO may be required to conduct Performance Improvement Projects…"

62. Article VI, I, 1., c., 1) – General Information

Delete the extra sentence that reads: “The patient may need a combination of these systems.”

63. Article VII, I – Report Mailing Addresses

Amend to read: “Department of Health Services.”

64. Article VIII, F, 1, (a) – Inmates of a Public Institution

Amend last sentence to read: “The disenrollment will be effective the first of the month following the first full month of incarceration or the date of BadgerCare Plus and/or Medicaid SSI ineligibility, which ever comes first.”

65. Article IX, A, 11

Amend second sentence to read: “The log must distinguish between BadgerCare Plus and Medicaid SSI enrollees, if the HMO serves both populations. If the HMO does not have a separate log for BadgerCare Plus and/or Medicaid SSI and their commercial enrollees, the log must distinguish between the programs.”

66. Article IX, C, 9

Amend to read: “The fact that punitive action will not be taken against an enrollee who appeals the HMO’s decision.”

67. Article IX, C, 12

Amend to read: “The fact that the enrollee, if appealing the HMO action, may file a request for a hearing with the Division of Hearings and Appeals (DHA) at any point in the process.”

68. Article X – Subcontracts

Amend third sentence to read: “Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of (HMO Name)’s contract with the Department of Health Services…”

69. Article XI, A – Suspension of New Enrollment

Amend third to last sentence of first paragraph to read: “The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that the enrollee’s health or welfare is jeopardized.”

70. Article XVIII, C, 7, Under Other terms of the Contract…1 – Case Mix Adjustment

Amend second sentence of Milwaukee Region to read: “The payment rates for enrollees will be adjusted based upon the prospective CDPS scores applied prospectively to the rate schedule in the attached Exhibit section, subject to CMS approval.”

Amend third paragraph second sentence to read: “The payment rates for enrollees will be adjusted based upon the final outcome of the CDPS analysis as applied to the rate schedule in the Exhibit Section, subject to CMS approval.”

71. Article XVIII – Subcontract for Chiropractic Services

Amend A to read: “THIS AGREEMENT is made and entered into by and between the HMO and the Department of Health Services.”

72. Addendum II – Enrollee Handbook

Your Forward Health or Forward ID Card Section: Delete the “d” in Fordward. Amend to read “Forward” and change Forward Health to ForwardHealth.”

Throughout Enrollee Handbook Section change Forward Health to “ForwardHealth.”

73. Addendum IV, J – Milwaukee County Common Carrier Detail Report

Amend third sentence to read: “If the HMO is contracted to serve both BadgerCare Plus and Medicaid SSI enrollees the reports must be submitted separately.”

74. Addendum V – Emergency Room

Amend to read: “Same coverage as Wisconsin Medicaid with a $60.00 co-payment if the member is not admitted as an inpatient to the hospital.”

75. Addendum V – Dental

Amend to read: “50 percent allowable charges as defined by the Department of Health Services for preventive, diagnostic, simple restorative, periodontics, and extractions for both pregnant women and children. A $200 deductible applies to all services except preventative and diagnostic. There is a coverage limit of $750 per enrollment year. This deductible does not apply to preventative and diagnostic services.”

76. Addendum V – Physician, Anesthesia, X-Ray, and Laboratory

Add the following after the last sentence: "Preventative services including pre-natal and post-natal care are exempted from copayments."

77. Addendum V – Durable Medical Equipment (DME)

Amend second sentence to read: "There is a $2,500 service limitation in an enrollment year."

Add the following after the last sentence: "Rental items are not subject to co-payment but count toward the $2,500 cap."

78. Addendum V – Home Health

Add the following after the last sentence: "Private duty nursing and personal care services are not covered."

79. Addendum V – HealthCheck

Amend the second sentence to read as follows: "HealthCheck "Other Services" or interperiodic services for individuals under 21 are not covered. There are no co-payments for preventative services, including HealthCheck screens."

80. Addendum V – Hearing Services

Add as **new** after Podiatric Services:

"Hearing Services – Services are covered for both the Speech and Hearing Clinics and Audiologist provider types. No coverage of hearing aids and related services, bone-anchored hearing devices, or cochlear implants. $15.00 co-payment per procedure for some services."

81. Addendum V – Transportation

Add as **new** after Ambulance Services:

"Transportation – Non-emergency transportation services are not covered."

82. Addendum V – Inpatient Hospital

Amend to read: "Same coverage as Wisconsin Medicaid with a $100 co-payment per hospital stay (medical surgery) and a $50.00 co-payment per stay for psychiatric treatment and substance abuse."

83. Addendum V – Physical Therapy (PT), Occupational Therapy (OT) and Speech-Language Pathology (SLP)

Amend to read: "Same coverage as Wisconsin Medicaid program. 20 visits per therapy discipline per enrollment year. 36 visits are covered for cardiac rehabilitation. There is a $15 co-payment per visit per date of service."

84. Addendum V - Disposable Medical Supplies (DMS)

Delete last sentence.

85. Addendum V – Mental Health and Substance Abuse

Amend the first sentence in the second paragraph to read: "Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, child/adolescent mental health day treatment, and substance abuse day treatment for adults and children."

Amend the first sentence in the first bullet to read: "$4,500 for non-hospital substance abuse services."

Add as **new**: "There is a $10 to $15 co-payment per visit for all outpatient services. A visit is defined as all services delivered on the same date of service by the same performing provider."

86. Addendum VI, 1 – Dental Care Utilization Incentive (BadgerCare Plus Only)

Amend first sentence to read: "For the HMO that is certified…"

87. Addendum VI, 2, d – Tobacco Cessation Incentive (TCI)

Amend second paragraph to read: "The Tobacco Cessation Workgroup…"

All terms and conditions of the February 1, 2008 through December 31, 2009 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect.

HMO NAME	**Department of Health and Family Services**
Official Signature	Official Signature
Printed Name	Printed Name Jason Helgerson
Title	Title Medicaid Director Division of Health Care Access and Accountability
Date	Date