FOSTER CARE MEDICAL HOME PROGRAM

Contract for Services

Between

Children's Hospital and Health System, Inc.

and

Wisconsin Department of

Health Services

for

January 1, 2022 – December 31, 2023

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CONTRACT FOR SERVICES

Between
The Wisconsin Department of Health Services
And
Children's Hospital and Health System, Inc.

This Contract for Services (the Contract) is entered into by and between the Wisconsin Department of Health Services (the Department) and Children's Hospital and Health System, Inc., a "Prepaid Inpatient Health Plan" as that term is defined under 42 CFR 438.2 (hereafter referred to as the PIHP), an organization that, in consideration of periodic fixed prepayments from the Department, on a non-risk and non-insurance basis, makes available or arranges for comprehensive health care services delivered by providers selected by the PIHP who are employees or partners of the PIHP or who have entered into a referral or contractual arrangement with the PIHP, for the purpose of providing and paying for services to participants enrolled in the PIHP under the State of Wisconsin Foster Care Medical Home (FCMH) benefit plan approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act and for the further specific purpose of promoting coordination and continuity of preventive health services and other medical care including prenatal care, emergency care, and HealthCheck services. The parties do herewith agree:

ARTICLE I: Definitions and Acronyms

I. DEFINITIONS AND ACRONYMS

A. Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid, in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health. Abuse also includes member practices that result in unnecessary costs to the Department of Health Services.

Access: Per 42 CFR §438.320, as it pertains to external quality review, "access" means the timely use of services to achieve optimal outcomes, as evidenced by the PIHP successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined in 42 CFR §438.68 (Network adequacy standards) and 42 CFR §438.206 (Availability of services).

Actuarially Sound Nonrisk Prepayment Rates: Actuarially sound nonrisk prepayment rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the PIHP for the time period and the population covered under the terms of the contract, and such nonrisk prepayment rates are developed in accordance with Centers for Medicare and Medicaid Services (CMS) requirements.

Actuary: An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board

Administrative Service Organization (ASO): An organization that provides outsourced solutions to meet the administrative and HR needs of the client, with the client retaining all employment-related risks and liabilities.

Adolescent: A child between the ages of 12 and 18 for the purpose of this contract.

Adverse Benefit Determination: Includes any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for

medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure of the PIHP to act within the standard resolution timeframes for grievances and appeals as detailed in the *Member Grievances and Appeals Guide*.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.
- A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a 'clean claim' at § 447.45(b) of this chapter is not an adverse benefit determination

Affirmative Action Plan: A written document that details an affirmative action program.

Appeal: For member appeals, a review by the PIHP of an adverse benefit determination. For provider appeals, an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: A claim is denied by the PIHP for untimely claim filing. The Provider must appeal the denial action to the PIHP; an internal review by the PIHP is required.

Authorized Representative: An individual appointed by the member, including a provider or estate representative, who may serve as an authorized representative with documented consent of the member. The role of the authorized representative primarily includes filing a grievance or appeal, and approving the member's care plan.

Auxiliary Aids & Services: Includes qualified interpreters, qualified readers, note takers, telephone handset amplifiers, telecommunications devices, audio recordings, large print or Braille materials, or other effective methods of making materials available to individuals with hearing or visual impairments.

BadgerCare Plus: BadgerCare Plus is Wisconsin's health care program for low income individuals that merged BadgerCare, the family portion of the current Wisconsin Medicaid population, with Healthy Start to form a single program that expands coverage to Wisconsin residents. Effective April 1, 2014, the following populations are eligible for BadgerCare Plus:

- Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Level (FPL).
- Pregnant women with incomes at or below 300 percent of FPL.
- Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.
- Childless adults with incomes at or below 100 percent of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL.

Balanced Workforce: An equitable representation of persons with disabilities, minorities and women available for jobs at each job category from the relevant labor market from which the PIHP recruits job applicants.

Business Associate: A person (or company) that provides a service to a covered program that requires their use of individually identifiable health information.

Business Continuity Plan: A plan that provides for a quick and smooth restoration of the health plan's administrative services after a disruptive event. The business continuity plan includes business impact analysis, plan development, testing, awareness, training, and maintenance and processes to ensure minimal member and provider disruption. This is a day-to-day plan.

Capitation Payment: See Nonrisk Prepayment

Care Coordination: The integration of all processes in response to a child's needs and strengths to ensure the achievement of desired health care outcomes and the effectiveness of services:

- Provided by a care coordinator for each member, and
- Supervised by individuals with the equivalent training and experience of a person with an RN nursing degree and experience with members with disabilities, or a certified social worker with medical background, or a nurse practitioner.

Care Management Model: Care management includes a comprehensive assessment and care plan, care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a person.

Care Management Staff: Staff that assists in patient-centered, evidence-based, coordinated care and services designed to effectively manage health conditions and help members meet their self-identified goals.

Care Plan: Written documentation of decisions made in advance of care provided, based on a comprehensive assessment of a person's needs, preferences and abilities, defining how services will be provided. This includes establishing objectives (desired outcomes) with the client and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing cycle of activity as long as care is being provided.

Case Management: The management of complex clinical services needed by the PIHP members, ensuring appropriate resource utilization and facilitation of positive outcomes. For persons with serious mental illness, case management should be provided by and supervised by staff with mental health expertise.

CESA (Cooperative Educational Service Agencies): The unit serving as a connection between the state and school districts within its borders. There are 12 CESAs in Wisconsin. Cooperative Educational Service Agencies coordinate and provide educational programs and services as requested by the school district.

Child in Out-of-Home Care: Refers to a child taken into custody and determined by a judge to meet the need for continuation of custody under s. 48.21(4)(b) or a parent/legal guardian signs a Voluntary Placement Agreement with DMCPS or the county Child Welfare Agency. A child in out-of-home care may reside in a variety of different placement settings, including a foster home, a group home, or a relative's home. Although this contract uses the term "Foster Care Medical Home" the reference applies to all children placed in an eligible out-of-home care placement setting.

Children with Special Health Care Needs: Children with or at increased risk for chronic physical, developmental, behavioral, or emotional conditions who also require health and related services of a type or amount beyond that required by children generally.

Claim: Bill for services, a line item of service, or all services for one member.

Clean Claim: A truthful, complete and accurate claim that does not have to be returned for additional information.

Clinical Decision Support Tools: Tools that support informed clinical decision-making by presenting information in an integrated, interactive manner.

Cold Call Marketing: Any unsolicited personal contact by the PIHP with a potential member for the purpose of marketing.

Communication Materials: Communication materials designed to provide members or potential members with clear and concise information about the PIHP's program, the PIHP's network, and resources about the FCMH program.

Community Based Health Organizations: Non-profit agencies providing community based health services. These organizations provide important health care services such as HealthCheck screenings, nutritional support, and family planning, targeting such services to high-risk populations.

Comprehensive Initial Health Assessment: A comprehensive initial health assessment is required for all children in out-of-home care who are enrolled in the foster care medical home program and must occur within 30 days of the child's enrollment in the PIHP. This assessment should be comprehensive with respect to the identification of possible acute and chronic physical health, behavioral/mental health, oral health, and developmental problems; and, must be in compliance with Wisconsin HealthCheck requirements. This assessment should include components of both developmental and behavioral/mental health screenings as indicated for each child based on his/her age and history, including any prior evaluations. This assessment should be performed by a clinician who is knowledgeable about the trauma-informed evaluation and treatment of children in out-of-home care.

Confidential Information: All tangible and intangible information and materials accessed or disclosed in connection with this Contract, in any form or medium (and without regard to whether the information is owned by the State or by a third party), that satisfy at least one of the following criteria:

- Personally Identifiable Information;
- Individually Identifiable Health Information;
- Non-public information related to the State's employees, customers, technology (including databases, data processing, and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; or
- Information designated as confidential in writing by the State.

Continuing Care Provider: A provider who has an agreement with the Department to provide:

- Any reports that the Department may reasonably require, and

- At least the following services to eligible HealthCheck members formally enrolled with the provider as enumerated in 42 CFR 441.60(a)(1)-(5):
    - Screening, diagnosis, treatment and referrals for follow-up services;
    - Maintenance of the members consolidated health history, including information received from other providers;
    - Physician's services as needed by the member for acute, episodic or chronic illness or conditions;
    - Provision or referral for dental services; and
    - Transportation and scheduling assistance.

Contract Services: Services that the PIHP is required to provide under this Contract.

Contractor: An entity to which the PIHP awarded a contract resulting from the Foster Care Medical Home (FCMH) certification process to provide managed care in accordance with this Contract.

Coordination of Benefits (COB): Industry term applied to agreements among payers to assign liability and to perform the end-to-end payment reconciliation process. This term applies mostly to the electronic data interchanges associated with Health Insurance Portability and Accountability Act (HIPAA) transactions.

Copayment: A fixed amount the PIHP or provider is allowed to charge a member for part of the cost of medically necessary covered services. Allowable copayment amounts are listed in the ForwardHealth online handbook. FCMH does not allow copayments.

Corrective Action Plan: A written plan required by the Department for a PIHP to address one of the below situations:

- Plan communicated by the State to the PIHP for the PIHP to follow in the event of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or in the event that any Confidential Information is lost or cannot be accounted for by the PIHP.

This also refers to the plan communicated to the State by the PIHP to address a deficiency in contractual performance.

Covered Entity: A health plan (such as an PIHP), a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162.

Culturally Competent: A set of congruent behaviors, attitudes, practices and policies that are formed within an agency, and among professionals that enable the system, agency, and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include understanding diversity issues at work, understanding the dynamic of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.

Days: Unless stated otherwise, "days" means calendar days. Calendar days include weekends and holidays.

Department: The Wisconsin Department of Health Services (DHS). The State agency responsible for the Foster Care Medical Home Program.

Department of Children and Families (DCF): The State agency responsible for the child welfare program in Wisconsin.

Department Values: The Department's shared values include:

- Serve people through culturally competent practices and policies.
- Foster supportive and trusting, team-oriented culture that recognizes excellence and provides opportunities for development
- Builds collaborative relationships with both internal and external stakeholders and partners.
- Encourage innovative, data-driven and collaborative decision making.
- Accountable for high value service delivery and customer service.

Disaster: Any natural event or communicable disease outbreak in which a national or Wisconsin state of emergency is declared.

Division of Milwaukee Child Protective Services (DMCPS): The state agency responsible for child protective services in Milwaukee County.

Durable Medical Equipment: Items that are primarily and customarily used to serve a medical purpose; generally are not useful to an individual in absence of disability, illness, or injury, can withstand repeated used and can be reusable or removable.

Electronic Visit Verification: An electronic system that uses technologies to verify that authorized services were provided. Workers are required to send information at the beginning and end of each visit to the EVV system including:

- Who receives the service
- Who provides the service

- What service is provided
- Where service is provided
- Date of service
- Time in and out

Emergency Medical Condition:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
    - Serious impairment of bodily functions, or
    - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant woman who is in active labor:
    - Where there is inadequate time to effect a safe transfer to another hospital before delivery; or
    - Where transfer may pose a threat to the health or safety of the woman or the unborn child.
- A psychiatric emergency involving a significant risk or serious harm to oneself or others.
- A substance abuse emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment.
- Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma. In all emergency situations, the PIHP must document in the member's dental records the nature of the emergency.

Emergency Medical Transportation: Transportation by ambulance, specialized medical vehicle (SMV) or county-approved or tribe-approved common carrier as defined under Wis. Admin Code s. DHS 107.23(1)(d) when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition. Wis. Admin Code s. DHS 107.23.

Emergency Recovery Plan: A plan developed by the health plan that outlines details for the restoration of the health plan's management information system in the event of an emergency or disaster. This is part of the business continuity plan.

Emergency Room Care: Any health care service given in an emergency room and provided to evaluate and/or treat any medical condition that a prudent layperson believes requires immediate unscheduled medical care.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under Title XIX of the Social Security Act, and needed to evaluate or stabilize an emergency medical condition.

Encounter:

- A service or item provided to a patient through the health care system. Examples include but are not limited to:
    - Office visits
    - Surgical procedures
    - Radiology (including professional and/or technical components)
    - Durable medical equipment
    - Emergency transportation to a hospital
    - Institutional stays (inpatient hospital, rehabilitation stays)
    - HealthCheck screens
- A service or item not directly provided by the PIHP, but for which the PIHP is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.
- A service or item not directly provided by the PIHP, and for which no claim is submitted but for which the PIHP may supplement its encounter data set. Such services might include HealthCheck screens for which no claims have been received and if no claim is received, the PIHP must have conducted a medical chart review. Examples of services or items the PIHP may include are:
    - HealthCheck Services
    - Lead Screening and Testing
    - Immunizations

  Services or items as used above include those services and items not covered by FCMH Program, but which the PIHP chooses to provide as part of its product. Examples include educational services, certain over-the-counter drugs, and delivered meals.

Encounter Priced Amount: The fee-for-service equivalent rate assigned to an encounter.

Encounter Record: An electronically formatted list of encounter data elements per encounter as specified in the current Encounter User Guide. An encounter record may be

prepared from paper claims such as the CMS 1500, UB-04, or electronic transactions such as ASC XX12N 837.

Enrollee(see also definition of "Member") : A child in out-of-home care who has been certified by the state as eligible to enroll under this Contract, and whose name appears on the Enrollment Reports that the Department transmits to the PIHP according to an established notification schedule. Children born to members of the PIHP will be enrolled in the PIHP if covered under the out-of-home care court order unless disenrolled at the request of the parent.

Enrollment Area: The geographic area within which members must reside in order to enroll in the PIHP under this Contract.

Enrollment Specialist: An entity contracted by the Department to perform counseling and enrollment activities, providing families with information about the benefits and services available under the FCMH Program compared to the standard fee-for-service benefit package. Enrollment activities refers to distributing, collecting, and processing enrollment materials. Enrollment activities refers to distributing, collecting, and processing enrollment materials and taking enrollments by phone, by mail, or in person.

Estimated Data Completeness: A measure used by the Department to evaluate PIHP compliance with encounter submission requirements.

Excluded Services: Services that Medicaid does not pay for.

Expedited Grievance or Appeal: An emergency or urgent situation in which a member or their authorized representative requests a review of a situation where further delay could be a health risk to the member, as verified by a medical professional.

Experimental Surgery and Procedures: Experimental services that meet the definition of Wis. Adm. Code DHS 107.035(1) and (2) as determined by the Department.

External Quality Review (EQR): Per 42 CFR §438.320, the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness, and access to the health care services that a PIHP or their contractors furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO): Per 42 CFR §438.320, an organization that meets the competence and independence requirements set forth in 42

CFR §438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR §438.358, or both.

Federally Qualified Health Center or FQHC: Defined in Section 4161 of the Omnibus Budget Reconciliation Act of 1990. The purpose of the FQHC Program is to enhance the provision of primary care services in underserved urban and rural communities. FQHCs are providers such as community health centers, outpatient health programs funded by the Public or Indian Health Service, and programs serving migrants and the homeless.

Fee-for-Service: A method of payment in which a provider is paid a fee for each service rendered for a Care4Kids member.

Fiscal Agent (as cited in 42 CFR §455.101): A contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Formally Enrolled with a Continuing Care Provider (as cited in 42 CFR §441.60(d)): 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.

ForwardHealth Handbook: Part of ForwardHealth interChange also provides users with access to health care information available via the Online Handbook. The Online Handbook is an interactive tool containing current health care policy and procedural information for ForwardHealth programs.

ForwardHealth interChange: The ForwardHealth Portal serves as the interface to ForwardHealth interChange, the Medicaid Management Information System for the state of Wisconsin. Through this Portal, providers, managed care organizations, partners, and trading partners can electronically and securely submit, manage, and maintain health records for members under their care.

Foster Care Health Screen: See "Out-of-Home Care Health Screen"

Foster Care Medical Home Program: The Foster Care Medical Home (FCMH) program is available to children in out-of-home care in the six Southeastern Wisconsin counties of Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha. It includes all benefits covered under Wisconsin Medicaid as well as additional benefits focused on the specific needs of children in out-of-home care. See definition at "Medical Home".

Fraud: An intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in some unauthorized benefit to him/herself, itself or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Grievance: An expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the PIHP to make an authorization decision. The member or authorized representative may file a grievance either orally or in writing.

Grievance and Appeal System: The processes the PIHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

Habilitation Services and Devices: Health care service and devices that help a person keep, learn, or improve skills and functioning for daily living.

Health Care Coordinator: An individual who serves as a clinical specialist to assess, develop, coordinate, and facilitate health care management for children in out-of-home placement. This individual should have equivalent training and experience of a person with a Master's Degree (preferred) or Bachelor's degree (required) with an additional two years of experience in health promotion, health advocacy, health education, clinical case management, child/family clinical social work, community outreach, or child welfare or related field.. All health care coordinators should have relevant experience in case management, home health nursing, special needs, SSI, child welfare, general child Medicaid population, and/or behavioral health; or must demonstrate proficiency and/or ability to serve the out-of-home care population as determined by PIHP.

Health Care Professional: A person who is trained and licensed to give health care. Examples include: A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, licensed midwife, or certified respiratory therapy technician.

Health Care Services: All Medicaid services provided by a PIHP under contract with the Department in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

HealthCheck: HealthCheck is Wisconsin's name for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for children under age 21. The EPSDT benefit is defined in federal law at §1905(r) of the Social Security Act. The benefit provides comprehensive and preventive health care services for all children under 21 years old.
Federal and state regulations establish certain requirements for comprehensive HealthCheck screenings. A comprehensive HealthCheck screen includes all of the following components:

- A complete health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical examination.
- An age-appropriate vision screening exam.
- An age-appropriate hearing screening exam.
- An oral assessment plus referral to a dentist beginning at one year of age.
- The appropriate immunizations (according to age and health history).
- The appropriate laboratory tests (including blood lead level testing when appropriate for age).

HealthCheck "Other Services: HealthCheck "Other Services" is Wisconsin's term for the federal mandate (under EPSDT) that requires that states cover "other necessary health care, diagnostic services, treatment, and other measures" which a child (under age 21) may require to treat, correct or reduce illnesses and conditions regardless of whether the necessary service is covered in a state's Medicaid plan. The needed service must be allowable under federal Medicaid law (§1905(a) of the Social Security Act), and coverage is determined on a case-by-case basis.

Health Insurance: A contract with an individual that requires a health insurer to pay some or all of an individual's health care costs.

HHS Transaction Standard Regulation: 45 CFR, Parts 160 and 162.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, federal legislation that is designed to improve the portability and continuity of health insurance.

Home Health Care: Home health skilled nursing and therapy services, including medication management, are provided to a recipient who, due to his/her medical

condition, is unable to leave home to obtain necessary medical care and treatment and therefore, must receive this care at home.

Hospice Services: Services necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient. Wis. Admin Code DHS 107.31(2)

Hospitalization: An inpatient stay at a certified hospital as defined in Wis. Admin Code DHS 101.03(76).

Hospital Outpatient Care: The provision of services by an outpatient department located within an inpatient hospital licensed facility which does not include or lead to an inpatient admission to the facility.

Indian: Pursuant to 42 CFR § 438.14(a), any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR § 136.12. The individual:

- Is a member of a Federally recognized Indian tribe;
- Resides in an urban center and meets one or more of the four criteria:
    - Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
    - Is an Eskimo or Aleut or other Alaska Native;
    - Is considered by the Secretary of the Interior to be an Indian for any purpose; or
    - Is determined to be an Indian under regulations issued by the Secretary;
- Is considered by the Secretary of the Interior to be an Indian for any purpose; or
- Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

Indian Health Care Provider (IHCP): Pursuant to 42 CFR § 438.14(a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Individually Identifiable Health Information (IIHI): Patient demographic information, claims data, insurance information, diagnosis information, and any other information that relates to the past, present, or future physical or mental health or condition, provision of health care, payment for health care and that identifies the individual (or that could reasonably be expected to identify the individual).

Information: Any "health information" provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term "health information" as defined by 45 CFR Part 160.103.

Language Access Services: Services that promote effective communication between the PIHP and providers with members or potential members who have Limited English Proficiency (LEP).

Limited English Proficiency (LEP): Potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

Marketing: Any unsolicited contact by the PIHP, its employees, affiliated providers, subcontractors, or agents to a potential member for the purpose of persuading such persons to enroll with the PIHP. Marketing does not include communication to a potential member from the issuer of a qualified health plan as defined in 45 CFR 155.200, about the qualified health plan.

Marketing Materials: Materials that are produced in any medium, by or on behalf of a PIHP that can be reasonably interpreted as intended to market to potential members.

Material Adjustment: An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the nonrisk prepayment such that its omission or misstatement could impact a determination whether the development of the nonrisk prepayment rate is consistent with generally accepted actuarial principles and practices.

Medicaid: 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.

Medical Home: The provision of care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent, per the American Academy of Pediatrics (AAP). The term "medical home" describes a structure and concept of coordinated medical care and is designed to provide high-quality, cost-effective health care services. The medical home is distinguished from other models of

care by the provider's level of expertise in serving children with complex needs and the fundamental commitment to address not only medical, but also psychosocial and community issues affecting the physical and emotional health of the child and family. The goal of a medical home is to link children to services and resources in a coordinated effort to maximize their developmental potential and provide them with optimal health care. The medical home model provides the family with central point of information, access, and service coordination from a trusted professional that is concerned for the wellbeing of the child and family. Pediatric health care professionals and parents act as partners in a medical home to identify and access all the essential medical and non-medical services needed to help children and their families achieve their maximum potential.

Medically Necessary: A medical service, device or item that meets the definition of Wis. Adm. Code §DHS 101.03(96m).

Medical Status Code: The two digit (alpha, numeric, or alphanumeric) code in the ForwardHealth interChange system that identifies the basis of eligibility, whether cash assistance is being provided funding sources, and other aspects of Medicaid eligibility. The medical status code is listed on the enrollment report.

Member: A child in out-of-home care who has been certified by the state as eligible to enroll under this Contract, and whose name appears on the Enrollment Reports that the Department transmits to the PIHP according to an established notification schedule. Children born to members of the PIHP will be enrolled in the PIHP if covered under the out-of-home care court order unless disenrolled at the request of the parent.

Member-Centric Care: Member-centric care is care that explicitly considers the member's perspective and point of view. For example, a member-centric care plan will include treatment goals and expected outcomes identified by the member, often expressed in the member's own words. A member-centric needs assessment includes the needs expressed by the member whether or not those needs fit neatly into medical or health nomenclatures. Member-centric care actively engages the patient throughout the care process.

Member Communication: Materials designed to provide the PIHP's members with clear and concise information about the program, the PIHP's network, and the Medicaid program.

Members with Special Needs: Pursuant to 42 CFR § 438.208(c)(1), the terminology used in clinical diagnostic and functional development to describe individuals who

require additional assistance for conditions that may be medical, mental, developmental, physical or psychological (this includes, but is not limited to, members who need intensive medical or behavioral case management or Birth to 3 members).

Mental Health Assessment: A diagnostic process that is conducted by a trained mental health provider/clinician using standardized clinical measure(s) that are reliable and valid. Assessment offers a structured framework for identifying and addressing the needs of children through a process designed to obtain specific information about current type and severity of symptoms, child functioning, family and caregiver environment, and strengths.

[1]National Culturally and Linguistically Appropriate Services (CLAS) Standards: The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Newborn: A member less than 100 days old.

Non-Participating Provider: Facility or provider that the PIHP does not have a contract with to provide services to a member of the FCMH.

Nonrisk Contract: The term refers to a contract in which the contractor is not at financial risk for changes in utilization or for costs incurred under the contract. The PIHP will receive monthly prepayments. The Department will reconcile to the actual cost of services provided and either recoup from or make additional reimbursements to the PIHP based on the reconciliation. Under a nonrisk contract, payments made to the contractor may not exceed what Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to members, plus the net savings of administrative costs the Medicaid agency achieves by contracting with the PIHP instead of purchasing the services on a fee-for-service basis.

Nonrisk Prepayment: A payment the State agency makes monthly to the PIHP on behalf of each member enrolled under a contract and based on the actuarially sound nonrisk prepayment rate for the provision of medical services under the State Plan. The monthly payment is made regardless of whether the particular member receives services during the period covered by the payment. Final reimbursement to the PIHP will be based on actual services provided.

[1] https://www.thinkculturalhealth.hhs.gov/clas

Outcomes: Per 42 CFR §438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

Out-of-Home Care Health Screen: The screening is completed no later than 2 business days after the child enters out-of-home care. The purpose of the screen is to identify any immediate medical, urgent mental health, or dental needs the child may have and any additional health conditions of which the out-of-home providers and child welfare caseworker should be aware of. This screen may also be referred to as the "Foster Care Health Screen".

Out-of-Home Caregiver: The individual(s) responsible for the temporary care of the child/youth while they are placed in out-of-home care. These individuals include the child's relative or like-kin, foster parents, or agency managing the group home, shelter care, or assessment center the youth is placed at.

Outpatient Drug: Outpatient Drug: any drug the meets that definition of covered outpatient drug as defined is Social Security Act s. 1927(k).

Outreach Materials: Materials used by the PIHP to help bring awareness of services to members.

Participating Provider: Facility or provider the PIHP has a contract with to provide covered services to a member of the plan.

Parent/Legal Guardian: Biological parent, parent by adoption, or a person named by the court having the duty and authority of guardianship.

Pay-for-Performance (P4P): DHS initiative to measurably improve quality of care provided to Medicaid members in focused areas. Includes PIHP payment withhold that can be earned back by PIHPs based on their performance relative to quality targets for measures applicable to them

Performance Improvement Projects (PIPs): Annual projects that PIHPs are required to undertake as part of Quality Assessment Performance Improvement (QAPI).

Personally Identifiable Information: An individual's last name and the individual's first name or first initial, in combination with and linked to any of the following elements, if the element is not publicly available information and is not encrypted, redacted, or altered in any manner that renders the element unreadable:

- The individual's Social Security number;
- The individual's driver's license number or state identification number;

- The individual's date of birth;
- The number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account;
- The individual's DNA profile; or
- The individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.

Pharmacy Services Lock-in Program: A program implemented by the Department to coordinate the provision of health care services for PIHP members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications. Members enrolled in the program will have one pharmacy provider and one primary prescriber for restricted medications.

Physician Services: Any medically necessary diagnostic, preventive, therapeutic, rehabilitative or palliative services provided in a physician's office, in a hospital, in a nursing home, in a recipient's residence or elsewhere, and performed by or under the direct, on-premises supervision of a physician within the scope of the practice of medicine and surgery as defined in Wis. Stats. 448.01 (9).

PIHP Administrative Services: The health plan's performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including: network adequacy, service utilization, clinical or quality management, service authorization, claims processing, management information systems operation, and reporting. This term also includes the infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract, outside of the Covered Services.

PIHP Technical Workgroup: A workgroup composed of PIHP technical staff, contract administrators, claims processing, eligibility, and/or other PIHP staff, who meet as necessary; with Department staff from the Division of Medicaid Services (DMS), and staff from the Department's Fiscal Agent.

Plan: A plan is an individual or group plan that provides, or pays the cost of, medical care.

Post Stabilization Services: Medically necessary non-emergency services furnished to a member after he or she is stabilized following an emergency medical condition.

Potential Member: A Medicaid member who has been determined by the state to be eligible to enroll in the PIHP, but who is not yet a member.

Prepaid Inpatient Health Plan (PIHP): An entity that provides medical services to members under contract with the State agency, on the basis of monthly prepayments that have been developed based on historical spending for the out-of-home care population with adjustments based on the FCMH service delivery requirements. The PIHP provides, arranges for, or otherwise has responsibility for the provision of all health care services, including inpatient hospital or institutional services for its members; and it does not have a comprehensive risk contract.

Premium: The amount a member may pay each month for Medicaid coverage. FCMH does not charge members premiums.

Prescription Drug Coverage: Drugs and drug products covered by Medicaid include legend and non-legend drugs and supplies listed in the Wisconsin Medicaid drug index which are prescribed by a physician, by a dentist, by a podiatrist, by an optometrist, by an advanced practice nurse prescriber, or when a physician delegates the prescribing of drugs to a nurse practitioner or to a physician's assistant.

Pricing Percentage: Refers to percent priced for a defined time period such as a calendar or fiscal year. This measure is calculated by the PIHP and is reported to the Department as a component of the Estimated Data Completeness measure.

Primary Care Physician: licensed physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions with specialties in general practice, family practice, internal medicine, obstetrics, gynecology, and pediatrics. A Primary Care Physician may be a Primary Care Provider.

Primary Care Provider (PCP): Primary Care Physician or other licensed provider who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions. Including, but not limited to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), tribal health centers, and physicians, nurse practitioners, nurse midwives, physician assistants and physician clinics with specialties in general practice, family practice, internal medicine, obstetrics, gynecology, and pediatrics. Pursuant to 42 CFR §438.208(b)(1), the primary care provider is a person formally designated as primarily responsible for coordinating the services accessed by the member.

Program Integrity: As defined by CMS, it is the commitment to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid members. This includes, but is not limited to, the responsibility to review Medicaid provider activities, audit claims, identify and recover overpayments, and provider and public education.

Prospective Risk Adjustment: Per 42 CFR §438.5(a), a methodology to account for anticipated variation in risk levels with the contracted PIHP that is derived from historical experience of the contracted PIHP and applied to rates for the rating period for which the certification is submitted.

Protected Health Information (PHI): Health information, including demographic, that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual, that identifies the individual or provides a reasonable basis to believe that it can be used to identify an individual. PHI is a subset of IIHI.

Provider: A person who has been enrolled by the Department to provide health care services to members and to be reimbursed by Medicaid for those services.

Provider Network: A list of physicians, hospitals, urgent care centers, and other health care providers that a PIHP has contracted with to provide medical care to its members. These providers are "network providers," "in-network providers" or "participating providers." A provider that has not contracted with the plan is called an "out-of-network provider" or "non-participating provider."

Public Institution: An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined by federal regulations, including but not limited to prisons and jails.

Quality: Per 42 CFR §438.320, as it pertains to external quality review, the degree to which a PIHP increases the likelihood of desired outcomes of its members through:

- Its structural and operational characteristics.
- The provision of services that are consistent with current professional, evidenced-based-knowledge.
- Interventions for performance improvement.

Rate Cell: A set of mutually exclusive categories of members that is defined by one or more characteristics for the purpose of determining the nonrisk prepayment rate and making a nonrisk prepayment; such characteristics may include age, gender, eligibility

category, and region or geographic area. Each member should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

Rating Period: A period of 12 months selected by the Department for which the actuarially sound nonrisk prepayment rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR §438.7(a).

Readily Accessible: Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

Reconsideration of a Claim: A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

Recovery: Refers to an approach to care which has its goals as a decrease in dysfunctional symptoms and an increase in maintaining the person's highest level of wealth, wellness stability, self-determination and self-sufficiency. Care that is consistent with recovery emphasizes the member's strengths, recognizes their ability to cope under difficult circumstances, and actively engages as partners in the provision of health care.

Rehabilitation Services and Devices: Services and devices designed for recovery or improvement of function and to restore to previous level of function if possible.

Resubmission of a Claim: A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information.

Risk Adjustment (Previously known as Chronic Illness & Disability Payment System (CDPS)): Per 42 CFR §438.5(a), a methodology to account for the health status of members via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of the PIHP contracted with the State.

Screening: The use of data-gathering techniques, tests, or tools to identify or quantify the health and/or cultural needs of a member. Screening methods may include telephonic contact, mailing, interactive web tools, or encounters in person with screeners or health care providers.

Secretary: The Secretary of HHS and any other officer or employee of the Department of HHS to whom the authority involved has been delegated.

Service Area: An area of the state where the PIHP has agreed to provide medical home services to children in out-of-home placement. The Department monitors enrollment levels of PIHP to assure an adequate provider network exists to serve the population.

Service Authorization: A member's request for the provision of a service

Significant Change: Any change within a PIHP's ability to fulfill the major components of the contract requirements, including but not limited to a change in provider network, service area, organizational structure or staff, or benefit package.

Skilled Nursing Care: Medically necessary skilled nursing services ordered by and to be administered under the direction of a physician that may only be provided by an advanced practice nurse, a registered nurse (RN), or a licensed practical nurse (LPN) working under the supervision of an RN.

Social Determinants of Health: Social, economic, environmental, and material factors surrounding people's lives, traumatic life events, access to stable housing, education, health care, nutritional food, employment and workforce development.

Specialist: A physician whose practice is limited to a particular branch of medicine or surgery, especially one who is professionally certified by a board of physicians.

State: The State of Wisconsin.

State Fair Hearing: The process used by the Wisconsin Division of Hearing and Appeals to adjudicate member appeals of PIHP adverse benefit determinations.

Subcontract: Any written agreement between the PIHP and another party to fulfill the requirements of this Contract.

Substantial Failure to Perform: Includes any violation of any requirement of this Contract that is repeated or ongoing, that goes to the essentials or purpose of the Contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of members.

Third Party Liability (TPL): The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims.

Trade Secret: Per Wis. Stat. 134.90(1), trade secrets are information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

- 134.90(1)(c)1.1. The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.
- 134.90(1)(c)2.2. The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

Trading Partner: Refers to a provider or PIHP that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162, or a business associate authorized to submit health information on the Trading Partner's behalf.

Transaction: The exchange of information between two parties to carry out financial or administrative activities related to health care as defined by 45 CFR Part 160.103.

Transitional Care: Processes to ensure continuity of care that include, but are not limited to, medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility or when a member is leaving out of home care or leaving the Foster Care Medical Home. Per 42 CFR § 438.208(b)(2), processes to coordinate services the PIHP furnishes to the member between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

Trauma-informed Care: An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

Urgent care/service needs: Services provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services are often but not always those that if not fulfilled could result in an emergency room visit or inpatient admission.

Validation: Per 42 CFR §438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

Voluntary: Refers to situations where the Department cannot or does not require Medicaid members to enroll in a PIHP.

Waste: The unnecessary incurrence of costs as a result of inefficient or inaccurate practices, systems or controls.

Wisconsin Statewide Health Information Network (WISHIN): Wisconsin's health information network that shares electronic health information securely between participating physicians, clinics, hospitals, pharmacies, clinical laboratories, Health Maintenance Organizations (HMOs), and Prepaid Inpatient Health Plans (PIHPs) across the state.

Wisconsin Tribal Health Directors Association (WTHDA): The coalition of all Wisconsin American Indian Tribal Health Departments.

Per 42 CFR 438.10, the PIHP must use the definitions for managed care terminology found above when communicating with members to ensure consistency in the information provided to members. Terms that are not defined above shall have their primary meaning identified in Wis. Adm. Code DHS 101-108.

B. Acronyms

Acronym	Meaning
AA	Affirmative Action
AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
ACOG	American Congress of Obstetricians and Gynecologists
ADRC	Aging and Disability Resource Center
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Organization
BC or BC+	BadgerCare or BadgerCare Plus
BCS	Bureau of Children's Services
BQO	Bureau of Quality and Oversight
BRS	Bureau of Rate Settings
CAH	Critical Access Hospital
CAP	Corrective Action Plan
CBRF	Community Based Residential Facility
CCS	Comprehensive Community Services
CDPS	Chronic Illness & Disability Payment System
CEHRT	Certified Electronic Health Record Technology

CEO	Chief Executive Officer
CESA	Cooperative Educational Service Agencies
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIP	Community Integration Program
CLA	Childless Adult
CLAS	Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COP	Community Options Program
CPT	Current Procedural Terminology
CRC	Civil Rights Compliance
CRS	Community Recovery Services
CSA	Child Support Agency
CSP	Community Support Program
CY	Calendar Year
DATA	Drug Addiction Treatment Act
DHCAA	Division of Health Care Access & Accountability
DMCPS	Division of Milwaukee Child Protective Services
DMHSAS	Division of Mental Health & Substance Abuse
DMS	Division of Medicaid Services
DOT	Directly Observed Therapy
DQA	Division of Quality Assurance
DRG	Diagnosis Related Groupings
DSPS	Department of Safety and Professional Services
DSS	Department of Social Services
DVT	Deep Vein Thrombosis
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERISA	Employee Retirement Income Security Act
EVV	Electronic Visit Verification
FCMH	Foster Care Medical Home
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol

FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Federal Department of Health and Human Services
HIF	Health Insurance Fee
HIPAA	The Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
ICD	International Classification of Diseases
IDSS	Institute for Data, Systems, and Society
IFSP	Individualized Family Service Plan
IHCP	Indian Health Care Provider
IIHI	Individually Identifiable Health Information
IMD	Institutes for Mental Disease
IRS	Internal Revenue Service
LAN	Learning Action Network
LEP	Limited English Proficiency
LTC	Long Term Care
MA	Medical Assistance/Medicaid
MAPP	Medicaid Purchase Plan
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MY	Measurement Year
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limits
NTS	Narcotic Treatment Services
OBMH	Obstetric Medical Home
OCI	Office of the Commissioner of Insurance
OIG	Office of the Inspector General
ONC	Office of National Coordinator
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PE	Pulmonary Embolism
PHI	Protected Health Information
PIHP	PrePaid Inpatient Health Plan

PIP	Performance Improvement Project
PNCC	Prenatal Care Coordination
PPACA	Patient Protection Affordable Care Act
PPR	Potentially Preventable Readmissions
P4P	Pay for Performance
QAPI	Quality Assessment Performance Improvement
RHC	Rural Health Center
SBS	School Based Services
SCHIP	State Children's Health Insurance Program
SFTP	Secure File Transfer Protocol
SIU	Special Investigations Unit
SMV	Specialized Medical Vehicles
SSA	Social Security Administration
SSI	Supplemental Security Income
TCM	Targeted Case Management
TCOC	Total Cost of Care
TMSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
UM	Utilization Management
URAC	Utilization Review Accreditation Commission
VFC	Vaccines for Children
WCAG	Web Content Accessibility Guidelines
WIC	Women, Infant, and Children
WICT	Wisconsin Interdisciplinary Care Team
WIR	Wisconsin Immunization Registry
WISHIN	Wisconsin Statewide Health Information Network

ARTICLE II: Enrollment and Disenrollment

II. ENROLLMENT AND DISENROLLMENT

A. Enrollment

1. Enrollment Authority

Enrollment in the PIHP is voluntary by the member as authorized in 2014 under an Alternative Benefit Plan (ABP) State Plan Amendment (TN#13-034) and as allowed in federal law under §1937 of the Social Security Act (2010).

Children placed in eligible out-of-home care settings, in Milwaukee, Racine, Kenosha, Waukesha, Washington and Ozaukee Counties, who are under the jurisdiction of the child welfare system in one of these counties are eligible for PIHP enrollment. Enrollment will be allowed to continue for up to 12 months after the child is discharged from out-of-home care, as long as the child remains eligible for full benefit Medicaid and continues to reside in one of the six identified counties. Children residing in secure facilities or Residential Care Centers (RCC) are not eligible for enrollment.

If there are two or more participating PIHPs in the child's service area, the child's parent/legal guardian will be given the option of choosing to enroll in one of the PIHPs or they may choose to receive services through Medicaid FFS.

If at any time during the Contract period the Department obtains a State Plan Amendment, a waiver or revised authority under the Social Security Act (as amended), the conditions of enrollment described, including but not limited to voluntary enrollment and the right to voluntary disenrollment will be amended by the terms of said waiver and a State Plan Amendment.

2. Enrollment Determination

The Department will identify and provide informing materials to the PIHP for members who meet the initial FCMH enrollment criteria with one of the following medical status codes:

Medical Status Code	Description
33	Foster Care, IV-E eligible

34	Foster Care, non IV-E
37	Foster Care, special needs, IV-E eligible
3P	Pre-adoption foster care, special needs, non IV-E

3. Member Information

   The Department will work closely with the PIHP to establish an informing plan with the Department's contracted enrollment specialist.

   The enrollment specialist will respond on the same or following working day to telephone calls or requests for information about the program. The PIHP shall refer parent/legal guardian to the enrollment specialist for assistance with the enrollment process.

   A PIHP representative will provide information on services consistent with the current Medicaid program. Information will be available in English, Spanish, Lao, Russian and Hmong if the members, or their authorized representatives are conversant only in those languages. Information will be available in other media as required for persons with visual impairments, without reading skills, and with other communication limitations.

   PIHP member informing materials and procedures must receive approval by the Department during the readiness review prior to implementation.

   a. Inform the member, parent/legal guardian of provisions for voluntary disenrollment required by 42 CFR 434 Subpart C. Relevant provisions include lack of access to quality care and to necessary specialty services covered under the State Plan (42 CFR 434.27(3).

   b. Inform the member, parent/legal guardian of the provisions for involuntary disenrollment, including just cause.

4. PIHP Enrollment Rosters

   The Department will promptly notify the PIHP of all members enrolled in the PIHP under this Contract. Notification will be effected through the PIHP Enrollment Rosters. These rosters shall be available through electronic file transfer capability and will include medical status codes.
   For each month of coverage throughout the term of the contract, the Department will provide "PIHP Enrollment Rosters" to the PIHP. These

rosters will provide the PIHP with ongoing information about its memberss and disenrollees and will be used as the basis for the monthly nonrisk payments to the PIHP. The PIHP Enrollment Rosters will be generated in the following sequence:

a. The Initial and Final Enrollment Rosters in the X12 834 format that will be available via the ForwardHealth Trading Partner Portal. These rosters will provide the PIHP with ongoing information about its FCMH members and will be used as the basis for the monthly PIHP nonrisk payments as described in this contract.

    1) The X12 834 Initial Enrollment Report will list all of the PIHP's members and those disenrolled for the enrollment month that are known on the date of report generation. The Initial Enrollment Report will be available to the PIHP on or about the twenty-first of each month. A monthly nonrisk prepayment shall be generated for each member listed as an ADD or CONTINUE on this report. Members who appear as PENDING on the Initial Report and are reinstated into the PIHP prior to the end of the month will appear as a CONTINUE on the Final Report and a payment will be generated for those members.

    2) The X12 834 Final Enrollment Report will list all of the PIHP's members for the enrollment month, which were not included in the Initial or who have had a status change since the Initial Enrollment Report. The Final PIHP Enrollment Report will be available to the PIHP on or around the first business day of the enrollment month. A monthly nonrisk prepayment will be generated for every member listed as an ADD or CONTINUE on this report.

    3) The Initial and Final Rosters will identify changes in member demographics and medical status codes, since the last enrollment roster.

b. The X12 820 Payment Listing Report will identify all members for which a non-risk prepayment was made or recouped for the specified enrollment dates. The report will be available via the ForwardHealth Trading Partner Portal on the Tuesday after the first Friday of every month.

5. Other Reports

a. The Monthly Member COB File is a report of members enrolled with the PIHP who had third-party coverage last month. The report will be available on the ForwardHealth MCO Portal on or around the first of each month.

b. Member Health History Report

c. The monthly initial and final reports (MGD-135-M and MGD-137-M, respectively) that are currently pushed out on the MCO portal, sorted by MCO assigned ID.

6. Enrollment Policy

The PIHP must not obtain enrollment through the offer of any compensation, reward, or benefit to the member except for additional health-related services that have been approved by the Department.

7. Enrollment Errors

The Department must investigate enrollment errors brought to its attention by the PIHP. The Department must correct systems errors and human errors and ensure that the PIHP is not financially responsible for members that the Department determines have been enrolled in error. Monthly payments made in error will be recouped.

8. Open Enrollment

The PIHP shall accept members eligible for coverage under this Contract, in the order in which they are enrolled. The PIHP will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin or health status, sex, sexual orientation, gender identity or disability.

9. Re-Enrollment

A FCMH member who voluntarily disenrolled from the PIHP can re-enroll if s/he meets the covered population eligibility criteria as specified in the

contract and remains in an eligible out-of-home care setting. A FCMH member who disenrolled from the PIHP after discharge from an out-of-home care setting is not eligible to re-enroll. The need for the PIHP to perform a comprehensive assessment on the re-enrolling member depends on how long s/he was disenrolled from the PIHP.

a. If the member is re-enrolled less than six months after the member's last disenrollment from the PIHP, the PIHP does not have to perform a comprehensive initial health assessment. The PIHP may use the previously developed comprehensive health care plan for that member. The comprehensive health care plan must be reviewed and updated if indicated.

b. If the member is re-enrolled at least six months after the member's last disenrollment from the PIHP, then the PIHP must perform a comprehensive initial health assessment of the member. The PIHP must develop a new comprehensive health care plan for that member.

B. Disenrollment

Disenrollment requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. If the Department fails to make a disenrollment determination within 30 days of receipt of all necessary information, the disenrollment is considered approved. The PIHP must direct all members with disenrollment requests to the Department's Enrollment Specialist for assistance and/or for choice counseling.

1. Voluntary Disenrollment

All legal guardians for members enrolled in FCMH shall have the right to disenroll their child from the PIHP at any time for any reason. The PIHP will promptly forward to the enrollment specialist all requests from the member's parent/legal guardian for disenrollment. Disenrollment requests will be processed as soon as possible and will be effective the last day of the month. Payment(s) made for the member disenrolled the last day of the month will be recouped based on a daily rate. The PIHP must direct all members with disenrollment requests to the Department's Enrollment Specialist for assistance and/or for choice counseling.

2. System Based Disenrollments

System disenrollments happen automatically in the system based on changes to the member's eligibility. If these eligibility changes are not updated timely, disenrollment requests may be requested through the Department's PIHP Enrollment Specialists by the PIHP.

a. Loss of Program Eligibility Disenrollment

If a member is no longer eligible for enrollment due to death or loss of full benefit Medicaid eligibility during their 12 month extension for more than one month, s/he shall be disenrolled. The date of disenrollment shall be effective on the first date of Medicaid ineligibility.

b. Out-of-Service Area Disenrollment

The member was placed in, or moves to a location outside of the PIHP's certified service area. The date of disenrollment shall be the date the placement/move occurred, even if this requires retroactive disenrollment to reflect the date of the out-of-county placement/move.

c. Ineligible Placement Setting Disenrollment

The member is placed in a Residential Care Center. The date of disenrollment shall be the date the placement/move occurred, even if this requires retroactive disenrollment. Recoupments will be made to the monthly payment to reflect the date of the ineligible placement/move.

d. Inmates of a Public Institution Disenrollment
The PIHP is not liable for providing care to members who are inmates in a public institution as defined in DHS 101.03(85) for more than a full calendar month. The PIHP must provide documentation that shows the member's placement. The disenrollment will be effective the first of the month following the first full month of placement or the date of Medicaid ineligibility, whichever comes first.

3. Involuntary Disenrollment Requests

The Department may approve an involuntary disenrollment with an effective date that will be the next available benefit month based on enrollment system logic, except for specific cases or persons where there is a situation where enrollment would be harmful to the interests of the member or in which the

PIHP cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. The PIHP must direct all members with involuntary disenrollment requests to the Department's Enrollment Specialist for assistance and/or for choice counseling. For any request for involuntary disenrollment, the PIHP must submit a disenrollment request to the Department and include evidence attesting to cause.

4. Indian Disenrollment

   Members who are Indian and members of a federally recognized tribe are eligible for disenrollment. Only the parent/legal guardian can make disenrollment requests.

5. Change in Member Circumstance
   When a member's change is circumstance has been identified and verified by the PIHP, the PIHP must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. Changes in circumstance include:

   a. Change in the member's residence when the member is no longer in the PIHP's service area.
   b. The death of a member.

C. Continuity of Care Requirement

   The PIHP shall assist members who wish to return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers, if necessary.

D. Re-Enrollment

   A FCMH member who voluntarily disenrolled from the PIHP can re-enroll if s/he meets the covered population eligibility criteria as specified in the contract and remains in an eligible out-of-home care setting. A FCMH member who disenrolled from the PIHP after discharge from an out-of-home care setting is not eligible to re-enroll. The need for the PIHP to perform a comprehensive assessment on the re-enrolling member depends on how long s/he was disenrolled from the PIHP.

1. If the member is re-enrolled less than six months after the member's last disenrollment from the PIHP, the PIHP does not have to perform a comprehensive initial health assessment. The PIHP may use the previously

developed comprehensive health care plan for that member. The comprehensive health care plan must be reviewed and updated if indicated.

2. If the member is re-enrolled at least six months after the member's last disenrollment from the PIHP, then the PIHP must perform a comprehensive initial health assessment of the member. The PIHP must develop a new comprehensive health care plan for that member.

ARTICLE III: FCMH Health Care Management

III. FCMH HEALTH CARE MANAGEMENT

A. General Requirements

The PIHP must establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care.

1. The PIHP must assign a lead care coordinator to:

    a. Serve as the primary contact for the Department on care coordination issues on behalf of individual members.

    b. Collaborate with the Division of Milwaukee Child Protective Services (DMCPS) and child welfare agencies to ensure that children suspected to be victims of physical or sexual abuse, or neglect receive any necessary evaluations (e.g. physical abuse/sexual abuse exams, comprehensive neglect evaluations, forensic interviews, mental health crisis services, etc).

    c. Establish effective lines of communication between the PIHP, health care providers (including behavioral/mental health providers) and child welfare staff.

        1) Effective communication includes developing procedures to ensure that information pertinent to the care and treatment of children are shared in a timely and comprehensible manner.

        2) All communication strategies must recognize the child welfare caseworker as the individual with ultimate responsibility for the child's overall health and wellbeing. This means that the child welfare caseworker must be a central participant in the communication plan. The child welfare caseworker can provide critical guidance pertaining to family dynamics as it relates to communicating with the child's parents/legal guardians.

        3) Communication plans must be shared with health care coordinators and providers as indicated.

d. Establish a process that streamlines responses to request for medical information, especially as these requests pertain to court proceedings.

e. Educate DMCPS and child welfare agency staff, legal staff, out-of-home care providers, and parents/legal guardians about health care issues pertinent to children in out-of-home care.

f. Assist DMCPS and child welfare agencies in providing ongoing training for out-of-home care providers who provide care for medically complex or fragile children.

g. Educate medical personnel about issues that are known to impact the health and medical care of children in out-of-home care. This education should include key information related to understanding the impact of adverse childhood experiences as it relates to interacting with the child in the health care setting.

h. Address access issues and concerns related to the PIHP.

2. The PIHP must assign a health care coordinator (HCC) to each child at the time of his or her enrollment in the medical home. The HCC oversees all aspects of the child's health care within the context of a larger health care coordination team. The PIHP must ensure that:

   a. The HCC has trauma-informed care training and experience working with children with special health care needs or children in out-of-home care. The HCC does not need to be separately enrolled as a Medicaid provider. See below for specific requirements related to the duties of the HCC.

   b. Other staff, in collaboration with the HCC and under the supervision of the Program Supervisor, will comprise the health care coordination team and may assist with duties related to service coordination. Delegated duties may include the scheduling of appointments, gathering medical history information, and obtaining current developmental and behavioral health screening information to be passed on to the clinical staff for scoring and review. There are no specific experience requirements for these individuals, but they must be provided with trauma-informed care training and training specific to children in out-of-home care.

c. HCCs are allowed adequate time to effectively coordinate the delivery of integrated care.

   The PIHP must have strategies in place to monitor workload and to assure that each HCC's assigned caseload does not regularly exceed 100:1. The HCC and other staff collaborating with the HCC must be allowed adequate time to effectively coordinate the care of each child on his or her caseload. In developing case load standards, the PIHP should consider the following:

   1) Workload – the complexity of the cases (refer below to, Guidelines for Determining Levels of Care Management Needs)

   2) The need for HCCs and other staff to coordinate and collaborate with child welfare staff

   3) The need for face-to-face contacts with the child, the OHC providers, and others instrumental to meeting needs of the child.

   4) Management duties which include,
      i. Time to gather and ensure all available medical, developmental and, behavioral health history is provided to the primary care provider prior to the 30-day comprehensive health assessment.
      ii. The need to provide necessary documentation timely to DMCPS and child welfare agencies for court proceedings (which are sometimes scheduled with little lead time) or other case-related meetings.
      iii. Time to adequately document case management activities.

3. The PIHP must ensure that the results of the comprehensive initial health assessment (defined in Article I and described in Addendum II) form the basis for the comprehensive health care plan. This includes ensuring that all recommended diagnostic assessments and treatment services are scheduled as indicated, including physical health, dental, mental health, and developmental assessments and/or treatment.

4. The PIHP must establish a process that maximizes the ability for the HCC to be informed of the results of assessments, evaluations and screenings that would necessitate an update or review of the child's care plan.

5. The PIHP must have procedures to ensure that each child has an individualized, health care plan in place within 60 days of enrollment in the medical home. See below for specific requirements related to the comprehensive health care plan.

6. The PIHP must ensure that children with emotional, behavioral, mental, or substance abuse problems have an individualized crisis plan which includes a list of progressive interventions to resolve/de-escalate an emotional crisis/safety situation.

   The crisis plan must be developed with input from the member and those who know the member best and must be distributed to all critical service/support providers in the member's life, including the out-of-home care provider. The crisis response plan could be included as part of the overall comprehensive coordinated services plan or be a separate document.

7. The PIHP must have a process for prioritizing the care management needs of each child. This includes adequate care for members with higher needs (e.g., children identified as medically complex or Level I) who require Health Care Coordinators with more specialized education and training (e.g., Advanced practice Social Workers, Licensed Professional Counselors, Registered Nurses).

8. The PIHP must establish protocols to assess each child's level of care management need. This assessment must occur at initial enrollment and as the child's needs change over time. Though not required, the PIHP may use the guidelines below to determine levels of care management needs.

9. The PIHP must have policies and procedures in place to ensure that, to the extent feasible, transitional care planning is included in the care planning for children exiting the medical home.

10. The PIHP must use information technology to improve communication within and across health care settings and to reduce fragmentation in the delivery of services to the member.

    The PIHP must encourage use of the Office of the National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care.

B. Guidelines for Determining Levels of Care Management

Care management is a process that links children to services and resources in a coordinated effort to maximize healthy development of children in out-of-home care and provide them with optimal health care. The focus of care coordination in this context is on the physical, dental, and behavioral/mental health care needs of the child. The HCC, who oversees all aspects of a foster child's health care, is responsible for ensuring that this important information is communicated and followed up on.

1. Children in out-of-home care have differing levels of service needs that often change over time. Levels of care may include:

    a. Level III – Information sharing (short-term technical assistance, information, and/or referral);
    b. Level II – Significant but not necessarily long-term assistance in planning and coordinating multiple services;
    c. Level I – Intensive case management (children at risk of institutionalization, family experiencing severe social and environmental risk factors and is at risk for disintegration).

The HCC must periodically reassess the child's level of service needs and, in collaboration with DMCPS or the child welfare agency, must recognize when more intensive care coordination may be needed. For example, needs may be greater during key periods in a child's life, such as entry into out-of-home care, change in health care status, discharge from inpatient hospitalization, after a change in placement, at reunification, at time of discharge from out-of-home care, or during transition to adolescence or adulthood.

C. Duties of Health Care Coordinators

1. The primary goal of the HCC is to collaborate with the child welfare caseworker and the child's team of health care providers to develop and implement a comprehensive health services plan of care that ensures integration of both health and social service needs. Other staff, in consultation with the HCC and under the supervision of the Program Supervisor, may assist with and/or conduct any of the duties below as appropriate.

    The role of the HCC can be characterized as a problem-solving process that involves four essential steps:

a. Case identification
b. Comprehensive assessment and planning
c. Referral and intervention
d. Monitoring outcomes

2. The duties of the health care coordinator include the following:

    a. Assessing the child and family's strengths and needs for the purpose of informing the development of the comprehensive care plan. The child welfare caseworker will be an essential partner in this activity, especially as it relates to reviewing the recommendations from the Child and Adolescent Needs and Strengths (CANS) assessment.

    b. Establishing a plan for ongoing and timely communication with the child's primary care provider.

    c. Collaborating and coordinating with the child welfare caseworker, OHC provider and parent/legal guardian to schedule, as necessary and appropriate, face-to-face visits to introduce care team members, review program benefits, and obtain current developmental and behavioral health screening information using a validated screening tool.

    d. Collaborating with an interdisciplinary team of providers and relevant stakeholders to develop, implement, and maintain a single coordinated care plan for each child.

    e. Ensuring that health information is transferred to a new primary care provider when a child is transferred between agencies or foster homes, or discharged from foster care.

    f. Arranging and facilitating the provision of all PIHP services and coordination with services provided through other systems and programs.

    g. Establishing measurable health care management goals and frequently re-evaluating progress towards the established goals and desired outcomes.

    h. Holding meetings as needed with the child, parent/legal guardian, out-of-home care provider, child welfare caseworker, health care provider staff, and others involved in the delivery of services to the child to monitor and evaluate progress/success.

i. Maintaining documentation of all PIHP services delivered to each child.

j. Developing a separate transitional health care plan with the child prior to their disenrollment from the PIHP.

D. Information Gathering (Assessment)

1. In the context of care management, an assessment (and regular re-assessment) of need is the information gathering phase. This information gathering must take place prior to the development of the comprehensive health care plan. The outcome of information gathering activities informs the course of action and the prioritization of services in the child's comprehensive health care plan. This could include, but is not limited to, identifying,

   a. The need for immediate appointment scheduling and referrals

   b. The need for immediate medication management

   c. The need for open and flexible scheduling, including the need to go beyond the PIHP's provider network

   d. The need for stabilization services for mental/behavioral health concerns

2. To ensure that the care plan is a comprehensive reflection of the child's needs, the HCC must make exhaustive efforts to complete the following tasks prior to completing the care plan:

   a. Obtain information related to the child's medical history and current medications

   b. To ensure continuity of care, where possible, obtain information regarding current providers

   c. Review the recommendations from the CANS assessment and any other behavioral/mental health screen for mental health and other behavioral health concerns

   d. Obtain input from the child welfare caseworker to determine if there are specific, court-ordered services that need to be identified in the child's comprehensive health care plan

e. Obtain input from the child's primary care provider to determine the need for additional referrals, diagnostic or treatment services

f. Review the results of other health assessments and screens, including the results of the comprehensive initial health assessment (defined in Article I and described in Addendum II) to ensure that the care plan addresses all identified health care needs.

E. Comprehensive Care Plan - Requirements

The HCC must ensure that each child has a comprehensive health care plan that is based on information collected during the information gathering (assessment) process. The initial care plan must be developed within the first 60 days of the child's enrollment in the PIHP.

In developing the comprehensive health care plan, the child's HCC will do the following:

1. Ensure that the care plan is child-centric and comprehensive.

   A child-centric plan addresses the unique needs of the child - recognizing the need for an enhanced schedule for physical, behavioral and dental care, as necessary; assuring continuity of care; and flexibility on location of services consistent with evidence-informed practices. For example, mental health services could be delivered in the home or another community-based setting, rather than in a clinic or hospital setting.

   A comprehensive care plan includes the following, at a minimum,

   a. Relevant prior and current diagnoses

   b. Current medications

   c. The names of all individuals who are instrumental to the child's care and treatment, including the name and contact information for the child's legal guardian

   d. The names of external supports (e.g., school nurse, public health nurse, community-based case managers, Birth-3 lead care coordinator)

e. The name of the lead prescriber for all children with 2 or more psychotropic medication prescriptions

f. The name of the provider responsible for metabolic monitoring of every child who is prescribed an antipsychotic medication

g. The enhanced periodicity schedule for comprehensive HealthCheck exams

h. The tracking and timely follow up on referrals

i. Short and long-term treatment goals

j. Barriers to care

k. An individualized crisis/action plan for behavior management (if appropriate)

l. An action plan for exacerbation of a chronic condition

m. Transitions between inpatient and outpatient settings, including home care. The transition plan must address the need for prompt follow up with the child's PCP after an inpatient stay or emergency room visit

n. Patient self-management, anticipatory guidance for caregivers, and home care (if appropriate)

o. Method and frequency of communication among treatment team. To the extent possible, the communication plan should include those members of the child's treatment team who may be outside the PIHP's network

p. Last date of contact with different team members (child/youth, parents, out-of-home caregivers, child welfare professionals, and key treatment providers).

q. Transition plan should be created at the same time as the initial comprehensive plan and then updated on the same schedule. See Article III, section G for more details on the transition planning.

2. Ensure that the child's PCP and child welfare caseworker are primary participants in the development and periodic reviews of the comprehensive care plan. The child's PCP is the lead for the child's overall health care needs. And, the child welfare caseworker has the overall responsibility for all aspects of the child's care.

   The participation of the PCP and child welfare caseworker will be key in eliminating duplication; mitigating caregiver confusion regarding the child's health care treatment plan; and will be paramount to ensuring full coordination and integration of the child's medical and non-medical needs.

3. Collaborate with the child welfare caseworker to obtain and incorporate input from the following,

   a. The child, as appropriate

   b. The child's out-of-home care provider

   c. The child's parent/legal guardian

   d. Other individuals who are instrumental to the care and treatment of the child

   The care plan will be communicated to the parent/legal guardian for input and feedback. Evidence of this action must be reflected in the care plan.

4. Collaborate with the broader health care team to prioritize the services necessary to address or further assess the child's health care needs across the health care system, including primary care, specialty care, inpatient care and care that will be obtained outside of the PIHP provider network.

5. Collaborate with the child welfare caseworker to establish specific communication plans for each child.

6. Document the Comprehensive Care Plan, preferably according to the specifications for Care Plans in the ONC Interoperability Standards Advisory.

F. Ongoing Monitoring

Ongoing monitoring includes all activities related to implementing and maintaining the child's comprehensive health care plan. The child's assigned HCC is responsible for all ongoing monitoring activities.

1. Ongoing monitoring includes:

    a. Developing and maintaining a system to track and follow up on changes in the health care status of the child and on the health care system's compliance with the comprehensive health care plan.

    b. Activities related to ensuring that the child is receiving the services identified in the care plan. The health care plan must be reviewed on a regular basis and updated as necessary following each health care encounter.

        The health care plan must be reviewed and updated after the child is discharged from an inpatient mental health hospitalization, within 30 days of such discharge.

    c. Following up with appropriate individuals to determine if the services in the care plan are adequately meeting the child's needs and making adjustments to the care plan if indicated.

    d. Periodically gathering information (re-assessment of need) and updating the care plan to ensure that changes in the child's health status or level of care management needs are reflected in the care plan.

    e. Communicating with individuals instrumental to the child's care and support, especially the child's primary care provider and the child welfare caseworker.

    f. The HCC must periodically review the child's health care plan in collaboration with the child's primary care provider, the child welfare caseworker, the child's parent/legal guardian, and out-of-home care provider.

    g. The plan must be reviewed and updated as indicated but at least every six months.

h. Making and tracking referrals (including following up on the results of laboratory tests to determine the need for additional services).

i. The HCC must collaborate with the child welfare caseworker to determine the need for and to secure additional health care services as necessary.

G. Transitional Health Care Planning

The HCC must engage in transitional health care planning prior to the child leaving the medical home. Transitions can be both expected and unexpected and HCCs must be prepared regardless of forewarning.

1. Transitional Plan Policy

a. The transitional planning must be developed with input from the child, their parents and out-of-home caregivers (as applicable), the child's health care providers, and the child welfare professional as appropriate.

b. Transition planning begins at enrollment.

c. Identifies all individuals critical to planning and execution of all transitions, including but not limited to:

i. Providers,
ii. Caregivers,
iii. Parents, and
iv. Child welfare professionals.

2. Elements of the transitional plan include, but are not limited to:

a. Medical summary of treatment provided including:
   i. Current medications and last prescription refill date;
   ii. Treatments provided throughout enrollment in WI FCMH;
   iii. List of significant health incidents during WI FCMH enrollment;
   iv. Inventory of relevant treatment plans (e.g., crisis plan, rescue inhaler plan, etc.); and
   v. List of maintenance needs.

b. Compile a full medication from all available sources a prescription renewal, when appropriate. Include:
    i. All indicators for beginning or ending medication, changing dosage amounts, etc.,
    ii. List of prescribers for each medication, and
    iii. Refill prescriptions either provided to the member and their caregivers OR called in to a pharmacy.

c. Upcoming appointments that have been scheduled or need to be scheduled;

d. Documentation of referrals and linkages to resources and services;

e. Medical education materials for new providers, caregivers, and parents with a summary of all relevant information for their child (e.g., new medication schedule or when to use a rescue inhaler), and

f. List of specialists involved in member's care.

3. Transition Activities

a. Care Management Case Closing

A care management review is completed, when possible, and includes all members of the care team, including caregivers and legal guardians, to review treatments, services that will need to be scheduled, and any other final information that the care team needs to share among relevant individuals.

b. Transfer of Records

A case is considered officially closed when all records are transferred to the member's new providers.

ARTICLE IV: Services

IV. SERVICES

A. Provision of Contract Services

1. The PIHP must promptly provide or arrange for the provision of all services required under Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and Wis. Adm. Code DHS 107 and the Online ForwardHealth Handbook.

2. The PIHP Contract Administrator or their designee, is responsible for subscribing to ForwardHealth Updates and Alerts, and disseminating them to PIHP staff for analysis and implementation.

3. The PIHP must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid, as set forth in 42 CFR § 438.210(a)(2), 42 CFR § 440.230, and 42 CFR part 441, subpart B. Pursuant to 42 CFR §438.210(a)(3), the PIHP:

    a. Must ensure that the services furnished to the member are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

    b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member

4. Medical Necessity

    a. The actual provision of any service is subject to the professional judgment of the PIHP providers as to the medical necessity of the service, except that the PIHP must provide assessment, evaluation, and treatment services ordered by a court.
    b. Per 42 CFR §438.210(a)(4), the PIHP can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and DHS 101.03(96m) or place appropriate limits on a service for

the purpose of utilization control provided that:

i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);

ii. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports; and

iii. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

c. The PIHP must specify what constitutes "medically necessary" in a manner that is no more restrictive than that used in the Medicaid program as indicated in Wis. Admin Code §DHS 101.03(96m), the State Plan, Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and Wis. Adm. Code ch. DHS 107, Wisconsin Health Care Programs Online Handbook and PIHP Contract Interpretation Bulletins, and the ForwardHealth Provider Updates.

d. The PIHP is responsible for covering services related to:

i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that result in health impairments and/or disability.

ii. The ability for a member to achieve age-appropriate growth and development.

iii. The ability for a member to attain, maintain or regain functional capacity.

e. The PIHP must consider reimbursement for any service allowable under Section 1905(a) of the Social Security Act under EPSDT (referred to in Wisconsin as HealthCheck "Other Services" coverage criteria for all members under age 21 prior

to denying coverage to any service.

For a service to be reimbursed through HealthCheck "Other Services," the requirements outlined in the ForwardHealth Online Handbook Topics 22 and 41 must be me.

f. Disputes between the PIHP and members about medical necessity can be appealed through the process described in Article IX. The Department will consider whether the PIHP would have covered the service on a FFS basis (except for certain experimental procedures).

5. In Lieu of Services

a. A PIHP may cover services for a member that are in addition to those services covered under the state plan per 42 CFR §438.3(e). In lieu of services can be covered by HMOs on a voluntary basis as follows:

i. the Department determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan;
ii. the member is not required by the HMO to use the alternative service or setting;
iii. the approved in lieu of services are identified in the HMO contract and will be provided at the option of the HMO;
iv. and the utilization and cost of in lieu of services is taken into account in developing the component of the capitation rates that represent the covered state plan services.

b. A PIHP may cover the following services:

i. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization.

B. The FCMH is not responsible to provide the following Medicaid services to its members:

a. Chiropractic services.

b. Community Recovery Services (CRS).

c. Community Support Program (CSP) services.

d. Comprehensive Community Services (CCS).

e. Crisis Intervention Benefit.

f. Directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring for individuals with tuberculosis.

g. Lead investigations, as defined in s. 254.11(8s), of persons having lead poisoning or lead exposure, as defined in s. 254.11(9).

h. Medication therapy management.

i. Non-emergency Medical Transportation (NEMT) as listed in Article IV Section A(6).

j. Prescription and over-the-counter drugs and diabetic and other drug related supplies (as defined by the Department dispensed by a provider licensed to dispense by the Wisconsin Department of Safety and Professional Services (DSPS)).

k. Provider administered drugs, as discussed in the following handbook topics: Provider-Administered Drugs (Topic #5697), of the Covered and Non-covered Services chapter of the ForwardHealth Online Handbook.

l. School-Based Services (SBS), except the PIHP must use its best efforts to sign a Memorandum of Understanding (MOU). SBS are those services identified in a student's Individualized Education Plan (IEP) and provided by a school district or CESA.

m. Targeted Case Management (TCM), except the PIHP must work with the TCM case manager as indicated in Addendum III.

n. Behavioral Treatment Services (Autism Services) as defined by the Department in ForwardHealth Online Handbook.

o. Residential Substance Use Disorder Treatment (RSUD) as defined by the Department in ForwardHealth Online Handbook.

p. Hub and Spoke Health Home benefit.

C. Key Components of Health Care Service

In providing services to children the PIHP must consider the goals of the FCMH program. Specific goals of the FCMH program include: integrated and comprehensive health service delivery; timely access; high quality and flexibility of care; transitional planning and cross-system coordination; and well-being outcomes. The FCMH must facilitate the following health care services:

a. An Out-of-Home Care Health Screen (aka Foster Care Health Screen)

1) Purpose: The purpose of this screen is to identify any immediate medical, dental, or urgent mental health needs a child may have, including any additional health conditions which the out-of-home providers and child welfare caseworker should be aware of.

2) Timeframe: within two business days of entry into out-of-home care

3) Performed by: The screen should be performed at a Child Advocacy Center (CAC). The exam may be performed by a provider designated by the PIHP to have sufficient training/expertise to perform the out-of-home care health screen consistent with the required clinical standards and required hours of operation.

4) Required Components:

i. Identification of health conditions that require prompt medical attention such as acute illness, chronic disease(s) requiring

immediate medical management and/or treatment (e.g. asthma, diabetes, seizure disorder), signs of infection or communicable disease, nutritional problems, pregnancy, and significant developmental or mental health conditions.

ii. Unclothed, symptom-targeted physical examination, including injury surveillance.

iii. Identification of medical treatment and/or follow up that may be required prior to the comprehensive initial health assessment which is completed within 30 days of entering out-of-home care.

5) The PIHP is not required to provide an Out-of-Home Care Health Screen under the following circumstances:

i. Newborns detained directly from the hospital

ii. Children detained during an inpatient hospitalization

iii. Children who are detained at the time of a forensic exam

iv. Children who are detained subsequent to a forensic exam but meet the criteria for an exemption

    a. These cases are reviewed by a CAC provider and a determination is made by the CAC provider with consideration of the following criteria:

        1. The Out-of-Home Care will occur within 7 days of the Forensic exam
        2. The child has been in a safe environment since the Forensic Exam
        3. There are no known acute health issues per worker and review of Forensic Exam notes

v. Other unique case scenarios may be reviewed by the Care4Kids Medical Director(s) and exemptions may be granted on a case by case basis if performing the Out-of-Home Care Health Screen would be duplicative of services recently provided.

A visit to the Emergency Department does not meet criteria for an Out-of-Home Care Health Screen exemption, even if seen by a CAPS provider in the ED.

Children who are determined to be exempt from requiring an OHC Screen are to be characterized as a Level 1 Triage patient upon entering Care4Kids. Follow appropriate policy/procedure found in: “Workflow for Initial 30 Days from Removal”.

b. The assignment of a Health Care Coordinator (HCC) to each child enrolled in the PIHP; member to HCC ratio may not regularly exceed 100:1. Please refer to Article III, D-G for the services provided by an HCC.

c. Comprehensive Initial Health Assessment

1) Purpose: the Comprehensive Initial Health Assessment should be performed by a clinician who is knowledgeable about the trauma-informed evaluation and treatment of children in out-of-home care. The assessment should be comprehensive with respect to the identification of possible acute and chronic physical health, behavioral/mental health, oral health and developmental problems and must be in compliance with Wisconsin HealthCheck requirements. It should include components of either developmental and/or behavioral health screenings as indicated for each child based on age and history, including any prior evaluations.

2) Timeframe: the comprehensive initial health assessment is required for all children entering out-of-home care and must occur within 30 days of enrollment

3) Performed by: The Comprehensive Initial Health Assessment should be performed at a Center of Excellence (COE). A COE refers to a pediatric health care clinic that has been specifically designated to meet the health care needs of children living in out-of-home care. COE staff receive training in a way that is responsive to the prior trauma that children in out-of-home care may have experienced. Services provided at a COE include but are not limited to:
    i. Comprehensive Initial Health Assessment
    ii. Standardized screening (developmental, mental health)
    iii. Referrals for early intervention, mental health evaluations as indicated
    iv. Subspecialty referrals, including dental
    v. Ongoing primary care well child exams
    vi. Transition health planning

4) It is strongly encouraged that children receive both the Comprehensive Initial Health Assessment and ongoing periodic, preventive well child care from a COE in order to receive the best possible care by a qualified professional that understands the unique needs of children in out-of-home care. A child can be seen for ongoing primary care by an in-network provider that is not within a COE, when maintaining a previously established relationship with an existing primary care provider for the purpose of continuity of care. Required Components (See Addendum II);

d. Completion of a comprehensive oral examination by a dentist for all children 12 months of age and above within 3 months of enrollment. If a comprehensive oral examination was conducted within 6 months prior to enrollment, ensure a follow-up comprehensive exam occurs within 3 months of enrollment or 6 months from the comprehensive exam, whichever comes later;

e. Referral to a qualified mental health or substance abuse professional for evaluation and/or treatment services in a timely manner if a mental health or substance abuse issue or need is identified; by any of the following sources:
   1) Child and Adolescent Needs and Strengths (CANS)
   2) Out-of-Home Care Health Screen or other medical assessment
   3) Crisis service intervention team
   4) Any medical, human service, or educational professional working with the child
   5) Out-of-home care provider, kin, or birth parent

   If a mental health or substance abuse issue or need is identified at the Comprehensive Initial Health Assessment, referral to a qualified mental health or substance abuse professional must take place within 30 days;

f. Completion of an initial comprehensive health care plan within 60 days of the child's enrollment in the FCMH which must be updated every six months thereafter at a minimum;

g. Ongoing monitoring of health status and provision of periodic preventive well child health care that is compliant with Wisconsin HealthCheck requirements;

h. Development of a transition health care plan to ensure continuity of care at discharge from the PIHP. The transition health care plan should identify the presumed source of ongoing insurance coverage, primary care provider, and any specialty care necessary to meet ongoing care needs, including peer support, and connections with natural support systems and community agencies as appropriate;

i. Metabolic screening and measurement of growth parameters (including BMI) for any child who is prescribed one or more antipsychotic medications, including identification of lead provider responsibility (refer to Addendum VII);

j. Monitoring of the rate and types of psychotropic medication usage among members, stratified by age and number of medications prescribed, including identification of the lead provider responsibility (refer to Addendum VII);

D. Medical Necessity

a. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);

b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports; and

c. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

a. ; and

b. The PIHP is responsible for covering services related to:
   1) The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that result in health impairments and/or disability.
   2) The ability for a member to achieve age-appropriate growth and development.
   3) The ability for a member to attain, maintain or regain functional capacity.

E. Physician and Other Health Services

Services required under Wis. Stats. §49.46(2), and Wis. Adm. Code ch. DHS 107, include (without limitation due to enumeration) private duty nursing services, nurse-midwife services and independent nurse practitioner services; physician assistant services and physician services, including primary care services, are not only services performed by physicians, but services under the direct, on-premises supervision of a physician performed by other providers such as nurses of various levels of certification.

F. Pre-existing Medical Conditions

The PIHP must assume responsibility for all covered pre-existing medical conditions for each member as of the effective date of coverage under the Contract. The aforementioned responsibility does not apply in the case of persons hospitalized at the time of initial enrollment.

G. Emergency Ambulance Services

The PIHP may require submission of a trip ticket with ambulance claims before paying the claim. Claims submitted without a trip ticket need only be paid at the service charge rate. The PIHP must:

a. Pay a service fee for an ambulance response to a call in order to determine whether an emergency exists, regardless of the PIHP's determination to pay for the call.

b. Pay for emergency ambulance services based on established Medicaid criteria for claims payment of these services.

c. Either pay or deny payment of a clean claim from an ambulance service within 45 days of receipt of the clean claim.

d. Respond to appeals from ambulance providers within the time frame described. Failure will constitute the PIHP's agreement to pay the appealed claim in full.

H. Non-Emergency Medical Transportation (NEMT)

Most NEMT is coordinated by the DHS' NEMT manager. The NEMT manager arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include public transportation such as a city bus, non-emergency ground ambulance, rides in specialized medical vehicles (SMV), or rides in other types of vehicles depending on a member's medical transportation needs, as well as compensated use of private motor vehicles for transportation to and from Medicaid covered services. Non-emergency medical transportation also includes coverage of meals and lodging in accordance with the ForwardHealth policy.

Members needing non-emergency medical transportation services should be directed to the DHS NEMT manager. Members may visit the Wisconsin Medicaid and BadgerCare Plus NEMT webpage for more information.

The PIHP must promptly provide or arrange for the provision of all NEMT ambulance services not reimbursed by the DHS NEMT manager listed in the ForwardHealth Online Handbook Topic #11898.

I. Transplants

Transplant coverage is as follows:

a. The PIHP is required to cover procedures that are approved only at particular institutions, including bone marrow transplants, liver, heart, heart-lung, lung, pancreas-kidney, stem cell, and pancreas transplants.

b. As a general principle, the Medicaid Program does not pay for transplants that it determines to be experimental in nature.

J. Dental Services

All dental services must be covered by the PIHP. The PIHP shall assist the out-of-home care provider in scheduling a dental examination within three months of enrollment, or a re-call exam if a comprehensive oral examination was conducted within 6 months prior to enrollment.

a. All Medicaid covered dental services as required under DHS 107.07, Wisconsin Health Care Programs Online Handbooks and Updates.

   Dental re-call exams and cleanings should be performed at least every six months, or more frequently as indicated by the child's risk status.

b. PIHPs providing dental coverage in the Racine County service area will be required to participate in a dental pilot program authorized in the 2015-17 biennial budget.

c. Diagnostic, preventive, and medically necessary follow-up care to treat a dental disease, illness, injury or disability of members while they are enrolled in the PIHP.

d. Completion of orthodontic or prosthodontic treatment begun while a member was enrolled in the PIHP if the member became ineligible for Medicaid or disenrolled from the PIHP, no matter how long the treatment takes. The PIHP will not be required to complete orthodontic or prosthodontic treatment on a member who began treatment before PIHP enrollment who subsequently was enrolled in the PIHP.

   [Refer to the chart following this page of the contract for the specific details of completion of orthodontic or prosthodontic treatment in these situations.]

e. The PIHP must cover emergency dental care

f. The PIHP must pay all charges relating to dental surgeries when a hospital or freestanding ambulatory care setting is medically indicated. These charges include, but are not limited to physician, anesthesia and facility charges.

g. Right to Audit

   The Department will conduct validity and completeness audits of dental claims. Upon request, the PIHP must submit paid claims to the Department along with any other records the Department deems necessary for the completion of the audit. Payment of incomplete or inaccurate claims will subject the PIHP to administrative sanctions outlined in Article XIII, Section C.

h. Requirements to Dental Service Providers

If a PIHP subcontracts with a dental benefits administrator, the participating dentist has the right to appeal to both the PIHP and Department, according to the Department's provider appeal requirements. This right to appeal is in addition to that of the provider's right to appeal. PIHPs must pay at a minimum the Medicaid fee-for-service rates for dental services. Providers rendering services must be paid at a minimum the Medicaid fee-for-service rates.

Responsibility for Payment of Orthodontic and Prosthodontic Treatment When There is an Eligibility Status Change During the Course of Treatment

	Who pays for completion of orthodontic and prosthodontic treatment[*] when there is an enrollment status change		
	First PIHP	**Second PIHP**	**FFS**
Person converts from one status to another: 1. FFS to the PIHP covering dental.		N/A	X
2a. PIHP covering dental to a PIHP not covering dental, and residence remains within 50 miles of the person's residence when in the first PIHP.	X		
2b. PIHP covering dental to an PIHP not covering dental, and person's residence changes to greater than 50 miles of the person's residence when in the first PIHP.			X
3a. PIHP covering dental to the same or another PIHP covering dental and the person's residence remains within 50 miles of the person's residence when in the first PIHP.	X		

[*] Orthodontia treatment is available only to members under age 21 to address concerns identified during a wellness visit such as an interperiodic or HealthCheck screen.

	Who pays for completion of orthodontic and prosthodontic treatment* when there is an enrollment status change		
	First PIHP	**Second PIHP**	**FFS**
3b. PIHP covering dental to the same PIHP or another PIHP covering dental and the person's residence changes to greater than 50 miles of the residence when in the first PIHP.			X
4. PIHP with dental coverage to FFS because: a. Person moves out of the PIHP service area but the person's residence remains within 50 miles of the residence when in the PIHP.	X		
b. Person moves out of the PIHP service area, but the person's residence changes to greater than 50 miles of the residence when in the PIHP.		N/A	X
c. Person disenrolled from PIHP enrollment.		N/A	X
d. Person's medical status changes to an ineligible PIHP code and the person's residence remains within 50 miles of the residence when in that PIHP.	X	N/A	
e. Person's medical status changes to an ineligible PIHP code and the person's residence changes to greater than 50 miles of the residence when in that PIHP.		N/A	X
5a. PIHP with dental to ineligible for Medicaid and the person's residence remains within 50 miles of the residence when in that PIHP.	X	N/A	
5b. PIHP with dental to ineligible for Medicaid and the person's residence changes to greater than 50 miles of the residence when in that PIHP.		N/A	X

K. Emergency and Post-Stabilization Services

a. 24-Hour Coverage

The PIHP must provide all emergency contract services and post-stabilization services as defined in this Contract 24 hours a day, seven days a week, either by the PIHP's own facilities or through arrangements approved by the Department with other providers.

The PIHP must:

1) Have one toll-free telephone number that members or individuals acting on behalf of a member can call at any time to obtain assistance in determining if emergency services are needed, to obtain authorization for urgent care and to obtain authorization for transportation. This telephone number must provide access to individuals with authority to authorize treatment as appropriate. Responses to these calls must be provided within 30 minutes. If the PIHP fails to respond timely, the PIHP will be liable for the cost of subsequent care related to that illness or injury incident whether the treatment is rendered by in or out-of-plan providers and whether the condition is emergency, urgent or routine.

   Authorization here refers to the requirements defined in the Standard Member Handbook Language, regarding the conditions under which a member must receive permission from the PIHP prior to receiving services from a non-PIHP affiliated provider in order for the PIHP to reimburse the provider.

2) Be able to communicate with the caller in the language spoken by the caller or the PIHP will be liable for the cost of subsequent care related to that illness or injury incident whether the treatment is in or out-of-plan and whether the condition is emergent, urgent, or routine. These calls must be logged with the time, date and any pertinent information regarding the persons involved, resolution and follow-up instructions.

3) Notify the Department and child welfare agency with which the PIHP has a MOU or in which the PIHP has enrollment of any changes to this toll-free telephone number for emergency calls within seven business days of the change.

b. Coverage of Payment of Emergency Services

The PIHP must promptly provide or pay for needed contract services for emergency medical conditions and post-stabilization services, regardless of whether the provider that furnishes the service has a contract with the entity. The PIHP may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or PIHP of the member's screening and treatment within ten (10) days of presentation for emergency services. The PIHP in coordination with the attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the PIHP as identified in 42 CFR 438.114(b) and 42 CFR 438.114(d) as responsible for coverage and payment. Nothing in this requirement mandates the PIHP to reimburse for non-authorized post-stabilization services.

1) The PIHP shall provide emergency services consistent with 42 CFR 438.114. It is financially responsible for emergency services whether obtained within or outside the PIHP's network. This includes paying for an appropriate medical screening examination to determine whether or not an emergency medical condition exists.

2) The PIHP may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

3) The PIHP may not deny payment for emergency services for a member with an emergency medical condition (even if the absence of immediate medical attention would not have had the outcomes specified in paragraphs 1., 2. and 3. of part a. of the definition of Emergency Medical Condition) or for a member who had PIHP approval to seek emergency services.

4) The member may not be held liable for payment of screening and treatment needed to diagnose the specific condition or stabilize the patient.

5) The treating provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the PIHP.

c. Coverage and Treatment of Post-Stabilization Care Services

1) The PIHP is financially responsible for:

i. Emergency and post-stabilization services obtained within or outside the PIHP's network that are pre-approved by the PIHP. The PIHP is financially responsible for post-stabilization care services consistent with the provision of 42 CFR 422.113(c).

ii. Post-stabilization services obtained within or outside the PIHP's network that are not pre-approved by the PIHP, but administered to maintain, improve or resolve the member's stabilized condition if:

- The PIHP does not respond to a request for pre-approval of further post-stabilization care services within one (1) hour;
- The PIHP cannot be contacted; or
- The PIHP and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the PIHP must give the treating physician the opportunity to consult with the PIHP care team or medical director. The treating physician may continue with care of the member until the PIHP care team or medical director is reached or one of the following occurs:
  - A network physician assumes responsibility for the member's care at the treating hospital or through transfer;
  - The treating physician and PIHP reach agreement; or,
  - The member is discharged.

2) The PIHP's financial responsibility for post-stabilization care services it did not pre-approve ends when a network provider assumes responsibility for care, at the treating hospital or through transfer, when the treating physician and PIHP reach agreement or when the member is discharged.

d. Additional Provisions

1) Payments for qualifying emergencies (including services at hospitals or urgent care centers within the PIHP service area) are to be based on the medical signs and symptoms of the condition upon initial presentation. The retrospective findings of a medical work-up may legitimately be the basis for determining how much additional care may be authorized, but not for payment for dealing with the initial emergency. Liability for emergency services continues until the patient is stabilized and can be safely discharged or transferred.

2) When emergency services are provided by non-affiliated providers, the PIHP is liable for payment only to the extent Medicaid pays, including Medicare deductibles, or would pay, FFS providers for services to Medicaid populations. For more information on payment to non-affiliated providers, see Article XIV, Section C, part 3. The PIHP must not make any payments to providers with a financial institution outside the United States. In no case will the PIHP be required to pay more than billed charges. This condition does not apply to:
   i. Cases where prior payment arrangements were established; and
   ii. Specific subcontract agreements.

e. MOU or Contract with Hospitals/Urgent Care Centers for the Provision of Emergency Services

The PIHP may have a contract or a MOU with hospital or urgent care centers within the PIHP's service area to ensure prompt and appropriate payment for emergency services. Unless a contract or MOU specifies otherwise, the PIHP is liable to the extent that FFS would have been liable for a situation that meets the definition of emergency. The Department reserves the right to resolve disputes between the PIHP, hospitals and urgent care centers regarding emergency situations based on the emergency definition. For situations where a contract or MOU is not possible, the PIHP must identify for hospitals and urgent care centers procedures that ensure prompt and appropriate payment for emergency services.

L. Family Planning Services and Confidentiality of Family Planning Information

a. The PIHP must give members the opportunity to have a different primary physician for the provision of family planning services. This physician does not replace the primary care provider chosen by or designated to the member.

b. The member may choose to receive family planning services at any Medicaid enrolled family planning clinic. Family planning services provided at non-network Medicaid enrolled family planning clinics are paid FFS for PIHP members including pharmacy items ordered by the family planning provider.

c. All information and medical records relating to family planning shall be kept confidential including those of a minor.

M. Pharmacy Coverage

PIHPs must carve out all SSA §1927 covered outpatient drugs to fee-for-service (covered outpatient drugs include drugs dispensed in a pharmacy, administered in a doctor's office, outpatient hospital or clinic; drugs reimbursed at bundled rate are not considered outpatient drugs).

a. Pharmacy Services Lock-In Program

DMS will manage a Pharmacy Services Lock-In Program to coordinate the provision of health care services for PIHP members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications.

Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wisconsin Administrative Code. Restricted medications are most controlled substances and tramadol.

PIHP members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one primary prescriber who will prescribe restricted medications.

PIHP members will remain enrolled in the Pharmacy Services Lock-In Program for two years. At the end of the two-year enrollment period, DMS or the PIHP will assess if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Policy on the Pharmacy Services Lock-In Program can be found in the BadgerCare Plus and Medicaid Pharmacy Provider Handbook.

1) DHS Responsibilities:

   i. The DMS or its designated representative shall manage the Pharmacy Services Lock-In Program and communicate directly with the PIHPs regarding their members.

   ii. The DMS or its designated representative will monitor prescription drug usage for members enrolled in the Pharmacy Services Lock-In Program.

   iii. The DMS or its designated representative will accept select review requests from the PIHP for potential Pharmacy Services Lock-In Program members. Not all select reviews may result in intervention letters or lock-in for the member.

   iv. The DMS or its designated representative will accept referrals from the PIHP for the Pharmacy Services Lock-In Program. DMS or its designated representative will proceed with Pharmacy Services lock-in for referred members.

   v. The DMS or its designated representative may request additional information from the PIHP for referrals. The PIHP must provide requested information to DMS or its designated representative.

   vi. The DMS or its designated representative will identify the lock-in pharmacy and the PIHP will identify the lock-in primary prescriber for each member. In addition, the PIHP will identify any alternate prescribers for restricted medications, as appropriate.

vii. The DMS or its designated representative will send letters of notification to the lock-in member and PIHP for the lock-in pharmacy.

viii. The DMS or its designated representative will provide an electronic monthly report to the PIHP that identifies any members in the Pharmacy Services Lock-In Program for the specific PIHP.

ix. The DMS or its designated representative will coordinate with the PIHP for the Pharmacy Services Lock-In Program policies and procedures.

2) PIHP Responsibilities:

i. PIHPs may request select reviews based on prescription drug utilization for potential Pharmacy Services Lock-In Program members. Not all select review requests may result in intervention letters or lock-in for the member.

ii. PIHPs may provide Pharmacy Services Lock-In Program referrals to DMS or its designated representative. The DMS or its designated representative will proceed with Pharmacy Services lock-in for all PIHP-referred members.

iii. The PIHP should evaluate referred Pharmacy Services Lock-In Program members at the end of the two-year enrollment period, to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program and notify the DMS or its designated representative.

iv. The PIHP will be responsible for preparing all documentation and acting as the DMS representative for member appeals to the Division of Hearings and Appeals related to the Pharmacy Services Lock-In Program referrals.

v. The DMS may request additional information from the PIHP for referrals. The PIHP must provide requested information to the DMS or its designated representative.

vi. PIHPs lock-in primary prescribers may designate alternate prescribers for restricted medications, as appropriate.

vii. PIHPs will send letters of notification to the lock-in member and the DMS or its designated representative. PIHPs are required to notify primary prescribing provider and alternate prescribers when assigned for a lock-in member.

viii. PIHPs must communicate with the DMS or its designated representative.

ix. The DMS or its designated representative will identify the lock-in pharmacy and the PIHP will identify the lock-in primary prescriber for each member. In addition, the PIHP will identify any alternate prescribers for restricted medications, as appropriate.

x. PIHPs may refer members to the DMS or its designated representative for the Pharmacy Services Lock-In Program if any of the following are documented by the PIHP:

1. Evidence of a member intentionally providing incorrect information such as ForwardHealth eligibility status or medical history to a provider to obtain restricted medications.

2. Evidence of a member being convicted within one year of a crime related to restricted medications. Crimes include: forgery, theft, distribution, etc.

3. Two or more occurrences of violating a pain management contract within six months from the same or different prescribers. A prescriber must agree to continue managing the member after the Lock-In Program has been initiated.

4. Any combination of four or more medical appointments/urgent care visits/emergency department visits within a 14 day time period at which the member is seeking a restricted medication as the primary reason for the visits.

5. A member required an ER visit or hospitalization due to suicide attempt, poisoning, or overdose from the use of restricted medication(s) in the last ninety days.

N. School-Based Services (SBS)

SBS are paid FFS by Medicaid when provided by a Medicaid certified SBS provider. For Medicaid certification purposes, a SBS service provider is a school district under ch. 120, Wis. Stats., or a cooperative educational service agency (CESA) under ch. 116, Wis. Stats. In situations where a member's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the PIHP is responsible for providing and paying for all Medicaid covered services.

O. Targeted Case Management (TCM) Services

The PIHP representative will work with the TCM case manager to identify what Medicaid covered services, in conjunction with other identified social services, are to be provided to the member. The PIHP is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the PIHP.

P. Electronic Visit Verification

The PIHP shall implement Electronic Visit Verification (EVV) for designated service codes by the deadlines established by the Department. The PIHP will use data collected from the EVV system to validate claims pertaining to affected service codes against approved authorizations during the PIHP's claims adjudication process. Encounters without a valid EVV record may be excluded in future rate-setting development. Prior to implementation, the PIHP shall outline expectations for contracted providers regarding the use of the EVV data collection system within subcontracts and/or provider manuals. The PIHP shall also provide assistance and support to both DHS and the contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested. As part of EVV implementation, the PIHP is required to submit accurate, complete, and timely data. Failure to comply with EVV implementation, as part of the federal 21st Century CURES Act may result in a corrective action plan and/or the application of remedies for violation, breach, or non-performance of the contract under Article XIV, C.

Q. Telehealth Services

The PIHP must develop policies and procedures that are consistent with ForwardHealth policies and Wisconsin Statute. The PIHP may not impose additional restrictions for in person services and must offer members like services in physical locations in addition to telehealth services.

A. Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies

The PIHP must provide Medicaid covered services, but the PIHP is not restricted to providing only those services. The PIHP may provide additional or alternative treatments if the other treatment modalities are more appropriate and result in better outcomes than Medicaid covered services. Whether the service provided is a Medicaid covered service or an alternative or replacement to a Medicaid covered service, the PIHP or PIHP provider is not allowed to bill the member for the service.

1. Conditions on Coverage of Mental Health/Substance Abuse Treatment:

   a. On the effective date of this Contract, the PIHP must be certified to provide or have contracted with facilities and/or providers enrolled to provide the mental health and substance abuse treatment services identified in Wis. Admin. Code DHS 107.13(1)-(4), 107.22(4) , and certain sections of the ForwardHealth Online Handbook:

      1) DHS 107.13(1) – Inpatient care in a hospital IMD (Online Handbook – Hospital, Inpatient)

      2) DHS 107.13(2) – Outpatient Psychotherapy Services (Online Handbook – Outpatient Mental Health, Outpatient Mental Health in the Home and Community for Adults)

      3) DHS 107.13(3) – Alcohol and Other Drug Abuse Outpatient Treatment Services (Online Handbook – Outpatient Substance Abuse)

      4) DHS 107.13(3m) – Alcohol and Other Drug Abuse Day Treatment Services (Online Handbook – Substance Abuse Day Treatment)

5) DHS 107.13(4) – Mental Health Day Treatment or Day Hospital Services (Online Handbook – Adult Mental Health Day Treatment)

6) Narcotic Treatment Services (Online Handbook – Narcotic Treatment)

7) DHS 107.22(4) HealthCheck "Other Services" (Online Handbook – Child/Adolescent Day Treatment, In-Home Mental Health/Substance Abuse Treatment Services for Children)

Certification requirements for mental health and substance abuse treatment providers eligible to provide the above services are found in Wis. Adm. Code DHS 105.21 – 105.25.

The PIHP may request variances of certain certification requirements for mental health providers. The Department will approve the variances to the extent allowed under federal or state law.

Department decisions to waive the requirement to cover these services shall be based solely on whether there is an enrolled provider that is geographically or culturally accessible to members, and whether the use of psychiatrists, or psychologists alone improves the quality and/or the cost-effectiveness of care.

In compliance with said provisions, the PIHP must further guarantee all enrolled FCMH members access to all covered, medically necessary mental health and substance abuse treatment.

In providing substance abuse treatment to members, the PIHP is encouraged to utilize, as well as encourage its provider network to utilize, the National Quality Forum's "National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices" and The Washington Circle's "Adopted Measures."

2. Mental Health Parity Compliance

The PIHP must comply with the Mental Health Parity Rule requirements of 42 CFR § 438.930. The Mental Health Parity Rule, in 42 CFR § 438.910(b)(2), requires the PIHP to provide mental health or substance abuse benefits to members in every classification in which medical

benefits are provided (e.g., inpatient, outpatient, emergency care, prescription drugs).

The PIHP must not establish any of the following when it has been determined that mental health or substance abuse treatment is medically necessary for the member:

- Any aggregate lifetime or annual dollar limits on mental health or substance abuse benefits;
- Any financial requirement or treatment limitation to mental health or substance abuse benefits;
- Any limit on the number of hours of outpatient treatment that the PIHP must provide or reimburse, and
- Any monetary limit or limit on the number of days of inpatient hospital treatment.

The PIHP prior authorization requirements must comply with the requirements for parity in mental health and substance abuse benefits in 42 CFR §438.910 (d). The same section of the Mental Health Parity Rule also specifies that the PIHP may not impose non-quantitative treatment limits (NQTL) for mental health or substance abuse benefits in any classification unless, the PIHP has processes, strategies evidentiary standards, or other factors used in applying the NQTL to mental health or substance abuse benefits that are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical benefits.

Pursuant to 42 CFR Part 438, subpart K, the PIHP will be required to submit to the Department its Mental Health Parity Rule compliance plan as part of the PIHP certification application process and upon request.

Additional information on covered services is available in Addendum VI, as well as in Provider Updates and through interChange.

3. Mental Health/Substance Abuse Assessment Requirements:

The PIHP must adjudicate mental health or substance abuse treatment service determinations following member requests or referrals from a primary care provider or physician in the PIHP's network. Any denials of service or selection of particular treatment modalities must be governed by an assessment conducted by qualified staff in a certified program who are

experienced in mental health/substance abuse treatment, a review of the effectiveness of the treatment for the condition (including best practice, evidence based practice), and the medical necessity of treatment. The lack of motivation of a member to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a client/member. The PIHP will use the Wisconsin Uniform Placement Criteria (WI-UPC), or the placement criteria developed by the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in Wis. Admin Code ch. DHS 75. The requirement in no way obligates the PIHP to provide care options included in the placement criteria that are not covered services under FFS.

The PIHP must involve and engage the member in the process used to select a provider and treatment option. The purpose of the participation is to ensure participants have culturally competent providers and culturally appropriate treatment and that their medical needs are met. This section does not require the PIHP to use providers who are not qualified to treat the individual member or who are not contracted providers.

4. Assurance of Expertise for Child Abuse, Child Neglect and Domestic Violence:

   The PIHP must consult with human service agencies on appropriate providers in their community. The PIHP must arrange for the provision of trauma-informed care by providers with expertise and experience in dealing with the medical and psychiatric needs of victims of child abuse and neglect; of victims of post-traumatic stress syndrome (PTSD); and of victims of domestic violence. The providers must have knowledge of and experience with statutory reporting requirements; local community resources for the prevention and treatment of child abuse and neglect; and resources for the prevention of domestic violence.

   The PIHP must notify all persons employed by or under contract to the PIHP who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. Services provided must include and are not limited to court-ordered physical, psychological and mental or developmental examinations and medical and psychiatric treatment appropriate for victims and perpetrators of child abuse and neglect.

The PIHP must have trauma-informed and developmentally appropriate systems of care in child abuse and neglect prevention in place. The PIHP must assure that individual providers dealing with perpetrators and victims of domestic abuse or incest have expertise and experience in trauma-informed care.

5. Court-Related Children's Services:

   The PIHP is liable for the cost of providing assessments under the Children's Code, Wis. Stat. s. 48.295, and is responsible for reimbursing for the provision of medically necessary treatment if unable to itself provide for such treatment ordered by a juvenile court. The medical necessity of court-ordered evaluation and treatment is assumed to be established and the PIHP is allowed to provide the care through its network, if at all possible. The PIHP may not withhold or limit services unless or until the court has agreed.

6. Court-Related Substance Abuse Services:

   The PIHP is liable for the cost of providing medically necessary substance abuse treatment, as long as the treatment occurs in the PIHP-approved facility or by the PIHP-approved provider ordered in the subject's Driver Safety Plan, pursuant to Wis. Stat. Ch. 343, and Wis. Adm. Code ch. DHS 62. The medical necessity of services specified in this plan is assumed to be established, and the PIHP shall provide those services unless the assessment agency agrees to amend the member's Driver Safety Plan. This is not meant to require PIHP coverage of substance abuse educational programs, or the initial assessment used to develop the Driver Safety Plan. Necessary PIHP referrals or treatment authorizations by providers must be furnished promptly. It is expected that no more than five days will elapse between receipt of a written request by the PIHP and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the fifth day, an assumption will exist that an authorization has been made until such time as the PIHP responds in writing.

   There are mental health and substance abuse coverage limitations specified in the ForwardHealth Provider Updates.

7. Emergency Detention and Court-Related Mental Health Services

The PIHP is liable for the cost of all emergency detention and court-related mental health/substance abuse treatment, including stipulated and involuntary commitment provided by non-PIHP providers to PIHP members where the time required to obtain such treatment at the PIHP's facilities, or the facilities of a provider with which the PIHP has arrangements, would have risked permanent damage to the member's health or safety, or the health or safety of others. The extent of the PIHP's liability for appropriate emergency treatment is the current FFS rate for such treatment.

a. Care provided in the first three business days (72 hours), plus any intervening weekend days and/or holidays, is deemed medically necessary and the PIHP is responsible for payment.

b. The PIHP is responsible for payment for additional care beyond the time period in paragraph a. above only if notified of the emergency treatment within 72 hours, excluding weekends and holidays, and if given the opportunity to provide such care within its own provider network. The opportunity for the PIHP to provide care to a member admitted to a non-PIHP facility is accomplished if the county or treating facility notifies and advises the PIHP of the admission within 72 hours, excluding weekends and/or holidays. The PIHP may provide an alternative treatment plan for the county to submit at the probable cause hearing. The PIHP must submit the name of an in-plan facility willing to treat the member if the court rejects the alternative treatment plan and the court orders the member to receive an inpatient evaluation.

c. If the county attempts to notify the person identified as the primary contact by the PIHP to receive authorization for care, and does not succeed in reaching the PIHP within 72 hours of admission excluding weekends and holidays, the PIHP is responsible for court-ordered care beyond the initial 72 hours. The county must document the attempts to notify with dates, times, names and numbers attempted to contact, and outcomes. The care provided to the PIHP member by the non-PIHP provider is deemed medically necessary, and coverage by the PIHP is retroactive to the date of admission.

d. The PIHP is financially liable for the member's court ordered evaluation and/or treatment when the PIHP member is defending him/herself against a mental illness or substance abuse commitment:

1) If services are provided in the PIHP facility; or

2) If the PIHP approves provision in a non-contracted facility; or

3) If the PIHP was given the opportunity but failed to provide the county with the name of an inpatient facility and, as a result, the member is sent for court ordered evaluation to an out-of-plan provider; or

4) If the PIHP gives the county the name of an in-plan facility and the facility refuses to accept the member.

e. The PIHP is not liable for the member's court ordered evaluation and treatment if the PIHP provided the name of an in-plan facility and the court ordered the evaluation at an out-of-plan facility.

8. Inpatient and Institutional Services

   If inpatient or institutional services are provided in the PIHP facility, or approved by the PIHP for provision in a non-contracted facility, the PIHP shall be financially liable for all children enrolled under this contract for the entire period for which prepayment is made. The PIHP remains financially liable for the entire period for which a nonrisk prepayment is made even if the child's medical status code changes.

9. Transportation following Emergency Detention

   The PIHP shall be liable for the provision of medical transportation to the PIHP-affiliated provider when the member is under emergency detention or commitment and the PIHP requires the member to be moved to a participating provider, provided the transfer can be made safely. If a transfer requires a secured environment by local law enforcement officials (i.e., Sheriff's Department, Police Department, etc.), the PIHP shall not be liable for the cost of the transfer. The county agency or the law enforcement agency makes the decision whether the transfer requires a secured environment. The PIHP is not prohibited from entering into an MOU or agreement with local law enforcement agencies or with the county agencies for such transfer.

10. Out-of-Network Benefit Coordination

The PIHP must coordinate the services it provides to members with services a member receives through Medicaid FFS or through community and social support providers. The PIHP must assign a representative to coordinate services with public health agencies or treatment programs within the PIHP's service area that are not included in the PIHP's network. These might include but are not limited to county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs, or inpatient programs. The PIHP must work with the agency/program to coordinate a member's transition to or from covered mental health and substance abuse care within the PIHP's network. Any member transitioning from crisis intervention services must be able to access an appropriate level of ongoing care within 30 days of the crisis. The PIHP is not required to pay for ongoing services outside the PIHP network, unless the PIHP has authorized those services.

11. MOU/Contract Requirement and Relations with other Human Service Agencies

    The PIHP must coordinate the services it provides to members with services a member receives through Medicaid FFS or through community and social support providers. The PIHP shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members. The PIHP must work cooperatively with other community agencies, to treat mental health and/or substance abuse conditions as legitimate health care problems.

    The PIHP must make a good faith attempt to negotiate either an MOU or a contract with the county(ies) in its service area. The MOU(s), contract(s) or written documentation of a good faith attempt must be available during the certification process and when requested by the Department. Failure of the PIHP to have an MOU, contract or demonstrate a good faith effort, as specified by the Department, may result in the application by the Department of remedies as indicated in this Contract.

    MOUs must be signed every two years as part of certification. If no changes have occurred, then both the county and the PIHP must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Children's Services upon request. The PIHP must conduct outreach to agencies that do not have an MOU with the health plan, at a

minimum, every two years. The PIHP must submit evidence that it attempted to obtain an MOU or contract in good faith.

12. Narcotic Treatment Services

    Within a reasonable distance from a member's residence, the PIHP must provide access to narcotic treatment services (NTS) or medication-assisted treatment (MAT) for opioid dependence via eligible facilities and/or providers. PIHPs must regularly monitor their NTS and MAT provider networks to ensure that members have access to these services. Narcotic treatment services include member assessment, screening for drugs of abuse, screening for certain infectious diseases, prescription and administration of narcotic medication, and substance abuse counseling. The ForwardHealth Online Handbook section for 'Narcotic Treatment' outlines policy for services provided by narcotic treatment programs certified under Wis. Adm. Code ch. DHS 75. For members who require narcotic treatment, the PIHP must ensure access to providers authorized to prescribe opioid dependency agents. Authorized providers include Wis. Adm. Code §DHS 75.15 facilities or physicians who have obtained a Drug Addiction Treatment Act (DATA) 2000 waiver allowing him or her to prescribe buprenorphine-based agents. The requirement to provide narcotic treatment services does not include coverage of opioid dependency agents themselves, which are covered by ForwardHealth. PIHP providers must adhere to all policy and prior authorization requirements for coverage of opioid dependency agents.

13. Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services

    a. Services
       This benefit will be limited to behavioral health: short term residential (non-hospital residential treatment program) per diem (over midnight census) using code: H0018 under the CBRF provider ID. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization.

       This benefit will be reimbursed at $450 per diem.

       Included in this per diem cost are services such as:

       1) Comprehensive interdisciplinary biopsychosocial mental health assessment;

2) Crisis assessment, intervention and stabilization;
3) Psychiatrist and Advanced Practice Nurse Prescriber to include medication assessment, review, consultation and prescribing;
4) Psychosocial group education;
5) Individual counseling;
6) Peer support;
7) Family consultation, as needed;
8) Individualized community linkage to ongoing services and supports within the community.

Post-discharge services will be provided on an individual outpatient basis in cooperation and consent with the County. These outpatient mental health services will be included as part of the County capitation.

b. Provider Qualifications

1) The provider must be a licensed Community Based Residential Facility (CBRF).
2) The provider must be experienced with at least 5 years as a community based provider of non-institutional sub-acute psychiatric services.
3) DQA certification as an Outpatient Mental Health clinic is required.
4) The staffing plan shall include the following positions:
   i. Director
   ii. Clinical Coordinator
   iii. Community Recovery Specialist
   iv. Peer Recovery Specialist
   v. Mental Health Professional
   vi. Registered Nurse
   vii. Advanced Practice Nurse Prescriber
   viii. Medical Director
   ix. Other professional and/or para-professional staff as required to meet the needs of the members.

14. SUPPORT Act Compliance

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, requires that behavioral health services, including mental health treatment, substance use disorder treatment, and interventions

for developmental delays be made available to Children's Health Insurance Program (CHIP).

In accordance with section 5022(d) of the Act, the PIHP must assure that age appropriate, validated screening tools are used to identify behavioral health needs for individuals ages 0-18 in primary care settings. Validated screening tools for children can be found at https://screeningtime.org/star-center/#/screening-tools and https://www.uspreventiveservicestaskforce.org/BrowseRec/Index.

The PIHP must assure that screenings are conducted according to the most recently published AAP/Bright Futures periodicity schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.
On an annual basis, the PIHP must report to the Department the specific tools and/or protocols used by their primary care providers when screening children for the following behavioral health areas:

a. General development;
b. Autism spectrum disorder;
c. Tobacco, alcohol or drug use;
d. Depression;
e. Any additional areas/tools.

This report must be submitted to the PIHP's DHS contract administrator , Attn: Behavioral Health Policy Section in Excel format by July 1st of each calendar year.

B. HealthCheck

HealthCheck, a federally mandated benefit, is key to ensuring that children receive the preventive and follow up care they need, including appropriate dental, mental health, developmental, and specialty care. To the maximum extent possible, the PIHP must make every effort to ensure that HealthCheck exams are provided by primary care providers who understand the concept of trauma-informed care and who provide services based on this understanding and approach.

1. The PIHP must provide comprehensive HealthCheck screens following the enhanced periodicity schedule recommended by the American Academy of Pediatrics (AAP) for children in out-of-home care:
   a. Every month for the first six months of age;
   b. Every 3 months from 6 months to 2 years of age;

c. Twice a year after 2 years of age.

The PIHP must schedule interperiodic visits when medically necessary. Interperiodic visits are follow up appointments that occur between the regularly scheduled comprehensive screens. These appointments may be necessary to follow up on a condition or need identified during the comprehensive HealthCheck screen.

2. The PIHP must provide the comprehensive initial health exam within 30 days of enrollment. This exam must meet HealthCheck requirements and must be performed according to AAP guidelines for children in out-of-home care (see Addendum II).

   Subsequent comprehensive HealthCheck exams must consist of, at a minimum, reassessments of the member's health, development and emotional status to determine the need for additional services and interventions.

3. The PIHP must ensure that comprehensive HealthCheck exams for children through two years of age include blood lead toxicity testing. Universal testing of children in this age range is a federal Medicaid requirement.

   Note: Federal regulations require lead toxicity screening for all children at ages 12 months and again at 24 months. In addition, children between 24 and 72 months must be screened if there is no record of a previous blood lead screening test.

4. Provide treatment referrals resulting from the HealthCheck physical exam when findings indicate the need for further evaluation, diagnosis, and treatment. All appointments for further diagnosis or treatment as a result of the screening should be scheduled within 60 days of the date of the HealthCheck screening. All Medicaid services on a HealthCheck referral should be provided within six months of the screening date.

5. Provide other necessary health care services, as medically-necessary, even if those services are not otherwise covered or, exceed coverage limitations (i.e., HealthCheck "Other Services"). The PIHP is responsible for all HealthCheck "Other Services" with the exception of services specified in Article IV(A)(1) in the Contract. Refer to Topic #2391 In the ForwardHealth Online Handbook for examples of HealthCheck "Other Services."

C. Immunization Program

As a condition of certification as a FCMH provider, the PIHP must share member immunization status with the Local Health Departments and other non-profit HealthCheck providers upon their request without the necessity of member authorization. The Department also requires that the Local Health Departments and other non-profit HealthCheck providers share the same information with the PIHP upon request. This provision ensures proper coordination of immunization services and prevents duplication of services.

The PIHP must have a signed user agreement with the Wisconsin Immunization Registry (WIR) or must be able to demonstrate that its major providers have signed WIR user agreements.

D. Abortions, Hysterectomies and Sterilizations

The PIHP shall comply with the following state and federal compliance requirements for the services listed below:

1. Abortions must comply with the requirements of Wis. Stats., s. 20.927, Wis. Stats., s. 253.107 and with 42 CFR 441 Subpart E - Abortions.

2. Hysterectomies and sterilizations must comply with 42 CFR 441 Subpart F - Sterilizations.

Sanctions in the amount of $10,000.00 may be imposed for non-compliance with the above compliance requirements.

The PIHP must also abide by Wis. Stats., s. 609.30.

E. Provider Moral or Religious Objection

The PIHP is not required to provide counseling or referral service if the PIHP objects to the service on moral or religious grounds. If the PIHP elects not to provide, reimburse for, or provide coverage of, counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

1. To the Department and Enrollment Specialist so the Department can notify members of the PIHP of the PIHP's non-coverage of service;
2. With the PIHP certification application;

3. Whenever the PIHP adopts the policy during the term of the contract;
4. Must be consistent with 42 CFR 438.10;
5. Must be provided to potential members before enrollment;
6. Must be provided to members within ninety (90) calendar days after adopting the policy with respect to a particular service; and
7. In a written and prominent manner, the PIHP shall inform its members via its website and member handbook of any benefits to which the member may be entitled under Medicaid but which are not available through the PIHP because of an objection on moral or religious grounds.

F. Health Homes

The Affordable Care Act of 2010, Section 2703, created an optional Medicaid benefit that allows states to establish health homes to coordinate care for people who have chronic conditions. The goals of health homes are to improve health outcomes while lowering Medicaid costs, and to reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members. PIHP must coordinate services with all members in enrolled in a specialized Hub and Spoke (H&S) Integrated Recovery Support Services Health Home for SUD treatment. All members diagnosed with or identified as being at risk of having Substance Use Disorder (SUD) or have been identified as being at risk of developing conditions frequently associated with SUD, may be referred with the members' consent for specialized Hub and Spoke services.

1. Program Evaluation and Ongoing Monitoring, Review, and Audit

   The Affordable Care Act includes a national evaluation requirement. In response, CMS has identified a core set of quality measures to inform the evaluation and to assess the impact of health home services on health outcomes. The Department will be responsible for obtaining data and reporting on these quality measures.

   The Department will conduct ongoing health home site visits for the purposes of program monitoring, review, and audit. The Department may use information obtained from site visits, encounter and paid claims data to respond to federal reporting and evaluation requirements. Health home providers are required to respond to data requests as a condition of continued health home participation.

2. Health Home Services

   Health home providers coordinate care across all settings, including medical, behavioral, dental, pharmaceutical, institutional, and community care settings.

Covered health home activities include the following:

a. Comprehensive care management,
b. Care coordination,
c. Health promotion,
d. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up,
e. Patient and family support, including authorized representatives, and
f. Referral to community and social support services.

Health home providers must be required to provide patient-centered health home services in accordance with the requirements detailed in the ForwardHealth online handbook.

When arranging direct care services, the health home provider must follow the PIHP's requirements regarding prior authorization for PIHP-covered services, referrals to in-network providers, and claim submission.

Health homes are strongly encouraged to use health information technology to link services and to facilitate communication.

3. Target Population

Hub & Spoke Integrated Recovery Support Services. Members must have a diagnosis of SUD and at least one other chronic condition, or be at risk of developing another chronic condition. The risk factors include but are not limited to: mood disorder, anxiety disorders, diabetes, heart disease, COPD, hypertension, asthma, HIV/AIDS, hepatitis A, B, and C, liver/kidney disease, PTSD, psychotic disorders, Traumatic Brain Injury and cognitive disorders, ADHD, and chronic pain. Pilot Hub sites will determine eligibility and enroll members in the Hub and Spoke services. Hubs may also clinically assess the member's needs for the health home service on a case by case basis, to determine eligibility for the Hub and Spoke benefit.

4. Designated Provider

Hub and Spoke pilot program sites were selected by the Department via a Grant Funding Opportunity Application (GFOA). Three authorized hub sites were selected to provide health home services and to contract for those services with authorized spoke sites. PIHPSs are expected to enter into MOUs with the DHS contracted hub and spoke pilot sites to coordinate services in the pilot program service areas.

5. Requirements

PIHPs serving members with an SUD who have access to a Hub and Spoke pilot site may refer the member to the pilot site, with the member's consent. PIHPs may not limit a member's participation in a health home.

PIHPs must continue to provide services in the PIHPs benefit package regardless of the member's participation in a health home.

Health home services include coordination beyond the health care community. A significant component is focused around the engagement of community partners to ensure successful linkages to community and social supports.

Eligible members may be identified by the PIHP or its providers and informed of the option to receive services the Hub and Spoke pilot sites. Members may also be identified by the Hub and Spoke pilot sites, who must then inform the PIHP to ensure care is coordinated. Members may not be obligated to receive health home services and must consent in writing to health home enrollment.

Non-Duplication of Services
To avoid duplication of care coordination activities, PIHPs are encouraged to work with the health home to develop a MOU or contract that clearly delineates the respective roles. At a minimum, the PIHP should address the following with the health home provider:

a. Communication
    1) Single points of contact within the health home and the PIHP
    2) Response to critical events (emergency room visit, hospitalization, detox/mental health crisis)
    3) Expanded access to health care, where appropriate
    4) PIHP notification and engagement if member opts out of health home
    5) Mode
    6) Frequency

b. Member engagement (in accordance with state and federal confidentiality requirements)
    1) Identification
    2) Outreach
    3) Obtaining member consent (to participate and for information sharing)
    4) Re-engagement if lost to follow-up (for example, member identified in an emergency room)

c. PIHP engagement in the member development and implementation of the member's care plan, especially in the following areas,

1) Identification and engagement of member's PCP and other health care providers
2) Access to needed health care
3) Identifying gaps in care, needed referrals, and referral follow-up
4) Addressing missed appointments
5) PIHP resources

d. Reporting and data sharing. The PIHP and health home should determine the level of reporting and data sharing necessary to ensure that the goals of health home services are accomplished. Examples of these activities include,

    1) Health home utilization (for example, member count, average number of contacts per month)
    2) ER use
    3) Hospitalization
    4) Referrals
    5) Adherence to prescribed therapy
    6) Results of member satisfaction surveys (conducted by the health home)

e. Use of Information Technology where feasible (for example, sharing clinical and care plan information, communication and referrals and follow-up).

V. PROVIDER NETWORK AND ACCESS REQUIREMENTS

The PIHP must demonstrate covered services within the provider network are available and accessible to members per 42 CFR § 438.206, 438.68, and 438.14 and has the capacity to serve expected enrollment in its service area per 42 CFR § 438.207.

The PIHP must establish provider network access, availability, and capacity expectations within provider's contracts, to include standards, protocols, methods of monitoring, reporting, and remediation.

A. Availability and Accessibility

The PIHP must establish mechanisms to ensure compliance by network providers; regularly monitor to determine compliance; take corrective action if there is a failure to comply by a network provider; and make readily available to the department upon request records of such actions.

1. Provider Network

The FCMH must:

a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

b. Provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

c. Provide for a second opinion from a network provider or arranges for the member to obtain one outside the network, at no cost to the member.

d. Provide necessary services, covered under the contract, to a particular enrollee. The FCMH must adequately and timely cover these services out of network for the member, for as long as the FCMH's provider network is unable to provide them.

e. Coordinate with out-of-network providers for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the network.

f. Reimburse for emergency services provided out-of-network at a cost to the member no greater than if the services were provided in-network.

g. Demonstrates network providers are credentialed as required by 42 CFR § 438.214.

h. Demonstrates network includes sufficient family planning providers to ensure timely access to covered services.

2. Furnishing of Services and Timely Access

The HMO must:

a. Require network providers meet standards for timely access to care and services.

b. Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid FFS. The FCMH must ensure appointment and facility wait time standards do not discriminate against members.

c. Make services included in the contract available 25 hours a day, 7 days a week.

d. Provide medically necessary high risk prenatal care within two weeks of the member's request for an appointment, or within three weeks fi the request is for a specific FCMH

provider, who is accepting new patients.

3. Access and Cultural Considerations

The FCMH must:

a. Participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.

b. Have written protocols ensuring children's Healthcheck.

c. Ensure that network providers provide physical access, reasonable acomodations, and accessible equipment for members with physical or mental disabilities.

B. Network Capacity

The FCMH must demonstrate sufficient capacity to serve members in service areas and must make documentation readily available, demonstrating it complies with the following:

1. Offers and appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members in the service area.

2. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

3. The FCMH notifies the Department and submits documentation regarding network providers when:

a. The FMCH enters into the initial contract with the Department,
b. annually, or
c. a significant change in benefits programs, geographic service area, member enrollment, new member population, or composition of or

payments to the provider network occur.

4. The FMCH must, at a minimum, sustain a network that meets standards specified in Table-1. This does not preclude the FCMH's requirement to demonstrate sufficient capacity among covered network services. The FCMH must develop network adequacy standards specified in 42 CFR § 438.68(c)(1)(i)-(ix) and must include covered geographic service areas. The FCMH may have varying standards within the same provider type based on geographic service area.

5. The FCMH may have requested an exception to provider specified network standards in Table 1 based, at a minimum, on the number of participating provider specialties in the specified service area.

6. DHS expects the FCMH submit member communications and transition plan 120 days before the intended geographic service area reduction.

C. Indians, Indian Health Care Providers (IHCP), and Indian Managed Care Entities (ICME)

1. The FCMH must demonstrate sufficient IHCPs participate in the network to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services as specified in 42 CFR § 457.1209 and 438.14. This section pertains to Indians, IHCP, and IMCE definitions defined in 438.14(a).

2. The FCMH must pay IHCPs for covered services provided to Indian members who are eligible to receive services. The FCMH shall pay all providers, including non-network providers, as follows:

a. At a rate negotiated between the FCMH and the IHCP, or

b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the FCMH would make for the services to a network provider which is not an IHCP; and

c. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group

practices under 42 CFR § 447.45 and 447.46.

3. The FCMH must permit any Indian member who is enrolled in the FCMH that is not an IMCE and eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, if that provider has capacity to provide the services.

4. The FCMH must permit Indian members to obtain covered services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

5. Where timely access to covered services cannot be ensured due to few or no IHCPs, the FCMH will be considered to have met the requirement in paragraph C(1) of this section if the FCMH permits Indian members to access out-of-state IHCPs.

6. The FCMH must permit an out-of-network IHCP to refer an Indian member to a network provider.

7. An IMCE may restrict enrolment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in § 438.3(d).

D. Contract Certification

The Department will conduct an annual network adequacy analysis confirming the FCMH's network adequately supports members' access availability, and capacity standards specified in Table-1. The Department will also consider additional metrics or data sources to determine network adequacy, including member grievances and appeals, out-of-network reports Consumer Assessment of Health Providers and Systems surveys, and the Department's external quality review organization. The network adequacy analysis will result in either an approval, conditional, or exception status by service area county.

1. Approval status is granted when the Department's review and the FCMH service area is within standards.

2. Conditional status is granted when the Department determines network conditions are such that the FCMH may continue providing services in an area

under but must remediate the specific deficiencies. Conditional terms may require the FCMH to produce a corrective action plan, lead to decertification, enrollment suspension and/or other action in the interest of the members. While under conditional status the FCMH must provide the Department member impact assessments and remedies to improve standards.

3. Exception status may be granted during the annual review and upon expansion requests where limited services preclude the FCMH from meeting adequacy standards only if the following conditions are met:
    a. Reason for limited services are outside the control of either or both the Department and FCMH.
    b. The FCMH provides documentation and justification for adequate network despite deficiencies.
    c. The FCMH monitors and provides periodic member access impact assessments.

    The Department will use this information to determine exception status or take alternative action.

4. The FCMH must establish provider network access, availability, and capacity expectations within provider's contracts, to include standards, protocols, methods of monitoring, reporting, and remediation.

E. Healthcare Provider Network Files

The FMCH must submit the Healthcare Provider Network and Healthcare Facility Network files weekly, upon significant changes, or upon the Department's request through the State SFTP. A significant network change prompting a file submission would include, but not limited to, inadequate provider type capacity and services, modification to FCMH benefits, service area, provider network, and member enrollment. The file must be submitted in the designated format specified in the *HMO Provider Network File Submission Specification Guide* and meet minimum threshold standards to be accepted.

F. FCMH Network Reviews

The FCMH must provide assurances to the Department demonstrating the FCMH's capacity to serve expected enrollment in its service area per 42 CFR § 438.207 and Department standards for access to care in Table-1. The Department's network review is based on the provider network files, and MMIS

enrollee data to determine Table-1 metrics. Wait times are assessed separately.

1. The urban areas are Brown, Dane, Eau Claire, Fond du Lac, Kenosha, La Crosse, Marathon, Milwaukee, Outagamie, Ozaukee, Racine, Rock, Sheboygan, St. Croix, Walworth, Washington, Waukesha, and Winnebago Counties based on similar population density characteristics. All other Counties are considered Rural.

2. The Provider-to-Enrollee Ratio is derived from the count of providers within distance standards, accepting new members, and place of service is within the given County as the numerator. A count of members within a given County is the denominator.
3. Distance standards are based on the most direct route, while the Drive Time is based on driving distance.

4. The 010 – Inpatient/Outpatient Hospital consists of non-specialized hospitals or specializing in Pediatrics as a non-specialized hospital. In all other instances a non-specialized hospital is one which is not exclusive to a single category of service or specialty including, but not limited to, behavioral health, cardiology, or orthopedics.

5. An Urgent Care Center is a facility consisting of the below criteria. A hospital emergency department may not serve to meet this requirement.

    a. X-ray on site.
    b. Phlebotomy services on site.
    c. Appropriately licensed providers on site with the resources to obtain and read an EKG and X-ray on site; administer PC, IM and IV medication/fluids on site; and perform minor procedures (ex. sutures, splinting) on site.
    d. Have an automated external defibrillator (AED), Oxygen, ambu-bag/oral airway equipment with adequately trained staff.
    e. At least two exam rooms.
    f. Available to members in the evening during weekdays and weekends.
    g. Advertise as an Urgent Care Center.

1. Table - 1								
Provider Type	**Provider Specialty Code - Description**	**Population**	**Program**	**Counties**	**Drive Time (min)**	**Distance (mls)**	**Provider-to-Enrollee Ratio - Acceptin**	**Wait Time**

							g New Members	
Dental	271 – General Dentistry Practitioner 289 – Dental Hygienist	Adult	BC+, SSI, IHS	Urban	45	30	1:1600	Routine: < 90 Days Emergent: < 24 Hrs
				Rural	90	75	1:1200	
	274 – Pediatric Dentist 289 – Dental Hygienist	Pediatric		Urban	45	30	1:1600	
				Rural	90	75	1:1200	
Mental Health & Substance Use Providers	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse 120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug Abuse Counselor 123 – Certified Psychotherapist with SAC 124 – Certified Psychothera	Adult & Pediatric	BC+, SSI, IHS	Urban	45	30	1:900 Psychiatrist and Psychologist	< 30 days
				Rural	75	60	1:700 Psychiatrist and Psychologist	

	pist 126 – Qualified Treatment Trainee (QTT) 339 – Psychiatry 532 – Registered Alcohol & Drug Counselor 740 – Mental Health							

Table - 1								
Provider Type	**Provider Specialty Code - Description**	**Population**	**Program**	**Counties**	**Drive Time (min)**	**Distance (mls)**	**Provider-to-Enrollee Ratio - Accepting New Members**	**Wait Time**
Narcotic Treatment Service for Opiate Addiction (DHS 75.15) (Medication-Assisted Treatment (MAT)	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse 120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug	Adult	BC+, SSI, IHS	Urban / Rural	70	50	Substance Abuse Counselor, Substance Abuse Counselor-In Training, or Clinical Substance Abuse Counsel	

	Abuse Counselor 123 – Certified Psychotherapist with SAC 124 – Certified Psychotherapist 126 – Qualified Treatment Trainee (QTT) 339 – Psychiatry 532 – Registered Alcohol & Drug Counselor 740 – Mental Health						or ratio is 1:50	
OB/GYN	095 – Nurse Practitioner/ Nurse Midwife 212 – Nurse Midwife 316 – Family Practice 318 – General Practice 328 – OB/Gynecologists 350 – Licensed Midwife	Adult & Pediatric	BC+, SSI, IHS	Urban	15	10	1:100	< 30 days
				Rural	45	30	1:80	

Table - 1

Provider Type	Provider Specialty Code - Description	Population	Program	Counties	Drive Time (min)	Distance (mls)	Provider-to-Enrollee Ratio - Accepting New Members	Wait Time
PCP	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine	Adult	BC+, SSI, IHS	Urban	15	10	1:100	< 30 days
				Rural	40	30	1:80	
	090 – Certified Pediatric Nurse Practitioners 092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine 345 – Pediatricians 080 – Federally Qualified Health Center (HealthCheck related) 734 – Screener (HealthCheck) 735 – Screener/Case Management (HealthCheck)	Pediatric	BC+, SSI, IHS	Urban	15	10	1:100	< 30 days
				Rural	40	30	1:80	

Hospital	010 – Inpatient/Outpatient Hospital	Adult & Pediatric	BC+, SSI, IHS	Urban	45	30		
				Rural	75	60		
Urgent Care Center		Adult & Pediatric	BC+, SSI, IHS	Urban	45	30		
				Rural	75	60		

G. Telehealth

PIHP must develop policies and procedures for internal monitoring of telehealth utilization. The PIHP will submit these policies and any applicable monitoring information to the Department as requested. Telehealth services will be considered during the annual network adequacy review only secondary to physical provider location requirements.

H. Online Provider Directory

The PIHP must post a provider directory on their website for members, network providers, and the Department to access. C4K must update the provider directory no later than 30 days after receiving updated provider information. The file must be updated at least monthly with hard copies available upon request from a member. The file must be in a machine readable file. The file must include the following information:

1. Provider full name and phone number
2. Provider gender
3. Clinic or facility address
4. Clinic or facility website (if available)
5. Accommodations for members with disabilities
6. Specialty
7. Languages spoken, including American Sign Language, and
8. If they are accepting new patients.

VI. MARKETING AND MEMBER MATERIALS

The PIHP is required to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code of Federal Regulations § 438.10 and 42 CFR §438.104, as detailed in the *Communication Outreach and Marketing Guide*, dated December 2021, which is fully incorporated herein by reference.

ARTICLE VII: Member Rights and Responsibilities

VII. MEMBER RIGHTS AND RESPONSIBILITIES

As cited in 42 CFR 438.100, the contract requires the PIHP to have written policies guaranteeing each member's right to be treated with respect and with due consideration for his or her dignity and privacy. Members of PIHPs have the following rights:

- Receive information in accordance with 42 CFR §438.10.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Participate in decisions regarding his or her health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
- If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.
- Be furnished health care services in accordance with 42 CFR §438.206 through §438.210.
- Be free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PIHP and its network providers treat the member.

A. Advocate Requirements

The PIHP must employ a FCMH Member Advocate(s) during the entire contract term. The Advocate(s) must work with both members and providers to facilitate the provision of benefits to members. The advocate is responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. The advocate position must be in an organizational location within the PIHP that provides the authority needed to carry out these tasks. The detailed requirements of the FCMH Advocate are listed below:

1. Functions of the FCMH Member Advocate(s)

a. Investigate and resolve access and cultural sensitivity issues identified by PIHP staff, State staff, providers, advocate organizations, and members.

b. Monitor grievances and appeals, along with the grievance and appeal personnel, for the purposes of identification of trends or specific problem areas of access and care delivery. The monitoring function includes ongoing participation in the PIHP grievance and appeal committee.

c. Attempt to resolve grievances and appeals without formal hearings or reviews whenever possible. Resolution of issues and concerns should happen through internal review, negotiation, or mediation, when possible.

d. Recommend policy and procedural changes to PIHP management including those needed to ensure and/or improve member access to and quality of care. The recommended changes can be for both internal administrative policies and subcontracted providers.

e. Act as the primary contact for member advocacy groups. Work with member advocacy groups on an ongoing basis to identify and correct member access barriers.

f. Act as the primary contact for local community based organizations (local governmental units, non-profit agencies, etc.). Work with local community based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of members.

g. Participate in working with DMS Managed Care staff assigned to the PIHP on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.

h. Analyze on an ongoing basis internal PIHP system functions that affect member access to medical care and quality of medical care.

i. Attend, organize and provide ongoing training and educational materials for the PIHP staff and providers to enhance their understanding of the values and practices of all cultures with which the PIHP interacts.

j. Provide ongoing input to PIHP management on how changes in the PIHP provider network will affect member access to medical care and member quality and continuity of care. Initiate and participate in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

k. Review and approve the PIHP's informing materials to be distributed to members to assess clarity and accuracy.

l. Assist members and their authorized representatives for the purpose of obtaining their medical records.

m. The lead advocate position is responsible for overall evaluation of the PIHP's internal advocacy plan and is required to monitor any contracts the PIHP may enter into for external advocacy with culturally diverse associations or agencies. The lead advocate is responsible for training the associations or agencies and ensuring their input into the PIHP's advocacy plan.

n. Be willing to travel, as needed, to be accessible to meet the needs of members in different areas of the state.

Upon request from the Department, the PIHP must provide evidence of compliance with the job duties mentioned above, such as proof of complaint or grievance investigations and participation in cultural competency training.

2. Staff Requirements and Authority of the FCMH Advocate

a. The FCMH Advocate must be knowledgeable and have experience working with the out-of-home care program and with children in out-of-home placement.

b. The FCMH Advocate(s) must be located in the organizational structure so that they have the authority to perform the functions and duties listed in Section A, 1, a-n above.

c. The PIHP must monitor enrollment levels when evaluating the number of advocates necessary to meet the needs of its FCMH members. The FCMH advocate staffing levels must be submitted to the Department for approval. If the PIHP employs less than one FTE advocate, it must justify to the

satisfaction of the Department why this is sufficient. The Department reserves the right to require the PIHP to increase the number of FTE Advocates if the PIHP demonstrates that their staffing level is inadequate to meet the Advocate duties required in this contract.

d. Staffing levels must be maintained, and solely devoted to the functions and duties listed subsection 1, a-n above throughout the contract term. Changes in the PIHP advocate staffing levels must be approved by the Department 30 days prior to the effective date of the change.

e. The PIHP must regularly evaluate the advocate position, work plan(s), and job duties and allocate an additional FTE if there is significant increase in the PIHP's member population or in the PIHP's service area.

f. If the PIHP contracts with or has a formal MOU for advocacy and/or translation services with associations or organizations within the PIHP's service area, the final responsibility for the advocate position resides within the PIHP. The PIHP must monitor the effectiveness of the associations and/or agencies under contract and may alter their Contract(s) with written notification to the Department.

g. The FCMH Advocate must develop an advocacy work plan, with the timelines and activities specified, and must maintain and modify it as necessary, throughout the contract term.

B. Advance Directives

The PIHP must maintain written policies and procedures related to advance directives. (Written information provided must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.) An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. The PIHP must:

1. Provide written information at the time of PIHP enrollment to all adults receiving medical care through the PIHP. Per 42 CFR 438.3(j), if a member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not he or she has executed an advance directive, the PIHP may give advance directive information to the member's

family or authorized representative. The written information should be regarding:

a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and

b. The individual's right to file a grievance with the DHS, DQA, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the DQA regarding noncompliance with advance directive requirements, and

c. The PIHP's written policies respecting the implementation of such rights.

2. Per 42 CFR 438.3(j), maintain written policies and procedures concerning advance directives which must, at a minimum, do the following:

a. Clarify any differences between any PIHP conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives.

b. Describe the range of medical conditions or procedures affected by the conscientious objection.

c. Document in the individual's medical record whether or not the individual has executed an advance directive.

d. Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

e. Ensure compliance with the requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

f. Provide education for staff and the community on issues concerning advance directives.

g. Provide staff training about PIHP specific policies and procedures related to advance directives.

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

C. Primary Care Provider Assignment

Per 42 CFR § 438.208(b)(1), the PIHP must ensure that every member has a primary care provider or a primary care clinic responsible for coordinating the services accessed by the member. The PIHP must have a process in place to link each member with a primary care provider, a primary care clinic, or a specialist when appropriate based on the preferences and health care needs of the member. The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. The PIHP shall allow members an initial choice of primary care provider or primary care clinic prior to designating one for them.

1. PIHP primary care provider or primary care clinic selection and designation strategy.

   The strategy the PIHP uses to link members to a primary care provider or primary care clinic must take into account the preferences and health care needs of the member.

   The PIHP must ensure members are linked to a primary care provider or primary care clinic that provides culturally appropriate care. Specifically, the provider must be able to relate to the member and provide care with sensitivity, understanding, and respect for the member's culture.

   As part of the primary care provider or primary care clinic selection and designation strategy, PIHPs must include the following:

   a. A process for linking all members to an appropriate primary care provider or primary care clinic (or specialist for members identified with chronic conditions), including a step in which members are given the opportunity to choose their PCP. PIHPs shall ensure care is coordinated between the primary care provider, primary care clinic and/or specialists, which includes the development of a patient-centered and comprehensive treatment plan.

b. Communication methods that notify members of their primary care provider, primary care clinic or specialist to ensure the member utilizes primary care and encourages members to keep their scheduled appointments.

c. The PIHP will evaluate the effectiveness of their primary care provider selection and designation strategy to ensure quality of care.

2. Changing and lock-in PCP Designation

The PIHP must permit members to change primary providers at least twice in any year, and to change primary care providers more often than that for just cause. Just cause includes a lack of access to quality, culturally appropriate health care. The PIHP must treat a request for change in primary care provider due to just cause as a grievance, and adhere to the notification and timeframe requirements detailed in the *Member Grievances and Appeals Guide.*

3. Data sharing with PCP

The PIHP must have a process to share information on members with their primary care provider on a regular basis. The information must include, but is not limited to, utilization data and prescription drug data such as from the pharmacy extract provided by the Department.

D. Member Appointment Compliance

The PIHP must have a strategy in place to reduce the number of members who do not show up for scheduled appointments. This strategy must include outreach and education components for both members and providers. DHS may request additional information from PIHPs on member appointment compliance during the contract period.

E. Choice of Health Care Professional

The PIHP must offer each member covered under this Contract the opportunity to choose a primary care provider affiliated with the PIHP, to the extent possible and appropriate. If the PIHP designates a primary care provider to a member, then the PIHP must notify members of the designation. If the PIHP has reason to lock in a member to one primary provider in cases of difficult care coordination, the PIHP must submit a written request in advance of such lock-in to the PIHP's managed

care analyst. Culturally appropriate care in this section means care by a provider who can relate to the member and who can provide care with sensitivity, understanding, and respect for the member's culture.

F. Coordination and Continuation of Care

The PIHP must have a system in place to ensure well-managed patient care, including at a minimum:

1. Management and integration of health care through primary provider/gatekeeper/other means.

2. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.

3. Systems to ensure provision of care in emergency situations, including an education process to ensure that members know where and how to obtain medically necessary care in emergency situations.

4. Systems that clearly specify referral requirements to providers and subcontractors. The PIHP must keep copies of referrals (approved and denied) in a central file or the patient's medical records.

5. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and substance abuse providers who are not subcontracted with the PIHP. The determination must be made within 10 business days of the member's request. If the PIHP determines that the member does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.

6. Systems to ensure referrals and coordination for mental health and substance abuse services between the health care manager, the DMCPS or the county child welfare agency, the primary care physician and the mental health and substance abuse providers.

7. Systems to ensure coordination with existing programs for children with special health care needs through the Milwaukee Public Schools (MPS) and other school systems in its service area.

8. The PIHP must comply with the Department's transition of care policy to ensure that members transitioning to the PIHP from FFS Medicaid or transitioning from one Managed Care Entity 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. The Department's transition of care policy can be found at: https://www.dhs.wisconsin.gov/publications/p02364.pdf.

G. Cultural Competency and Culturally and Linguistically Appropriate Services (CLAS) Standards

1. Mission, vision, and goals

   It is DHS' vision that all members who receive health care in Wisconsin will routinely and systematically receive respectful, culturally competent and confidential services. Such services will be those that are known to be effective in promoting health equity and reducing health disparities as advocated for in the Institute of Medicine Report (2002) and enhanced in the Affordable Care Act (2010). DMS is working to include cultural competence strategies and goals in major projects and in the daily activities of the Division.

2. National Culturally and Linguistically Appropriate Services (CLAS) Standards[2]

   The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to implement culturally and linguistically appropriate services. The National CLAS Standards include:

   a. Principal Standard

      1) Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

   b. Governance, Leadership and Workforce

[2] National CLAS Standards - https://www.thinkculturalhealth.hhs.gov/clas/standards

1) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

2) Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

3) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

c. Communication and Language Assistance

1) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

2) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

3) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

4) Provide easy-to-understand print and multimedia and signage in the languages commonly used by the populations in the service area.

d. Engagement, Continuous Improvement, and Accountability

1) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.

2) Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

3) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

4) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

5) Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

6) Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

7) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

3. In support of DMS's efforts to promote the delivery of services in a culturally competent manner to all members, the PIHP must incorporate the National CLAS standards into organizational practices and the delivery of services with a particular focus on care management services for BadgerCare Plus and Medicaid SSI members. As part of PIHP certification and recertification, the PIHP must:

4. Develop and submit policies and procedures demonstrating how all National CLAS standards have been incorporated into organizational practices and delivery of services as part of certification. The PIHP must address the special health needs of members who are low income or members of population groups needing specific culturally competent services. The PIHP must incorporate in its policies, administration and service practice elements such as:

   a. Recognizing members' beliefs,

   b. Addressing cultural differences in a competent manner, and

c. Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds.

d. Permitting members to change provider's based on the provider's ability to provide culturally competent services.

e. Culturally competent grievance and appeal protocols.

The PIHP must have specific policy statements on these topics and communicate them to subcontractors as well as provide a strategic plan upon request by the Department.

The PIHP must encourage and foster cultural competency among providers. When appropriate the PIHP must permit members to choose providers from among the PIHP's network based on linguistic/cultural needs. The PIHP must permit members to change primary care providers based on the provider's ability to provide services in a culturally competent manner. Members may submit grievances to the PIHP and/or the Department regarding their inability to obtain culturally appropriate care.

H. Health Education and Disease Prevention

The PIHP must inform all members of ways they can maintain their own health and properly use health care services.

The PIHP must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:

1. An individual responsible for the coordination and delivery of services.

2. Information on how to obtain these services (locations, hours, telephone numbers, etc.)

3. Health-related education materials in the form of printed, audiovisual and/or personal communication.

Health-related educational materials produced by the PIHP must be at a sixth grade reading comprehension level and reflect sensitivity to the diverse cultures served. Also, if the PIHP uses material produced by other entities, the PIHP must review these materials for grade level comprehension and sensitivity to the diverse cultures served. Finally, the PIHP must make all reasonable efforts to locate and use culturally appropriate health-related material.

4. Information on recommended checkups and screenings, and prevention and management of disease states that affect the general population. This includes specific information for persons who have or who are at risk of developing such health problems as hypertension, diabetes, STD, asthma, breast and cervical cancer, osteoporosis and postpartum depression.

5. Health education and disease prevention programs, including injury control, family planning, teen pregnancy, sexually transmitted disease prevention, prenatal care, nutrition, childhood immunization, substance abuse prevention, child abuse prevention, parenting skills, stress control, postpartum depression, exercise, smoking cessation, weight gain and healthy birth, postpartum weight loss, and breast feeding promotion and support. (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by BadgerCare Plus and/or Medicaid SSI.)

6. The PIHP should offer a discrete substance abuse screening and prevention program for members at risk of substance abuse disorder. Wisconsin Medicaid covers a screening, brief intervention, and referral to treatment benefit (SBIRT) for all members (see ForwardHealth online handbook, Topic #8297) and a similar benefit for pregnant women (see Topic #4442).

7. Promotion of the health education and disease prevention programs, including use of languages understood by the population served, and use of facilities accessible to the population served.

8. Information on and promotion of other available prevention services offered outside of the PIHP, including child nutrition programs, parenting classes, programs offered by local health departments and other programs.

9. Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for Women, Infants, and Children

(WIC) and relevant medical information to the WIC program. More information about the WIC program as well as list of the local WIC agencies can be found on the WIC website (http://www.dhs.wi.gov/wic/).

ARTICLE VIII: Provider Appeals

VIII. PROVIDER APPEALS

Providers, who have attempted unsuccessfully to resolve payment disputes directly with the PIHP through the PIHP's established Appeal process, may choose to pursue resolution directly with the Department through the appeal process. The provider has 60 calendar days from the PIHP's final appeal decision to submit all required information pertaining to the case(s) in question. If, based on the preliminary information provided by the provider, the Department determines that there is insufficient evidence to overturn the original denial, the Department will not pursue additional contact with the PIHP or the provider and uphold the denial. If, however, the Department determines that the provider's appeal necessitates further review, it will seek rebuttal from the PIHP.

The Department may send an official Request for Additional Information notice to the PIHP or the provider. The Additional Information notice and requested documents must be returned to the Department, within 14 calendar days (unless 21 calendar days is granted by DHS due to volume of appeals), via US mail, fax or electronically if sent over a secure network. If the PIHP fails to submit the requested information by the date required by the Department, the Department will overturn the original denial and compel the PIHP to pay the claim. The Department will uphold the original denial if the provider fails to provide the requested information as outlined in ForwardHealth Online Handbooks.

The Department has 45 days from the date of receipt of all written comments to inform the provider and the PIHP of the final decision. If the Department's decision is in favor of the provider, the PIHP will pay provider(s) within 45 days of receipt of the Department's final determination. The PIHP and the provider must accept the Department's final decision regarding appeals of disputed claims. A reconsideration of a final decision will only be made if an error has been made or there was a misrepresentation of facts. The Department will review the appeal documents and make a Final Decision based on the contract (both the DHS-C4K contract and the PIHP-provider contract, if submitted, will be used to make the decision). The Department does not adjudicate appeals for clinical level of care (e.g. observation vs. inpatient) provided to the member, nor does the Department review the results of contractually agreed upon PIHP reviews of claims or medical records. As these actions are a contractual requirement, the PIHP review decisions are not appealable to DHS.

The following items outline the various responsibilities of the PIHP and the provider when an appeal is made to the Department:

A. PIHP Responsibility

1. The PIHP must have adequate staff available to train and support providers on resources available in order to prevent claims processing issues and denials. Refer to Article XI, B.7. The PIHP must perform ongoing monitoring of provider appeal numbers and perform provider outreach and education/training on trends to prevent future denials/partial payments, thus reducing future provider appeals to the PIHP and to the Department.

   The PHIP must:

   a. Provide information to network providers of any PIHP-facilitated training opportunities which may reduce denied claims and provider appeals.

   b. Ensure that providers know, understand and comply with all business standards regarding completion and submission of accurate, correct and timely claims. This includes correct coding and maintenance of medical record.

   c. Grant providers access to all online technology and communication offered by the PIHP (i.e. not limited to claim and appeal submission, policy resources, PIHP website). Electronic notification from the PIHP constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.

   d. Encourage providers to access and use the ForwardHealth Portal, including online Handbooks and Provider Updates.

2. The PIHP must inform providers, in writing at the time they enter into a contract, of the toll-free number for members to file appeals as well as the provider's and subcontractor's right to appeal a denied/reduced payment, or payment recoupment.

3. PIHPs must provide a clear process for claim dispute escalation which must include the below elements in their contract or MOU with providers, in their provider manual, on the PIHP website, or through written notification for non-contracted providers. In cases of denial of payment, written (or HIPAA 835 transaction) notification must occur on the date the payment was denied.

a. Language distinguishing “resubmission of a claim”, “reconsideration of a claim” and “appeal of a claim” as defined in Article I with a clear indication of level of action being taken. A “resubmission of a claim” or “reconsideration of a claim” is not a formal appeal.

~~b.~~ Each page of the payment remittance document must include the date the denial action was taken and specific explanation of the payment amount or a specific reason for nonpayment.

c. A statement regarding the provider’s rights to appeal to the PIHP, including the timeline.

d. The name of the person and/or function at the PIHP to whom the provider appeal should be submitted.

e. The appeal response must clearly state why the claim will not be paid, and include all contract language that supports the denial/recoupment of payment.

4. The PIHP must adhere to the following timelines

a. The PIHP must accept written appeals, including appeals submitted via PIHP automated programming from providers submitted within 60 calendar days of the PIHP’s initial payment and/or nonpayment notice, or notice of recoupment. In exceptional cases, the Department may override the PIHP’s time limit for submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably.

b. The PIHP must respond in writing within 45 calendar days from the receipt of the appeal letter. If the PIHP fails to respond within 45 calendar days, or if the provider is not satisfied with the PIHP’s response, the provider may seek a final determination from the Department.

c. The PIHP must provide an explanation of the process the provider should follow to appeal the PIHP’s decision to the PIHP once all claim reconsideration action has been exhausted, which includes the following steps:

1) Submit a completed PIHP designated Appeal form or a separate letter clearly marked “appeal”. The PIHP Appeal form

must include a date field to indicate the date the appeal was submitted.

2) Include the provider's name, date of service, date of billing, date of payment and/or nonpayment, member's name and Medicaid ID number.

d. Clearly state the reason(s) the claim is being appealed, including all documentation necessary to support the reason.

e. Clearly indicate if medical records are required and need to be submitted with the appeal.

f. Address the letter or form to the person and/or function at the PIHP that handles provider appeals.

g. Send the appeal to the PIHP by the contracted timely filing deadline, or at minimum, within 60 calendar days of the initial denial or payment notice.

h. The PIHP must provide a statement advising the provider of their right to appeal to the Department if the provider is not satisfied with the PIHP's decision on the appeal or the PIHP fails to respond to the appeal within 45 calendar days from the date of the receipt of the appeal.

5. The PIHP must submit to the Department, on a quarterly basis, a provider appeal log and data summary containing the following:

a. Name of the provider;
b. Type of service;
c. Date of Services
d. Amount of the claim;
e. Date the claim was denied;
f. Date of receipt of the appeal
g. Date of Decision
h. Appeal decision by the PIHP;
i. Reason for the decision;
j. Reason for the decision;
k. Total number of appeals denied for the reporting period;
l. Total number of appeals received year start to date of report;

m. Percent of appeals denied year star to date of report as percent of total appeals received; and
n. Percent of appeals upheld year start to date of report as percent of total appeals received.

The provider appeal log and data summary must be submitted to the Department within 45 days of the end of each quarter.

B. Provider Responsibility

The PIHP should educate providers of their responsibilities:

1. Receive access to and use the ForwardHealth Portal, including online Handbooks and Provider Updates in order to understand and correctly bill a covered service.

2. Access online technology and communication/trainings offered by the PIHP (i.e. not limited to claim and appeal submission, policy resources, PIHP website). Electronic notification from the PIHP constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.

3. Understand and comply with all business standards regarding completion and submission of accurate, correct and timely claims. This includes correct coding, maintenance of medical record and correct coordination with other insurance plans.

4. To reserve the right to appeal to the Department, the Medicaid providers must exhaust all appeal rights with the PIHP if they disagree with the PIHP's appeal response. Failure to follow the provider appeal process with the PIHP will result in the appeal denial being upheld.

5. Appeals to the Department must be submitted in writing within 60 calendar days of the date on the PIHP's final decision notice or, in the case of no response, within 60 calendar days from the 45 calendar day timeline allotted the PIHP to respond.

6. A decision to uphold the PIHP's original payment denial or to overturn the denial will be made based on the documentation submitted for Departmental review. Failure to submit the required documentation or submitting

incomplete/insufficient/illegible documentation may lead to an upholding of the original denial. The decision to overturn the PIHP's denial must be clearly supported by the documentation submitted for review.

7. Providers may use the Department's form when submitting an appeal for State review. All elements of the form must be completed or listed in the letter if the form is not used. The form with instructions is available at the following website: https://www.dhs.wisconsin.gov/library/f-12022.htm

8. Providers are required to submit legible copies of all of the following documentation, regardless of whether the Managed Care Program Provider Appeal form or their own appeal letter is used. Incomplete appeals will not receive Departmental review and the denial will be upheld. The appeal packet must contain:

    a. A copy of the original claim submitted to the PIHP. If applicable, include a copy of all corrected claims submitted to the PIHP.

    b. A copy of all of the PIHP's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.

    c. A copy of the provider's written appeal to the PIHP.

    d. A copy of the PIHP response to the appeal.

    e. A copy of the medical record for appeals regarding coding issues or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication of where supporting information is found, will not be reviewed. Large documents should be submitted on a CD.

    f. A copy of any contract language that supports the appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed and the appeal denial upheld. Contract language will be used to determine compliance.

    g. Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).

Appeals regarding Care4Kids to the Department can be faxed or mailed to:

BadgerCare Plus and Medicaid SSI
Managed Care Unit – Provider Appeal
P.O. Box 6470
Madison, WI 53716-0470
Fax Number: 608-224-6318

Providers should notify ForwardHealth if the PIHP subsequently overturns their original denial and reprocesses and pays the claim for which an appeal has been submitted. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record and the appeal withdrawn.

Providers can also call Managed Care Unit at (800) 760-0001, option 1, to check on the status of a submitted appeal.

IX. MEMBER GRIEVANCES AND APPEALS

The PIHP is required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F, as contained in the *Member Grievances and Appeals Guide*, dated December 2021, which is fully incorporated herein by reference.

ARTICLE X: Quality Assessment Performance Improvement

X. QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The PIHP Quality Assessment Performance Improvement (QAPI) program must conform to the requirements of 42 CFR Part 438, Medicaid Managed Care Requirements, Subpart E, Quality Measurement and Improvement. At a minimum, the program must comply with 42 CFR 438.330 which states that the PIHP must:

- Conduct performance improvement projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time in clinical care areas.
- Collect and submit performance measurement data.
- Have in effect mechanisms to detect both underutilization and overutilization of services.
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

A. QAPI Program

The PIHP must have a comprehensive QAPI program that protects, maintains and improves the quality of care provided to FCMH members. The QAPI program should include an ongoing comprehensive quality assessment and performance improvement strategy that supports integrated care and comprehensive service delivery. The PIHP must collect and report on data that permits an evaluation of coordination of care and integrated complex care management on individual-level outcomes, experience of care outcomes, and quality of care outcomes at both the individual and population levels.

The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., incorporation of trauma-informed care, comprehensive/complex care coordination, transitional care across settings) are studied and prioritized for performance improvement and/or development of practice guidelines. Standardized quality indicators must be used where appropriate to ensure achievement of minimum performance levels, assess improvement, monitor adherence to established guidelines, and identify patterns of over and underutilization. Measures will be defined in the Annual Foster Care Medical Home Quality Guide.

1. The PIHP must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its FCMH population.

2. The PIHP must incorporate access for medical home practice sites to an information system that supports ongoing communication and follow-up of health care information, as well as the commitment of resources to monitor quality and outcomes, including periodic submission and analysis of clinical and administrative health care data for the purpose of utilization monitoring and continuous quality improvement.

3. The PIHP must document all aspects of the QAPI program and make it available to the Department for review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the PIHP is in compliance with contract requirements. The review and audit may include:

    a. On-site visits;
    b. Staff and member interviews;
    c. Medical record reviews;
    d. Review of all QAPI procedures, reports, committee activities, including credentialing and re-credentialing activities;
    e. Corrective actions and follow-up plans;
    f. Peer review process;
    g. Review of the results of the member satisfactions surveys; and
    h. Review of staff and provider qualifications.

4. The PIHP must have a written QAPI work plan that is ratified by the board of directors and outlines the scope of activity and the goals, objectives, and time lines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results from member satisfaction surveys and performance measures. The QAPI work plan must include:

    a. Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time;
    b. Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the Department and to the Department's External Quality review Organization (EQRO), MetaStar.

5. The PIHP governing body is ultimately accountable to the Department for the quality of care provided to FCMH members. Oversight responsibilities of the governing body include, at a minimum:

    a. Approval of the overall QAPI program;

    b. An annual QAPI plan, designating an accountable entity or entities within the organization to provide oversight of QAPI;

    c. Review of written reports from the designated entity on a periodic basis, which include a description of QAPI activities;

    d. Progress on objectives, and improvements made;

    e. Formal review on an annual basis of a written report on the QAPI program; and

    f. Directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the PIHP.

6. The QAPI committee must be in an organizational location within the PIHP such that it can be responsible for all aspects of the QAPI program. The committee membership must be interdisciplinary and be made up of both providers and administrative staff of the PIHP, including:

    a. Persons with expertise in the care of children with chronic conditions

    b. Persons who are knowledgeable and familiar with the needs of children in out-of-home placement

    c. A variety of health professions (e.g., pediatricians, physical therapy, nursing, etc.)

    d. Qualified professionals specializing in mental health and substance abuse on a consulting basis

    e. Qualified professionals specializing in dental care on a consulting basis when an issue related to this area arises

f. A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.)
g. An individual with specialized knowledge and experience with persons with disabilities

h. Child welfare social workers

i. Other persons who work with children in out-of-home placement in counties in the PIHP's service area

j. PIHP management or governing body

7. The PIHP must also have a system to receive input from FCMH members, out-of-home care providers and/or birth parents on quality related issues, document the input received, the PIHP's response to the input, including a description of any changes or studies it implemented as a result of the input, and any associated feedback to members in response to input received. The Department will review the PIHP's system to ensure that consumers are involved in the QAPI process.

8. The PIHP must demonstrate the capacity for reporting on enrollee satisfaction, including caregiver, provider and cross-system level input/feedback where appropriate.

9. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body. All documentation and minutes reflecting activities and meetings of the Committee must be available to the Department upon request.

10. QAPI activities of the PIHP providers and subcontractors, if separate from the PIHP's QAPI activities, must be integrated into the overall FCMH QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, must be incorporated into all provider and subcontractor contracts and employment agreements. The FCMH QAPI program shall provide feedback to the providers and/or subcontractors regarding the integration of, operation of, and corrective actions necessary in provider and/or subcontractor QAPI efforts. Other management activities (utilization management, risk management, customer service, complaints and grievances, etc.) must be integrated with the QAPI program. Physicians and

other health care practitioners and institutional providers must actively cooperate and participate in the PIHP's quality activities.

The PIHP remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the PIHP delegates any activities to contractors, the conditions listed in the "Delegations of Authority" section must be met.

11. There must be evidence that PIHP management representatives and providers participate in the development and implementation of the QAPI plan. This provision shall not be construed to require that PIHP management representatives and providers participate in every committee or subcommittee of the QAPI program.

12. The PIHP must designate a medical director to oversee the FCMH quality improvement program. The designated individual shall be accountable for the QAPI activities of the PIHP's own providers, as well as the PIHP's subcontracted providers.

13. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to: monitoring and evaluation of important aspects of care and services; utilization monitoring; facilitating appropriate use of preventive services; monitoring provider performance; provider credentialing; involving members in QAPI initiatives; and conducting performance improvement projects.

    Written documentation listing the staffing resources that are directly under the organizational control of the person who is responsible for QAPI (including total FTEs, percent of time dedicated to QAPI, background and experience, and role) must be available to the Department upon request.

B. Monitoring and Evaluation

1. The PIHP in conjunction with the DHS, DCF, DMCPS, county child welfare agencies in the PIHP's service area, and their designees, shall develop performance measures that meet the following objectives:

    a. <u>Integrated and Comprehensive Health Service Delivery</u>. The PIHP will deliver coordinated, comprehensive health care including physical,

behavioral and oral health care that is tailored to each FCMH member's individualized needs.

The health system must have sufficient capacity and informatics to support and implement multi-directional communication and quality reporting at the provider, plan, and enrollee level, including clinically integrated community agencies and providers external to the health system where applicable.

b. Timely Access. The PIHP will provide timely access to a full range of developmentally appropriate services. The needs of the individual child will be assessed by an out-of-home care health screen within 2 business days of entering out-of-home care (i.e. a child removed from the home at 4:00pm on Wednesday will receive an out-of-home care health screen by end of the business day on Friday), followed by a comprehensive health assessment within 30 days of enrollment. Children will receive well child check-ups at the increased frequency for children in out-of-home care recommended by the American Academy of Pediatrics. All other identified medical, developmental, behavioral/ mental health, and oral health needs of the child will be met in an effective and timely manner.

c. High Quality and Flexibility of Care. The PIHP will coordinate, organize, and facilitate care in order to deliver services in an effective and efficient manner. The PIHP will be expected to utilize trauma-informed and evidence-informed practices. The PIHP will have the flexibility to deliver services to its members in the most effective manner, including in home settings.

d. Transitional Planning and Cross-System Coordination. Children in out-of-home placement will receive transitional planning and follow-up services necessary to assure continuity of health care after achieving permanency or aging out of out-of-home care. The PIHP will coordinate with other systems providing health and developmental services, including the local school system, the county-administered Birth - 3 and Children's Long-Term Support Waiver programs, and county-funded mental health services.

e. Well-Being Outcomes. The PIHP will support children to have better physical health, improved developmental, behavioral and mental health outcomes, positive permanency outcomes, and enhanced resiliency.

f. Psychotropic Medication Management. The PIHP will establish case management strategies to link psychotropic medication management at the medical home provider level to an individualized integrated physical and behavioral health care plan.

2. The PIHP must demonstrate the capacity for tracking and reporting on:

   a. Uniform and complete encounter data for all covered services as specified by the state, including case planning and care coordination information

   b. Health care data and outcomes at both the individual child and aggregate systems levels.

   c. Specific performance measurement data using standard metrics/performance measures required by the state.

   d. Priority and non-clinical areas relevant to children in out-of-home care as specified by the state for quality improvement

   e. The rates and types of psychotropic medication usage among enrollees, as well as identification of non-standard and/or inappropriate prescribing practices based on analysis of state-level data regarding the characteristics of and variations in psychotropic prescribing patterns relative to integrated health system enrollees.

   f. All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made, which must be reported by all providers to the PIHP per 42 CFR s.438.6(f)(2)(ii).

3. The Department will evaluate the PIHP's performance using approved performance measures, based on PIHP-supplied encounter data and other relevant data (for selected measures). Evaluation of PIHP performance on each measure will be conducted on timetables determined by the Department. The technical specifications for each measure will be established by the Department with the PIHP and other stakeholder input.

4. Unless otherwise noted within a specific performance measure, the Department may specify minimum performance levels and require the PIHP to develop a plan to respond to those areas that fall below the minimum

performance levels. Additions, deletions or modifications to the Performance Measures must be mutually agreed upon by the parties. The Department will give 90day notice to the PIHP of its intent to change any of measures, technical specifications or goals. The PIHP shall have the opportunity to comment on the measure specifications, goals and implementation plan within the 90-day notice period. The Department reserves the right to require the PIHP to report such performance measure data as may be deemed necessary to monitor and improve PIHP-specific or program-wide quality performance.

5. Provider performance must be measured against practice guidelines and standards adopted by the QAPI Committee. Areas identified for improvement must be tracked and corrective actions taken when warranted. The effectiveness of corrective actions must be monitored until problem resolution occurs. Reevaluation must occur to ensure that the improvement is sustained.

6. The PIHP must use persons with knowledge and experience working with children in out-of-home placement to evaluate the data on clinical performance, and multi-disciplinary teams to analyze and address data on systems issues.

7. The PIHP must mandate provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR s. 434.6(a)(12) and 42 CFR s. 447.26. The PIHP must report all identified provider-preventable conditions through its encounter data.

   Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

   Other provider-preventable conditions for non-payment are identified as:
   a. Wrong surgical or other invasive procedure performed on a patient;
   b. Surgical or other invasive procedure performed on the wrong body part;
   c. Surgical or other invasive procedure performed on the wrong patient.

8. The PIHP must also monitor and evaluate care and services in certain priority clinical and non-clinical areas relevant to children in out-of-home placement specified by the Department, including incorporation of trauma-informed principles and treatment(s) into provider education, health system policies,

and service delivery. Non-clinical areas of monitoring and evaluation must include member satisfaction.

9. The PIHP must make documentation available to the Department upon request regarding quality improvement and assessment studies on plan performance, which relate to the FCMH population. See reporting requirements in "Performance Improvement Priority Areas and Projects."

10. The PIHP must develop or adopt practice guidelines in accordance with 42 CFR 438.236(b) and meet the following requirements:
    a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.

    b. Consider the needs of the PIHP members.

    c. Are adopted in consultation with network providers.

    d. Are reviewed and updated periodically as appropriate.

    The PIHP must disseminate the practice guidelines to providers and, upon request to members and potential members.

    Decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply must be consistent with the guidelines.

11. The State will arrange for an independent, external review of the quality of services delivered under the PIHP's contract with the State. The review will be conducted for the PIHP contractor on an annual basis in accordance with Federal requirements described in 42 CFR 438, Subpart D, Quality Measurement and Improvement; External Quality Review. The entity which will provide the annual external quality reviews shall not be a part of the State government, PIHPs, or an association of any PIHPs.

C. Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing)

1. The PIHP must have written policies and procedures for provider selection and qualifications. Initial credentialing consideration must be submitted to the FCMH through a written application. Each practitioner, including each member of a contracting group, must provide documentation of:

a. Primary source of licensure verification;
b. Disciplinary status;
c. Eligibility for payment under the FCMH; and
d. Provider Number or National Provider Identifier.

The PIHP must complete the credentialing process within 180 days after receipt of all required documents from the providers.

The Wis. Adm. Code, Ch. DHS 105 and the ForwardHealth Handbook, contains information regarding provider certification requirements. The FCMH must require every physician providing services to members to have a Provider Number or National Provider Identifier (NPI). The Department requires that Medicaid-enrolled providers undergo periodic revalidation. During revalidation, providers update their enrollment information with ForwardHealth, and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers who fail to revalidate are terminated from Wisconsin Medicaid.

The PIHP shall not credential or recredential individual providers employed by a Narcotic Treatment Service (NTS) certified under DHS 75.15. These providers must be enrolled in the Wisconsin Medicaid Program (i.e., "certified") in order to be reimbursed for services provided to Wisconsin Medicaid members per DHS 105. The PIHP can rely upon NTS providers' status as Medicaid-enrolled in lieu of credentialing at the provider level. The PIHP may have credentialing and recredentialing policies for facilities certified under DHS 75.15.

The PIHP may not employ or contract with providers debarred or excluded in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

2. The PIHP must periodically monitor (no less than every three years) the provider's documented qualifications to ensure that the provider still meets the PIHP's specific professional requirements. This includes ensuring that Medicaid enrolled providers have undergone the Department's periodic revalidation procedure. Providers must update their enrollment information with ForwardHealth and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Term of Participation. Failure to revalidate with the Department will result in termination from Wisconsin Medicaid.

3. The PIHP must also have a mechanism for considering the provider's performance. The recredentialing method must include updating all the information (except medical education) utilized in the initial credentialing process. Performance evaluation must include information from the QAPI system, reviewing member complaints, and the utilization management system.

4. The selection process must not discriminate against providers such as those serving high-risk populations, or specialize in conditions that require costly treatment. The PIHP must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the PIHP's network.

   If the PIHP declines to include groups of providers in its network, the PIHP must give the affected providers written notice of the reason for its decision.

5. If the PIHP delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.

6. The PIHP must have a formal process of peer review of care delivered by providers and active participation of the PIHP's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The PIHP must supply documentation of its peer review process upon request.

7. The PIHP must have written policies that allow it to suspend or terminate any provider for quality deficiencies. There must also be an appeals process available to the provider that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC 11101 etc. Seq.).

    a. The FCMH must terminate a provider for cause in all the following circumstances:
        i. Criminal Conviction. The provider or any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the

department determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. 42 CFR § 455.416(b).

ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a).

iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within 30 days of a CMS or the Department request, unless the Department determines that the termination or denial of enrollment is not in the best interests of the Medicaid program and the Department documents that determination in writing. 42 CFR § 455.416(e).

iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider failed to submit timely and accurate information, unless the Department determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. 42 CFR § 455.416(d).

v. Onsite Review. The provider fails to permit access to provider locations for any site visit, unless the Department determines the termination is not in the best interests of the Medicaid program. 42 CFR § 455.416(f).

vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment.

The names of individual practitioners and institutional providers who have been terminated from the HMO provider network as a result of quality issues must be immediately

forwarded to the Department and reported to other entities as required by law (42 USC 11101 et. Seq.).

b. The FCMH may terminate a provider for cause in all the following circumstances:

   i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

   ii. Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension.

   iii. False or Misleading Information. The provider certified as "true" false or misleading information on their enrollment application to be enrolled or maintain enrollment in the State Medicaid program. Please note that CMS considers this authority mandatory under the Medicare program. 42 CFR § 455.416(g)(1).

   iv. Improper Prescribing Practices. The Department determines that a provider has a pattern of practice of prescribing drugs that is abusive or represents a threat to the health and safety of Medicaid beneficiaries or the pattern or practice of prescribing fails to meet Medicaid requirements.

   v. Inability to Verify. The Department cannot verify the identity of any provider applicant. 42 CFR § 455.416(g)(2).

   vi. Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.

   vii. Noncompliance. The provider is determined to not be in compliance with enrollment requirements established by the

Department. This does not include license expiration.

viii. Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration.

ix. Onsite Review. The provider failed onsite review due to one of the following circumstances: no longer operational to furnish Medicaid covered items or services, or otherwise fails to satisfy any Medicaid enrollment requirement

x. Other. Any other reason that poses a threat of fraud, waste, or abuse to the Medicaid program.

xi. Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs.

xii. Provider Conduct. The provider or any owner, managing employee, Medicaid director as defined in 42 C.F.R. § 1001.2 of the provider is excluded from the Medica or Medicaid programs.

8. The names of individual practitioners and institutional providers who have been terminated from the PIHP provider network as a result of quality issues must be immediately forwarded to the Department and reported to other entities as required by law (42 USC 11101 et. Seq.).

9. The PIHP must determine and verify at specified intervals that:

    a. Each provider, other than an individual practitioner is licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and

    b. The PIHP verifies if the provider claims accreditation, or is determined by the PIHP to meet standards established by the PIHP itself.

10. These standards do not apply to:

a. Providers who practice only under the direct supervision of a physician or other provider, and

b. Hospital-based providers such as emergency room physicians, anesthesiologists, and other providers who provide services only incident to hospital services.

These exceptions do not apply if the provider contracts independently with the PIHP.

D. Member Feedback on Quality Improvement

1. The PIHP must have a process to maintain a relationship with its members that promotes two way communications and contributes to quality of care and service. The PIHP must treat members with respect and dignity.

2. The PIHP must demonstrate monitoring of member satisfaction as an input to improving quality of care and service.

3. The PIHP is encouraged to find additional ways to involve members in quality improvement initiatives and in soliciting member feedback in quality of care and services the PIHP provides. Other ways to bring members into the PIHP's efforts to improve the health care delivery system include but are not limited to focus groups, member advisory councils, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services. All efforts to solicit feedback from members must be approved by the Department.

E. Medical Records

1. Per 42 CFR § 438.208(b)(5), the PIHP must have policies and procedures for participating provider health records content and documentation that have been communicated to providers and a process for evaluating its providers' medical records based on the PIHP's policies. The PIHP should encourage use of Certified Electronic Health Record Technology (CEHRT) by clinicians for documenting and sharing clinical information as well as use of the Office of the National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care. These policies must also address patient confidentiality, data organization and completeness, tracking, and important aspects of

documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The PIHP must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must include information with respect to disclosure of member-identifiable medical record and/or enrollment information and specifically provide:

a. That members may review and obtain copies of medical records information that pertains to them.

b. That policies above must be made available to members upon request.

2. Patient medical records must be maintained in an organized manner (by the PIHP, and/or by the PIHP's subcontractors) that permits effective patient care, reflect all aspects of patient care and be readily available for patient encounters, administrative purposes, and Department review.

3. Because the PIHP is considered a contractor of the state and therefore (only for the limited purpose of obtaining medical records of its members) entitled to obtain medical records according to Wis. Adm. Code, DHS 104.01(3), the Department requires Medicaid-enrolled providers to release relevant records to the PIHP to assist in compliance with this section. The PIHP that has not specifically addressed photocopying expenses in their provider contracts or other arrangements, are liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.

4. The PIHP must have written confidentiality policies and procedures in regard to individually-identifiable patient information. Policies and procedures must be communicated to PIHP staff, members, and providers. The transfer of medical records to out-of-plan providers or other agencies not affiliated with the PIHP(except for the Department) are contingent upon the receipt by the PIHP of written authorization to release such records signed by the member or, in the case of a minor, by the member's parent, guardian or authorized representative.

5. The PIHP must have written quality standards and performance goals for participating provider medical record documentation and be able to demonstrate, upon request of the Department, that the standards and goals have been communicated to providers. The PIHP must actively monitor compliance with established standards and provide documentation of

monitoring for compliance with the standards and goals upon request of the Department.

6. Health records must be readily available for PIHP-wide Quality Assessment/Performance Improvement (QAPI) and Utilization Management (UM) activities.

   For health records and any other health and enrollment information that identifies a particular member, the PIHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

7. The PIHP must have adequate policies in regard to transfer of medical records to ensure continuity of care. When a member switches providers, it is the responsibility of the PIHP to facilitate and/or broker the transfer of medical records between a member's previous and current providers upon provider request.

   The PIHP policy regarding transfer of medical records to ensure continuity of care policies must include:

   a. When members are treated by more than one provider.

   b. The provider-to-provider transfer may be facilitated and/or brokered between the PIHP on behalf of providers.

   c. How provider requests for records are received and processed.

   d. The process for transmitting and receiving provider records to providers.

   e. This may include transfer to DMCPS or county child welfare agencies in the service area, subject to the receipt of a signed authorization form as specified above.

   Direct provider-to-provider exchanges are permitted if both providers are in agreement. It is then the responsibility of the agreeing providers to administrate the member medical record transfer, including PIHP notification of the transfer.

The Department requires PIHP participation in Wisconsin Statewide Health Information Network (WISHIN) to facilitate exchange of medical records between health plans and providers. The Department considers PIHPs compliant with the medical record requirements in Article X (E)(7)(a)-(e) by participating in WISHIN. All PIHPs must participate in WISHIN, specifically including submission of member roster as specified by WISHIN, access to WISHIN Pulse, receive PAR reports, and access to Admissions, Discharges, and Transfer (ADT) data.

8. The PIHP shall use its best efforts to assist members and their authorized representatives in obtaining complete records, including progress notes, within 10 working days of the record request.

9. Minimum medical record documentation per chart entry or encounter must conform to the Wis. Adm. Code, Chapter DHS 106.02(9)(b) medical record content.

F. Utilization Management (UM)

1. The PIHP and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity, and processing requests for initial and continuing authorization of services (42 CFR 438.210(b)(1)).

   The PIHP must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than what is used in the State Medicaid program as set forth in, Wis. Adm. Code DHS 101.03(96m), including any quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other published State policy and procedures. Documentation of denial of services must be available to the Department upon request.

   Pursuant to 42 CFR § 438.210(b)(2), the PIHP must:

   a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

   b. Consult with the requesting provider for medical services when appropriate.

When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The PIHP may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or results in the under-utilization of services.

2. If the PIHP delegates any part of the UM program to a third party, the delegation must meet the requirements in this Contract.

3. If the PIHP utilizes telephone triage, nurse lines or other demand management systems, the PIHP must document review and approval of qualification criteria of staff and of clinical protocols or guidelines used in the system. The system's performance will be evaluated annually in terms of clinical appropriateness.

4. The PIHP's policies must specify time frames for responding to requests for initial and continued service authorizations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the PIHP must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

    a. Within the time frames specified, the PIHP must give the member and the requesting provider written notice of:

        1) The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision.
        2) The member's grievance and appeal rights (as detailed in the *Member Grievances and Appeals Guide*).

        3) Denial of payment, at the time of any action affecting the claim.

    The notice(s) must adhere to the timing and content requirements detailed in the *Member Grievances and Appeals Guide.*

b. Authorization decisions must be made within the following time frames and in all cases as expeditiously as the member's condition requires:

1) Within 14 days of the receipt of the request, or
2) Within 72 hours if the provider indicates, or the PIHP determines, that following the ordinary time frame could jeopardize the member's life, health or ability to regain, attain, or maintain maximum function.

One extension of up to 14 days may be allowed if the member requests it or if the PIHP justifies the need for more information.

On the date that the time frames expire, the PIHP gives notice that service authorization decisions are not reached. Untimely service authorizations constitute a denial and are thus adverse benefit determinations.

5. Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence, current standards of medical practice, or a consensus of relevant health care professionals, and are regularly updated. This includes PIHP utilization management practice for emergency and post-stabilization services.

6. The PIHP oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

7. Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The PIHP may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement.

G. Accreditation

Per 42 CFR 438.332, the PIHP must report to the Department if it is accredited by a private independent accrediting agency. CMS has recognized the following entities as private independent accrediting agencies: The National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC). PIHPs that have received accreditation by a private independent accrediting agency must provide the state with a copy of its most recent accreditation review, as part of the PIHP certification application process. This copy must contain:

1. PIHP accreditation status;

2. Name of the CMS-recognized accreditation entity;

3. The effective start and end dates of accreditation;

4. The lines of business / specific member population for which the accreditation was achieved (e.g., commercial and/or Medicaid, etc.);

5. The specific accreditation status of the PIHP, including survey type and level (as applicable); and

6. Accreditation results from the accreditation entity, including recommended actions or improvements, correction action plans and summaries of findings.

The Department will post the accreditation status of all PIHPs on its website including the accreditation entity, accreditation program, and the accreditation level. The Department will update this accreditation status annually.

H. Performance Improvement Priority Areas and Projects

Per 42 CFR §. 438.330, the PIHP must have an ongoing program of performance improvement projects to address the specific needs of the FCMH population served under this Contract. The PIPs may include clinical and non-clinical performance areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.

The Department will permit the development of collaborative relationships among the PIHP, DMCPS, county child welfare agencies, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. The Department and the PIHP will collaborate to develop and share

"best practices" on the Performance Improvement Projects. The Measurement Year (MY) starts on January 1 and ends on December 31 of the applicable contract year.

1. The PIHP is required to submit two PIPs each year.

    a. One clinical and one non-clinical.
    b. The Racial Disparity PIP referenced in Article X, section J of this contract may constitute the non-clinical.

2. The State has the authority to select a particular topic for the PIPs. Additionally, CMS, in consultation with the State and stakeholders, may specify performance measures and topics for performance improvement projects. The performance improvement topic must take into account the prevalence of a condition among, or need for a specific service by, the FCMH members served under this Contract; enrollee demographic characteristics and health risks; and the interest of consumers or purchasers in the aspect of care or services to be addressed.

3. The PIHP should use quality-of-care measures for children, including assessments of structure, process, health, and/or functional outcomes.

    Clinical priority areas include, but are not limited to:

    a. Incorporation of trauma-informed competence and services into FCMH practice and service delivery;
    b. Utilization of evidence-based, trauma-informed behavioral health/substance abuse services;
    c. Quality of outpatient behavioral and mental health services;
    d. Behavioral health joint care planning and accountability;
    e. Evaluation of the need for specialty services;
    f. Children with special health care needs identification and services;
    g. High volume/high-risk services identified by the PIHP (e.g., psychotropic medication management, asthma);
    h. Prevention and care of acute and chronic conditions;
    i. Comprehensive/complex care coordination;
    j. Care coordination and health/mental health promotion;
    k. Transitional care across settings;
    l. Appropriate monitoring and management of medication by a qualified provider.

Non-clinical priority areas include, but are not limited to:

m. Wait times for an appointment to see a primary care provider or medical specialist or to receive a specialized service or piece of equipment;
n. Access to specialized transportation services;
o. Adequacy of the behavioral and mental health network with regard to geographic accessibility to its members;
p. Monitoring of complaints, grievances and appeals (e.g., are the PIHP's complaint mechanisms easy to use?);
q. Mechanisms to collect information from pediatric providers on how well the FCMH's system works for their patients;
r. Mechanisms to involve consumer/family participation in the PIHP's policy development;
s. Using a member satisfaction survey targeted to specific pediatric populations (e.g., with chronic conditions);
t. Use of health information technology.

4. The PIHP should submit PIPs which use objective quality indicators to measure the effectiveness of the interventions. Per 438.330(d)(2), the PIHP should submit PIPs which include the planning and initiation of activities for sustaining or continuing PIP improvement over time. The PIHP should not submit baseline studies which are designed to evaluate whether a problem exists.

5. The PIHP must submit a preliminary PIP proposal summary stating the proposed topic, the study question/project aims with a measurable goal study indicators, study population, sampling methods if applicable, data collection procedures, improvement strategies, and the prospective data analysis plan.. The preliminary PIP proposal must be submitted to the Department or the EQRO as directed by the Department by December 1st of each calendar year.

   The Department and the EQRO will review the preliminary PIP proposal and meet with the PIHP to give feedback to the PIHP on the PIP proposal. The Department will determine if the PIP proposals are approved. Suggestions arising from the EQRO and PIHP dialogue should be given consideration as the PIHP proceeds with the PIP implementation.

If the proposal is rejected by the Department, the PIHP must re-submit a new or revised PIP proposal within the timeframe specified by the Department. That re-submission will be reviewed again by the Department and the EQRO.

6. After receiving the State's approval, the PIHP may communicate with the EQRO throughout the implementation of the project if questions arise.

7. The PIHP should perform ongoing monitoring of the project throughout the year to evaluate the effectiveness of its interventions.

8. After implementing the PIP over one calendar year, the PIHP must submit to the FCMH Contract Monitor, or the EQRO as directed by the Department, their completed PIP reports utilizing the format recommended by the Department by the first business day of July of the following year.

9. The EQRO will schedule a conference call with the PIHP to review the EQRO feedback on the final PIP report.

10. Per 438.330(e)(1), if the PIHP submits a multi-year PIP, then the EQRO will review and report on results trended over multiple years.

11. The EQRO may recommend a PIHP's PIP for inclusion in Wisconsin's Best Practices Seminars in which all the PIHPs will participate.

12. The Department will consider that the PIHP failed to comply with PIP requirements if:

    a. The plan submits a final PIP on a topic that was not approved by the Department and the EQRO.

    b. The EQRO finds that the PIP does not meet federal requirements:

        1) The PIP does not define a measurable goal using clear and objective quality indicators.

        2) The PIP does not include the implementation of systemic interventions to improve quality of care.

        3) The PIP does not evaluate systematically the effectiveness of the interventions.

4) The PIP does not reflect the adoption of continuous cycles of improvement through which the PIHP can sustain quality improvement.

c. The PIHP does not submit the final PIP by its due date of the first business day of July of the year in which it's due. The Department may grant extensions of this deadline, if requested prior to the due date.

Failure to comply with PIP requirements may result in the application of sanctions described in Article XIII, Section C.

13. Ten Steps to A Successful PIP

Step 1: Describe the project/study topic.

Step 2: Describe the study questions/project measurable goals.

Step 3: Describe the selected study indicators/project measures and baseline data.

Step 4: Describe the identified population for which the study or project is aimed at.

Step 5: Describe the sampling methods used (if any).

Step 6: Describe the organization's data collection procedures.

Step 7: Describe the organization's interventions and improvement strategies.

Step 8: Describe the organization's data analysis plan and the interpretation of results from data collection.

Step 9: Describe the likelihood that the reported improvement is real improvement.

Step 10: Identify lessons learned and assess the sustainability of its documented improvement.

I. Public Reporting

The Department will publicly report various quality and other performance metrics for the PIHP via a website and other media, per 42 CFR 438.340.

J. Health Disparity Plan

Per 42 CFR § 438.340(b)(6) of the Managed Care Rule, the State is required to create and implement a "plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide available information to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability."
The Department will employ a phased approach. The FCMH must provide an additional PIP focused on reducing health disparities. As part of the ongoing PIP efforts, the PIHP has developed a health disparities reduction plan and must continue to make progress in identifying and addressing disparities within its membership.

If the FCMH is working in conjunction with another entity on a health disparity project (e.g., an HMO), the PIP may use the foundations of the other entity's project but provide analysis specific to their population.

K. FCMH Quality Measures

The FCMH is required to report on quality measures and operational details to support program operation. For details and information pertinent to submission of data and calculation of results, please refer to the *Foster Care Medical Home Quality Measures Operational Guide*.

1. Timeframe

The Measurement Year (MY) starts on January 1 and ends on December 31 of the applicable contract year.

2. Measures and Targets

The program will use the quality measures described in the guide as finalized by the Department. Targets for each measure will be defined by the Department. Further details of the methodology for setting targets, including definitions, are specified in the Guide.

a. Initial Measures
   Initial measures represent activities happening when children first enter Out of Home Care and are enrolled in the Foster Care Medical Home. These include:
      i. Acute health screen within 2 business days of enrollment
      ii. Initial Comprehensive Health Assessment within 30 days of enrollment
      iii. Timely Developmental and/or Mental Health Screen
      iv. Timely Developmental Assessment
      v. Timely Mental Health Assessment

b. HealthCheck Periodicity
   All enrolled children in FCMH are expected to receive their HealthCheck exams at an enhanced periodicity:
      i. Every month for the first 6 months of age;
      ii. Every three months between ages 6 months and 2 years of age;
      iii. Twice a year after 2 years of age.

c. Dental Exams
   Children enrolled in FCMH age 12 months and older are required to be seen twice yearly for comprehensive dental exams. Two measures capture related data, the first being for newly enrolled children to receive their first comprehensive dental exam within 3 months of enrollment and the second measures the ongoing receipt every six months for children age 12 months or older.

d. Blood Lead Testing
   . All children enrolled in the FCMH at ages 12 months, 18 months, and 24 months will be screened for blood lead toxicity. In addition, children between 24 and 72 months will be screened if there is no record of a previous blood lead screening test.

e. Immunization Status
   Children enrolled in the FCMH will be fully immunized within 6 months of enrollment. The Department will use the latest HEDIS specifications applicable.

f. Outpatient Mental Health Follow Up

HEDIS Measure for Outpatient MH Follow Up within 30 days following Inpatient MH Hospitalization. The department will use the latest HEDIS specifications applicable.

g. Emergency Department Utilization
This is a utilization measure (# of ED visits per 1000 member months). The HEDIS AMB measure has two components—ED and Outpatient visits.

h. Follow-Up after ED Visit for Mental Illness
HEDIS measure for Outpatient Mental Health Follow Up within 30 days following ED visit for mental illness or intention self-harm. The department will use the latest HEDIS specifications applicable.

i. Anti-Psychotic Medication Measures
There are three measures that make up the Anti-Psychotic Medication objective:
i. Number and % of children starting on anti-psychotic medication after entering the FCMH program, for whom all metabolic measures were recorded (BMI, Glucose, and/or HbA1c, non-fasting Lipid profile) as baseline before or at the time of starting on anti-psychotics.
ii. Number and % of children already on anti-psychotic medication before entering the FCMH., for whom all metabolic measures were recorded (BMI, Glucose, and/or HbA1c, non-fasting Lipid profile) as baseline, within 60 days of entering the program.
iii. Number and % of children on anti-psychotic medication for whom all metabolic measures were updated at or near the 6-month mark from the last previous date of metabolic measurement.

j. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey
The CAHPS survey measures the experience of patients enrolled in the FCMH. The survey measures patient experience in the areas of getting needed care, getting care quickly, howe well doctors communicate, health plan costumer service, and how people rate the health plan. The Department will use the latest AHRQ specifications available.

XI. PIHP ADMINISTRATION

A. Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations that are in effect when the Contract is signed, or that come into effect during the term of the Contract. This includes, but is not limited to Title XIX of the Social Security Act, Title XXI, SCHIP, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The American with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and Title 42 of the CFR.

Changes to Medicaid covered services mandated by federal or state law subsequent to the signing of this Contract will not affect the Contract services for the term of this Contract, until agreed to by mutual consent, or the change is necessary to continue to receive federal funds or due to action of a court of law.

The Department may incorporate into the Contract any change in covered services mandated by federal or state law effective the date the law goes into effect, if it adjusts the monthly prepayments accordingly. The Department will give the PIHP at least 30 days' notice before the intended effective date of any such change that reflects service increases, and the PIHP may elect to accept or reject the service increases for the remainder of that contract year. The Department will give the PIHP 60 days' notice of any such change that reflects service decreases, with a right of the PIHP to dispute the amount of the decrease within 60 days. The PIHP has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the state budget.

The PIHP shall not express that it is endorsed by the federal or state government, CMS, or similar entity.

Federal funds must not be used for lobbying. 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 standards requirements, the federal Clean Air Act and the federal Water Pollution Control Act.

B. Organizational Responsibilities and Duties

1. Ineligible Organizations

Upon obtaining information or receiving information from the Department or from another verifiable source, the PIHP must exclude from participation in the PIHP all organizations that could be included in any of the categories defined in a, 1) of this section (references to the Act in this section refer to the Social Security Act).

a. Entities that could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has direct or indirect ownerships or control interest of 5% or more in the entity has:

1) Been convicted of the following crimes:

i. Program related crimes (i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid). (Section 1128(a)(1) of the Act.)

ii. Patient abuse (i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care). (Section 1128(a)(2) of the Act.)

iii. Fraud (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government). (Section 1128(b)(1) of the Act.)

iv. Obstruction of an investigation (i.e., conviction under state or federal law of interference or obstruction of any investigation into any criminal offense described in Subsections a), b), or c). (Section 1128(b)(2) of the Act.)

v. Offenses relating to controlled substances (i.e., conviction of a state or federal crime relating to the manufacture, distribution, prescription or dispensing of a controlled substance. (Section 1128(b)(3) of the Act.)

2) Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described in C, 1, a, above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

3) Been assessed a civil monetary penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards. (Section 1128(b)(8)(B)(ii) of the Act.)

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in Subsection 1. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

1) The administration, management, or provision of medical services.

2) The establishment of policies pertaining to the administration, management, or provision of medical services.

3) The provision of operational support for the administration, management, or provision of medical services.

c. Entities that employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the PIHP must refrain from contracting with any entity that employs, contracts with, or contracts through an entity that has been debarred or excluded from participation in Medicaid by the Secretary of

Health and Human Services under the authority of Section 1128 or 1128A of the Act.

The PIHP attests by signing this Contract, that it excludes from participation in the PIHP all organizations that could be included in any of the above categories.

d. Foreign Entities

1) Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with a PIHP located outside of the United States. In the event an PIHP moves outside of the United States, this contract will be terminated.

2) Pursuant to 42 C.F.R. § 438.602(i), no claims paid by a PIHP to a network provider, out-of-network provider, subcontractor or financial institution outside of the United States will be considered in the development of actuarially sound payments.

2. Contract Representative

The PIHP is required to designate a staff person to act as liaison to the Department on all issues that relate to the Contract between the Department and the PIHP. The contract representative will be authorized to represent the PIHP regarding inquiries pertaining to the Contract, will be available during normal business hours, and will have decision making authority in regard to urgent situations that arise. The Contract representative will be responsible for follow-up on contract inquiries initiated by the Department.

3. Attestation

The PIHP'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. This includes encounter data, ventilator dependent member data, provider and facility network submissions, comprehensive exam reports and health data indicators and any other data regarding claims the PIHP paid. The PIHP must use the Department's attestation form in Addendum V, H. The attestation form must be submitted quarterly to the PIHP's Managed Care Analyst in the Bureau of Children's Services (Article XII, J).

4. Affirmative Action (AA) and Equal Opportunity, and Civil Rights Compliance (CRC)

   All recipients of federal and/or state funding to administer programs, services and activities through the Wisconsin Department of Health Services must comply with the Department's CRC Plan requirements. Information about these requirements can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

   Certain Recipients and Vendors must also comply with Wis. Stats., s.16.765, and Administrative Code (ADM) 50, which require the filing of an Affirmative Action Plan (AA Plan).

   The Affirmative Action Plan is NOT part of the CRC Plan.

   a. Affirmative Action Plan

      1) For agreements where the PIHP has 50 employees or more and will receive $50,000 or more, the PIHP shall complete the AA plan. The PIHP with an annual work force of less than 50 employees or less than $50,000 may be exempt from submitting the AA plan.

         The AA Plan is written in detail and explains the PIHP's program. To obtain instructions regarding the AA Plan requirements go to http://vendornet.state.wi.us/vendornet/contract/contcom.asp

      2) The PIHP must file its AA plan every 3 years and includes all programs. The plan must be submitted to:

         Department of Health Services
         Division of Enterprise Services
         Bureau of Procurement and Contracting
         Affirmative Action Plan/CRC Coordinator
         1 West Wilson Street, Room 672
         P.O. Box 7850
         Madison, WI 53707
         dhscontractcompliance@dhs.wisconsin.gov
         Compliance with the requirements of the AA Plan will be monitored by DHS

   b. Civil Rights Compliance (CRC) Plan

1) The PIHP receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA). All PIHPs with fifty (50) or more employees AND who receive over $50,000 in funding must complete a Civil Rights Compliance Plan (CRC Plan)**.** The CRC Plan is to be kept on file and made available upon request to any representative of the Department of Health Services. The instructions and template to complete the requirements for the CRC Plan are found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

   For technical assistance on all aspects of the Civil Rights Compliance, the PIHP is to contact the Department at:

   Department of Health Services
   Civil Rights Compliance
   Attn: Civil Rights Compliance Officer
   1 West Wilson Street, Room 651
   P.O. Box 7850
   Madison, WI 53707-7850
   Telephone:(608) 267-4955 (Voice)
   711 or 1-800-947-3529 (TTY)
   Fax: (608) 267-1434
   Email: DHSCRC@dhs.wisconsin.gov

2) PIHPs subcontracting federal or state funding to other entities must obtain a CRC LOA from their subcontractors. The CRC LOA must be kept on file and produced upon request or at the time that an on-site monitoring visit is conducted. Subcontractors with fifty (50) or more employees AND who receive over $50,000 in funding must complete a CRC Plan. The CRC Plan is to be kept on file and produced upon request by DHS or at the time the PIHP conducts an on-site monitoring visit.

3) The PIHP agrees to not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion or sex/gender. This policy covers enrollment, access to services, facilities, and treatment for all programs and activities. All employees of the PIHP are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

4) The PIHP agrees not to exclude qualified persons from employment otherwise. The PIHP agrees to not discriminate on the basis of the conscience rights of health care providers as established and protected following Federal Health Care Provider Conscience Protection Laws: the Church Amendments; the Public Health Service Act Section 245; the Weldon Amendment; and the Affordable Care Act.

5) The PIHP agrees to comply with all of the requirements contained in the Department CRC Plan and to ensure that their subcontractors comply with all CRC requirements during this Contract period. The instructions and template to complete the CRC Plan requirements can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

6) The Department will monitor the Civil Rights and Affirmative Action compliance of the PIHP. The Department will conduct reviews to ensure that the PIHP is ensuring compliance by its subcontractors or grantees. The PIHP agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the PIHP, interview with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

7) The PIHP agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

5. Non-Discrimination in Employment

The PIHP must comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity including Wis. Stats., s.16.765, Federal Civil Rights Act of 1964, regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985, and ensure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable Department regulations (45 CFR part 84) and all guidelines and interpretations issued pursuant thereto, and the provisions of

the Age Discrimination and Employment Act of 1967 and Age Discrimination Act of 1975.

Wis. Stats., Chapter 16.765, requires that in connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5), sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the non-discrimination clause.

Contractor further agrees not to subject qualified persons to discrimination in employment in any manner or term or condition of employment on the basis of arrest record, conviction record, genetic testing, honesty testing, marital status, military service, pregnancy or childbirth, or use of legal products during non-work hours outside of the employer's premises, except as otherwise authorized by applicable statutes.

All PIHP employees are expected to support goals and programmatic activities relating to non-discrimination and non-retaliation in employment.

With respect to provider participation, reimbursement, or indemnification, the PIHP will not discriminate against any provider who is acting with the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to require the PIHP to contract with providers beyond the number necessary to meet the needs of the BadgerCare Plus and/or Medicaid SSI population. This shall not be construed to prohibit the PIHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities. If the PIHP declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

6. Provision of Services to the PIHP Members

   The PIHP must furnish covered services in an amount, duration, and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries under FFS Medicaid as set forth in 42 CFR 440.230.

   Per 42 CFR § 438.210(a)(3), the PIHP

   a. Must ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished to members in Medicaid fee for service.

   b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

   c. May place appropriate limits on a service on the basis of criteria applied under the State Plan, such as medical necessity; or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

7. PIHP Staffing Level to Support Providers

   At the time of contract renewal and at service area expansion request, the PIHP must have appropriate staffing levels for the entire service area to support contracted provider participation and timely claim payment, per Art. XIV, D, #2.

   The PIHP must:

   a. Have adequate customer service and help desk staff to answer inquiries from providers (via phone or email); adequate home office or regional provider representatives to provide training to new and ongoing providers on PIHP policy, communication methods, correct claim submission and appeal process.
   b. Clearly communicate to providers the availability of support resources provided through the PIHP website or Provider Manual, including but not limited to the methods used by the PIHP to communicate policy changes,

electronic claim submission, claim reconsideration, internal appeal process, and how to appeal to the Department.

The Department reserves the right to request a staffing plan from the PIHP at the time of contract renewal and at service area expansion request to demonstrate the PIHP has appropriate staffing levels for its entire service area to support provider participation and timely claim payment.

8. Access to Premises

   The PIHP must allow duly authorized agents or representatives of the state or federal government access to the PIHP's or PIHP subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the PIHP's or subcontractor's contractual activities and shall produce all records requested as part of such review or audit within a reasonable time, but not more than 10 business days. Upon request for such right of access, the PIHP or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the performance of PIHP's or subcontractor's activities. The PIHP will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

9. Liability for the Provision of Care

   Remain liable for provision of care for that period for which prepayment has been made in cases where medical status code changes occur subsequent to payment.

10. Subcontracts

    The PIHP must ensure that all subcontracts are in writing, comply with the provisions of this Contract that are appropriate to the service or activity, and ensure that all subcontracts do not terminate legal liability of the PIHP under this Contract. The PIHP may subcontract for any function covered by this Contract, subject to the requirements of Article XIV, B.

11. Memoranda of Understanding (MOUs)

The PIHP must submit to the Department copies of new MOUs, or changes in existing MOUs for review and approval before they take effect. The Department will review the new or changed MOU and respond to the PIHP within 15 business days of submission. If the Department does not respond to the request for review within 15 business days, the PIHP must contact the Bureau of Children's Services. A response will be prepared within five business days of this contact.

The PIHP shall submit MOUs referred to in this contract to the Department upon the Department's request and during the certification process if required by the Department.

MOUs between the PIHP and agencies that are involved with children in out-of-home care must contain:

- Contact information for the PIHP and other agencies/programs responsible for executing the agreement;
- Dated signatures by the PIHP and the agency or program director;
- Referral procedures for services to the health system and other agencies or programs;
- Clearly defined responsibilities between the health system and the agency or program with respect to FCMH members and their out-of-home care provider or birth families;
- Procedures for the coordination of assessment information between the PIHP and the agency or program;
- A clearly defined process for communication between the two agencies on behalf of individual children in out-of-home care and their families;
- A process for resolving conflicts between agencies or programs regarding areas of mutual responsibility on behalf of enrollees.

a. Child Welfare Agencies

The PIHP must have an MOU with the State of Wisconsin DMCPS and the Bureau of Permanency and Out of Home Care, Adoption and Interstate Services Section. The PIHP must have an MOU with the Child Welfare agencies in each county in its service area. The PIHP must designate at least one staff member to serve as a contact with the county child welfare agencies, the DMCPS, and the Bureau of Permanency and Out of Home Care, Adoption and Interstate Services Section.

b. Wraparound Milwaukee (WAM)

The PIHP must have an MOU with the Wraparound Milwaukee Program and must designate a staff member to serve as a contact.

c. County Human Service Programs

The PIHP must use its best effort to have an MOU with each of the six counties in the service area for county programs or services other than child welfare. In counties other than Milwaukee, the MOU with the child welfare agency may be combined with other county programs as long as the responsibilities between the PIHP and child welfare are clearly delineated. (See Article IV, B, 11)

d. Local Education Agencies

The PIHP must use its best effort to have an MOU with local education agencies (LEAs) that include the Head Start and Early Head Start providers.

e. Local Health Departments

The PIHP must use its best effort to have an MOU with local public health departments that are not county agencies or are not part of a county human services department if those agencies provide services to children in out-of-home care or their families in order to ensure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunizations, blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others). WIC projects provide nutrition services and supplemental foods, breast feeding promotion and support; and immunization screening. Many projects screen for blood lead poisoning during the WIC appointment.

The Department encourages the PIHP to work closely with local health departments. Local health departments have a wide variety of resources that could be coordinated with the PIHP to produce more efficient and cost-effective care for the PIHP members. Examples of such resources are ongoing medical services programs, materials on health education,

prevention, and disease states, expertise on outreaching specific sub-populations, communication networks with varieties of medical providers, advocates, community-based health organizations, and social service agencies, and access to ongoing studies of health status and disease trends and patterns.

f. School-Based Services (SBS) Providers

The PIHP must use its best effort and document attempts to sign an MOU with all SBS providers in the PIHP service area to ensure continuity of care and to avoid duplication of services. School based services are paid FFS when provided by a Medicaid certified SBS provider. However, in situations where a member's course of treatment is interrupted due to school breaks, after school hours or during the summer months, the PIHP is responsible for providing and paying for all Medicaid covered services. The PIHP must not consider SBS (e.g. physical, occupational, and speech and language therapy services) as automatically duplicative when it is considering the medical necessity of a requested community based service.

MOUs must be signed every three years as part of certification. If no changes have occurred, then both the school and the PIHP must sign off that no changes have occurred and documentation to this effect must be submitted to the Bureau of Children's Services upon request. The PIHP must conduct outreach to schools that do not have a MOU with the PIHP, at a minimum, every two years. The PIHP must submit evidence that it attempted to obtain a MOU or contract in good faith.

g. School-based Mental Health Services

The Department encourages the PIHP to contract with community-based mental health agencies and/or school-based providers for the provision of mental health care to FCMH children in the school setting. The PIHP is encouraged to assist with the coordination of covered mental health services to its members (including those children with an IEP who may have mental health needs) with the school, mental health provider, and family as appropriate.

h. Targeted Case Management (TCM) Agencies

The PIHP must use its best effort to have an MOU with the case manager from the TCM agency to identify what Medicaid covered services or social services are to be provided to the member. The PIHP is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the PIHP.

i. Birth to Three Program Providers

The PIHP is required to contract with Birth to 3 Program service providers that have a contractual agreement with the Birth to 3 Program agencies within their service area to authorize and pay claims for their members that are enrolled in the Birth to 3 Program. Birth to 3 program services include physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services provided as Birth to 3 Program services.

The PIHP reimburses for Birth to 3 Program services when a member under the age of 3 receives an initial evaluation and assessment, as well as an Individualized Family Services Plan (IFSP), and the provider is employed by or under contract with a Birth to 3 Program Agency. The PIHP must reimburse for the initial evaluation and assessment, as well as re-evaluations, even when a member does not qualify for the Birth to 3 program.

The PIHP must authorize PT, OT, or SLP services that are provided with an initial evaluation and assessment that are identified in and requested at the same frequency, intensity, and duration listed in the member's IFSP. The PIHP should not impose additional medical necessity criteria for Birth to 3 Program services. The PIHP is encouraged to follow ForwardHealth policy for prior authorization of Birth to 3 Program services by not requiring Birth to 3 Programs to frequently re-submit authorization requests to the PIHP.

The PIHP is encouraged to follow the ForwardHealth policy for prior authorization of therapy services provided outside the Birth to 3 Program, and to require receipt of the completed Child Enrollment Status Regarding Birth to 3 Program form prior to authorizing any PT, OT, or SLP for a child under 3. The PIHP may impose their standard medical necessity criteria when authorizing therapy services outside the Birth to 3 Program for a child under 3.

If a provider's Birth to 3 Program services are provided in the member's natural environment, the provider must receive an enhanced reimbursement rate. The PIHP is encouraged to develop MOUs with county Birth to 3 Program agencies in their service area.

PIHPs can find a list of county contacts for Birth to Three programs at: http://www.dhs.wisconsin.gov/children/birthto3/contacts/countycontacts.asp

j. Agency Agreement on Access to eWiSACWIS

The PIHP shall have an MOU and data-sharing agreement with the Department of Children and Families in order for the PIHP to have eWiSACWIS read-only access to specific sections of a member's child welfare case. The DCF will develop eReports for the PIHP based on the needs of the program and within the parameters of sharing confidential child welfare records. The PIHP shall identify appropriate staff to access eWiSACWIS and the eReports.

k. Healthy Wisconsin

The Department encourages the PIHP to serve as partners in Healthy Wisconsin, the state's health assessment and health improvement plan. This includes the PIHP working towards objectives that influence the health of the public and long-term goals for the decade. More information on Healthy Wisconsin can be found at:

http://www.dhs.wisconsin.gov/hw2020/ l. Local WIC Agencies

The PIHP is encouraged to enter into an agreement with Local WIC Agencies within the PIHP's service area for the purpose of collaboration of care and to ensure referrals between the parties are made. The PIHP is required to refer all WIC categorically eligible PIHP members to the Local WIC Agency. The WIC Program provides nutrition services, supplemental foods, breast feeding promotion and support, and immunization screening. Some Local WIC Agencies are WI Medicaid enrolled as HealthCheck – Other Services providers and may contract with PIHPs for blood lead poisoning screenings performed during the WIC appointment as a Medicaid-billable service.

m. Federally Qualified Health Centers (FQHC)

PIHPs must make at least two good faith written and documented efforts to contract at a reasonable market rate with FQHCs located within their service area for the provision of care to PIHP members.

12. Clinical Laboratory Improvement Amendments (CLIA)

The PIHP must use only certain laboratories. All laboratory testing sites providing services under this Contract must have a valid CLIA certificate along with a CLIA identification number, and comply with federal CLIA regulations as specified by 42 CFR Part 493, 42 CFR 263a, and Wisconsin Administrative Code, Chapter 105, DHS 105.42(1-2) and DHS 105.46 – Medical Assistance. Those laboratories with certificates must provide only the types of tests permitted under the terms of their certification.

Sanctions in the amount of $10,000.00 may be imposed for non-compliance with the above compliance requirements.

13. PIHP Responsibilities in the Event of a Federal or State Declared Emergency:

PIHPs are required to submit an annual plan to maintain business operations in the event of a state or federal declaration of disaster or State of Emergency by June 30th. The PIHP must cooperate with DHS' efforts to ensure minimal disruption to the ForwardHealth program and the members served.

a. Continuity of Operations
   1.Business Continuity Plan

The health plan must maintain a business continuity plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a federal or state declared disaster or State of Emergency. Business Continuity Plans shall address, at a minimum, the following:

1. A description of how the health plan will organize and assign the urgency with which activities and processes will need to be resumed in the event of a disruption including:
   a. Member's access to services. The health plan must:
      i. Establish provisions to ensure that members are able to see Out-of-Network Providers if the

member has a permanent address in the federal or state declared disaster areas and are unable to access In-Network providers.

ii. Establish provisions to ensure that members are able to use telehealth services if the member has a permanent address in the federal or state declared disaster areas.

iii. Provide detailed plans it will use to ensure that prior authorizations are extended and transferred without burden to new providers if directed by DHS, and the means by which the health plan will identify the location of members who have been displaced.

iv. Report status of members and issues regarding member access to covered services as directed by DHS.

2. Claims Payment
    a. A description of how the health plan will address the following activities:
        i. Timely provider claims processing and payment consistent with DHS contract requirements and health plan-provider contract policies.
        ii. Establishing provider contract language that addresses relaxed health plan timely filing requirements for provider service claims provided in good faith with reasonable submission delay due to a Federal or State declared disaster or emergency and submit to DHS for review.
        iii. Honoring unauthorized provider claims consistent with ongoing treatment due to demonstrated patient need or urgent patient need occurring during a Federal or State declared disaster or emergency period where health plan authorization communications and processes were delayed or failed.
        iv. Providing a communication and interim plan for approval by DHS should they experience a disruption that risks the ability to meet the claims processing/payment timeline requirements.
3. Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at

the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.

4. Inclusion of a risk assessment that reviews the probability and impact of various threats to the health plan's operations. This involves stress testing the health plan's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the health plan in refining its business impact analysis and in developing a business continuity strategy.
5. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.
    a. Health Plans must ensure that proper training is provided for each role under this provision.
6. Criteria for executing the business continuity plan, including escalation procedures.
    a. A detailed communication plan with members, employees, providers, the Department, and other stakeholders including: Coordinating with DHS or any other local, state, or federal agencies as needed during the disaster or emergency response. This coordination may vary based on type of situation; however, anticipated coordination includes, but is not limited to:
        i. Designating a Point of Contact (POC) for continuity of operations specifically related to disaster preparedness in order to communicate the health plan's response to the DHS emergency preparedness POC.
        ii. Designating a POC to support members residing in Tribal Lands where applicable.
        iii. Participating in meetings with DHS or other agencies
        iv. Assisting with impacted member or provider communications
        v. Facilitate effective communication with members, providers and staff regarding the impact of the disaster as well as a process by which inquiries may be submitted and addressed.

vi. Implementing policy, process, or system changes at the direction of DHS, keeping DHS informed on the progress of the implementation
vii. Additional communication and/or reporting requirements through the duration of the emergency
viii. The health plan must notify DHS of any contract flexibilities or extensions needed during the course of the emergency or disaster. DHS will maintain a health plan emergency/disaster response guide to document any such approved flexibilities or revised deadlines, outside the contract amendment process.
ix. Permission from DHS, contingent on approval of content, to do one-time member outreach via text message to those who have not opted into text messaging, to inform members about the disaster or emergency, offer PIHP resources or contact information, and instructions on how to opt into text messaging.

7. Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.

    a. Including the ability of providers and suppliers to provide ongoing services for maintaining critical operations, and
    b. The level of ongoing monitoring and oversight provided by the PIHP.

8. Recovery time for each major business function, based on priority.
9. Business workflow and workaround procedures, including alternate processing methods and performance metrics.
10. Recording and updating business events information, files, and data, once business processes have been restored.
11. Documentation of security procedures for protection of data through web-based cloud application.
12. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
13. A description of an annual testing and evaluation plan.

14. A description of the health plan familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The health plan will negotiate the role of the health plan and the county roles in emergency response.
    a. Health plans must ensure annually the readiness of the plan by conducting exercises carrying out the plan's provisions, evaluate its performance and make necessary updates. The health plan must coordinate with local emergency management departments, local agencies and DHS prior to an event to understand local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

15. A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.
    a. Care Coordination
        i. The health plan must ensure that care coordination for all members are compliant with the health plan's emergency recovery plan. In particular, care coordination for members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if covered service are disrupted or interrupted.
16. Emergency Recovery Plan
    a. The Emergency Recovery Plan shall address, at a minimum, the following recovery aspects related to the management information system and where appropriate, use web-based cloud applications:
        i. Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.
        ii. Communication plan for critical personnel, key stakeholders and business partners involved in the health plan's management information system.
            1. Including the health plan's ability to provide continuous services to members and maintain critical operations in the even employees are unavailable to work remotely for extended periods of time.

iii. Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).
iv. Full and complete back-up copies of all data and software.
v. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
vi. Policies and procedures for purging outdated backup data.
vii. Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.

Upon DHS request, health plan shall submit an 'After Emergency Report' to DHS after the federal or state declared disaster is completed to provide feedback on success and challenges faced during the emergency.

C. Confidentiality of Records and HIPAA Requirements

The parties agree that all information, records, and data collected in connection with this Contract will be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., DHS 108.01, Wis. Adm. Code, 42 CFR 431 Subpart F, 42 CFR 438 Subpart F and 45 CFR 160, 162, and 164 and any other confidentiality law to the extent that these requirements apply. Except as otherwise required by law, rule or regulation, access to such information shall be limited by the PIHP and the Department to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

1. Duty of Non-Disclosure and Security Precautions

Contractor shall not use Confidential Information for any purpose other than the limited purposes set forth in the Agreement. Contractor shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents *("Representatives")* who have a business-related need to have access to such Confidential Information in furtherance of the limited

purposes of this Agreement and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Agreement. Contractor shall be responsible for the breach of this Agreement by any of its Representatives.

Contractor shall institute and/or maintain such procedures as are reasonably required to maintain the confidentiality of the Confidential Information, and shall apply the same level of care as it employs to protect its own confidential information of like nature.

Contractor shall ensure that all indications of confidentiality contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. If requested by the State, Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed.

If requested by the State, Contractor shall return or destroy all Individually Identifiable Health Information and Personally Identifiable Information it holds upon termination of this Agreement.

2. Limitations on Obligations

The obligations of confidentiality assumed by Contractor pursuant to this Agreement shall not apply to the extent Contractor can demonstrate that such information:

a. is part of the public domain without any breach of this Agreement by Contractor;
b. is or becomes generally known on a non-confidential basis, through no wrongful act of Contractor;
c. was known by Contractor prior to disclosure hereunder without any obligation to keep it confidential;
d. was disclosed to it by a third party which, to the best of Contractor's knowledge, is not required to maintain its confidentiality;
e. was independently developed by Contractor; or
f. is the subject of a written agreement whereby the State consents to the disclosure of such Confidential Information by Contractor on a non-confidential basis.

3. Legal Disclosure

   If Contractor or any of its Representatives shall be under a legal obligation in any administrative, regulatory or judicial circumstance to disclose any Confidential Information, Contractor shall give the State prompt notice thereof (unless it has a legal obligation to the contrary) so that the State may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor and its Representatives shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

4. Unauthorized Use, Disclosure, or Loss

   If the FCMH becomes aware of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or if any Confidential Information is lost or cannot be accounted for, Contractor shall notify the State's DHS Privacy Officer and managed care analyst within the same business day the FCMH becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the Contractor's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

   The FCMH shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The FCMH shall reasonably cooperate with the State's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its Confidential Information, including complying with a reasonable Corrective Action Plan.

   If the unauthorized use, disclosure, or loss is of Personally Identifiable Information, or reasonably could otherwise identify individuals, Contractor shall, at its own cost, take any or all of the following measures that are directed by the State as part of a Corrective Action Plan:

   a. Notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the

Contractor shall provide notice by a method reasonably calculated to provide actual notice.

b. Notify consumer reporting agencies of the unauthorized release.

c. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the State for one year from the date the individual enrolls in credit monitoring.

d. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as established by the State.

e. Adequately staff customer service telephone lines to assure an actual wait time of less than five (5) minutes for callers.

5. Trading partner requirements under HIPAA

For the purposes of this section Trading Partner means the PIHP.

a. Trading Partner Obligations

1) Trading Partner must not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915(a)).

2) Trading Partner must not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915(b)).

3) Trading Partner must not use any code or data elements that are either marked “not used” in the HHS Transaction Standard’s implementation specifications or are not in the HHS Transaction Standard’s implementation specifications (45 CFR Part 162.915(c)).

4) Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard’s implementation specifications (45 CFR Part 162.915(d)).

5) Trading Partner must submit a new Trading Partner profile form in writing if any of the information provided as part of the Trading Partner profile form is modified.

b. Trading Partner understands that there exists the possibility that the Department or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, Trading Partner must participate in such test modification (45 CFR Part 162.940 (a) (4)).

c. Trading Partners or Trading Partner's Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.

d. Trading Partner or their Business Associate agrees to cure transaction errors or deficiencies identified by the Department.

e. Trading Partner or Trading Partner's Business Associate understands that from time-to-time HHS may modify and set compliance dates for the HHS Transaction Standards. Trading Partner or Trading Partner's Business associate must incorporate by reference any such modifications or changes (45 CFR Part 160.104).

f. The Department and the Trading Partner agree to keep open code sets being processed or used for at least the current billing period or any appeal period, whichever is longer (45 CFR Part 162.925 (c)(2)).

g. Privacy

1) The Trading Partner or the Trading Partner's Business Associate will comply with all applicable state and federal privacy statutes and regulations concerning the treatment of Protected Health Information (PHI).

2) The Department and the Trading Partner or Trading Partner's Business Associate will promptly notify the other party of any unlawful or unauthorized use or disclosure of PHI that may have an impact on the other party that comes to the party's attention, and will cooperate with the other party in the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of PHI.

3) The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Trading Partner, Trading Partner's Business Associate, or any agent, contractor or third Party that received PHI from the Trading Partner.

h. Security

1) The Department and the Trading Partner or Trading Partner's Business Associate must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's operating system when the attempt may have an impact on the other party.

2) The Department and the Trading Partner or Trading Partner's Business associate must develop, implement, and maintain appropriate security measures for its own operating system. The Department and the Trading Partner or Trading Partner's Business Associate must document and keep current its security measures. Each party's security measure will include, at a minimum, the requirements and implementation features set forth in 'site specific HIPAA rule' and all applicable HHS implementation guidelines.

6. Indemnification

In the event of a breach of this Section by the PIHP, the PIHP shall indemnify and hold harmless the State of Wisconsin and any of its officers, employees, or agents from any claims arising from the acts or omissions of the PIHP, and its subcontractors, employees and agents, in violation of this Section, including but not limited to costs of monitoring the credit of all persons whose Confidential Information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the State in the enforcement of this Section. In addition, notwithstanding anything to the contrary herein, the PIHP shall compensate the State for its actual staff time and other costs associated with the State's response to the unauthorized use or disclosure constituting the breach.

7. Equitable Relief

   The PIHP acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury will not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the State, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Agreement or under applicable law.

8. Liquidated Damages

   The PIHP agrees that an unauthorized use or disclosure of Confidential Information may result in damage to the State's reputation and ability to serve the public interest in its administration of programs affected by this Agreement. Such amounts of damages which will be sustained are not calculable with any degree of certainty and thus shall be the amounts set forth herein. Assessment under this provision is in addition to other remedies under this Agreement and as provided in law or equity. The State shall assess damages as appropriate and notify the PIHP in writing of the assessment. The PIHP shall automatically deduct the damage assessments from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice.

   Liquidated Damages shall be as follows:

   a. $100 for each individual whose Confidential Information was used or disclosed;

   b. $100 per day for each day that the PIHP fails to substantially comply with the Corrective Action Plan under this Section.

   c. Damages under this Section shall in no event exceed $50,000 per incident.

9. Compliance Reviews

The State may conduct a compliance review of the PIHP's security procedures to protect Confidential Information.

10. Survival

    This Section shall survive the termination of the Agreement.

D. Party in Interest

1. The PIHP agrees to report to the state and, upon request, to the Secretary of the U.S. Department of Health & Human Services (DHHS), the Inspector General of the U.S. DHHS, and the Comptroller General a description of transactions between the PIHP and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

    a. Any sale or exchange, or leasing of any property between the PIHP and such a party.

    b. Any furnishing for consideration of goods, services (including management services), or facilities between the PIHP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

    c. Any lending of money or other extension of credit between the PIHP and such a party.

E. Declaration of National or State Emergency

In the event of a Federal or State declared emergency or disaster, DHS has the ability to modify or waive contractual obligations and regulations on health plans that are necessary to address the emergency or disaster. DHS will maintain documentation of any modifications to or waivers of contract requirements, including effective and end dates for each change. DHS reserves the right to identify flexibilities or waivers of contract requirements for DHS responsibilities, if DHS is impacted by the emergency or disaster. This may include, but is not limited to, extension of deadlines or timeframes for DHS or subcontractor activities.

The health plan must follow all relevant ForwardHealth Updates or other DHS communications issued during a federal or state disaster to ensure members continue to receive all medically necessary services.

F. Interoperability and Access to Health Information – Patient Access Application Programming Interface (API, Provider Directory API, and Payer-to-Payer Data Exchange)

The PIHP shall implement requirements from the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers" final rule (85 FR 25510). The PIHP shall implement these interoperability requirements in accordance with the applicable specifications of the Office of the National Coordinator's (ONC's) "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" companion final rule (85 FR 25642).
The PIHP shall implement:

1. Patient Access Application Programming Interface (API):
   The PIHP shall provide members with the ability to access their own personal health information, including unstructured claims and encounter information, costs, and a defined sub-set of their clinical information as outlined at 42 CFR § 422.119, 42 CFR § 431.60, 42 CFR § 457.730, and 45 CFR § 156.221, specifically for the Patient Access API, and current version of the United States Core Data for Interoperability (USCDI) dataset. The PIHP will be responsible for the Patient Access API, including all applicable technology standards, supporting technology infrastructure, and security protocols required to conform with the CMS final rule. This information shall be provided via an HL7 FHIR compliant standards-based API available to third-party applications of the member's choice.

2. Provider Directory API:
   The PIHP shall make their Member-enrolled provider directory information publicly available via an HL7 FHIR complaint standards-based API per the requirements outlined at 42 CFR § 438.242(b)(6) and 42 CFR § 457.1233(d). At a minimum, the HMO must make the provider names, addresses, phone numbers, and specialties available.

3. Payer-to-Payer Data Exchange:
   The PIHP shall provide members with the ability to exchange certain patient clinical data (specifically the current version of the U.S. Core Data for Interoperability (USCDI) data set). Members shall have the ability to request the transfer of all clinical and claims-related data from an assigned payer to a future payer to enable health data portability. The PIHP is required to conform with 42 CFR 438.62(b)(1)(vi) & (vii) for Medicaid managed care plans (and by extension under § 457.1216 CHIP managed care entities) and implement a process for this data exchange beginning January 1, 2022.

4. PIHP shall review the ONC 21st Century Cures Act Final Rule to determine its obligation to comply with the final rule. Specifically, PIHP shall review the terms "Health Information Exchange" (HIE) and "Health Information Network" (HIN) which are defined in 45 CFR § 171.102, and the exceptions to information blocking as amended by Section 4004 of the Cures Act and as found in 42 USC § 300jj-52, in relation to their contractual and financial relationships. If the PIHP meets the definition for an HIE/HIN as it pertains to information blocking, PIHP shall comply with all the requirements set forth in the rule.
5. Access to Educational Materials:
   Pursuant to 42 CFR § 431.60(f) and 42 CFR § 457.730(f), PIHP shall develop educational resources regarding privacy and security, including information regarding the possible risk of sharing their data with third-party app and how members can protect the privacy and security of their health information in non-technical, simple and easy-to-understand language. The PIHP shall publish these resources on its publicly accessible website.

PIHPs must make documentation related to implementation of these requirements as required in the CMS final rule (85 FR 25510) available to Wisconsin Division of Medicaid Services upon request.

XII. REPORTS AND DATA

A. Required Use of the Secure ForwardHealth Portal

The PIHP must request a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions and other business with DHS. When the PIHP requests an account, the designated PIHP contact will receive a PIN via their email address. The PIN is used to access specific PIHP information on the Portal.

The PIHP must assign users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. The PIHP must ensure all users understand and comply with all HIPAA regulations.

Detailed information can be found at:

https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Account/Setup.aspx

B. Access to and/or Disclosure of Financial Records

The PIHP and any subcontractors must make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the PIHP or subcontractors that relate to the PIHP's services performed and amounts paid or payable under this Contract. The PIHP must comply with applicable record keeping requirements specified in Wis. Adm. Code DHS 105.02(1)-(7) as amended.

C. Access to and Audit of Contract Records

Throughout the duration of this Contract, and for a period of ten years after termination of this Contract, the PIHP must provide duly authorized representatives of the state or federal government access to all records and material relating to the PIHP's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material, including but not limited to computer records system, invoices, and to verify reports furnished in compliance

with the provisions of this Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations. Refusal to provide required materials during an audit may subject the PIHP to sanctions in Article XIV, Section C.

D. Encounter Data and Reporting Requirements

The PIHP is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. PIHP staff will participate with the Department in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA and MSIS/TMSIS requirements applicable to the PIHP. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual PIHP meetings with the Department to address changes in requirements, local applications or databases. The PIHP must cooperate with the Department on data submission protocol and testing. The Department or its designees reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract and anytime thereafter. Per 42 CFR 438.602(e), the Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

1. Data Management and Maintenance: The PIHP must have a system that is capable of providing information on utilization, processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, grievance and appeals, and meeting reporting requirements. The required formats and timelines are specified in Article XII, Section J. The PIHP must:

    a. Participate in PIHP encounter technical workgroup meetings scheduled by the Department.

    b. Capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contact. The original claim submitted by the provider must be stored and retrievable upon request by either the Department or CMS.

    c. Have a database which is a complete and accurate representation of all services the PIHP provided during the Contract period.

d. Be responsible for monitoring the integrity of the database, and facilitating its appropriate use for such required reports as encounter data and targeted performance improvement studies.

e. Be responsible for maintaining unique identifiers assigned by the Department or its designee such as the identification number assigned to each submitted encounter. The PIHP must maintain all national code sets and Department specific fields as defined in ForwardHealth and the HMO Encounter User Guide.

f. Be responsible for updating and testing new versions of national codes sets and/or state specific code set.

g. Submit adjudicated clean claims as encounters no later than 120 days after the date the PIHP adjudicates the claim. If a PIHP paid encounter is denied within the Department's Medicaid Management Information System (MMIS), the PIHP has 90 days to resolve the encounter to priced status within the system.]

h. Not alter encounters with dates of service older than two years of the current year. For example, if the current calendar year is 2015, the PIHP must not alter encounters with a date of service of 2012 or older.

i. Comply with section 6504(a) of the Affordable Care Act, including operating systems that allow the Department to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meet the requirements of section 1903(r)(1)(F) of the Act.

j. Verify the accuracy and timeliness of data reported by providers, including data from network providers the PIHP is compensating on the basis of payments.

k. Screen the data received from providers for completeness, logic, and consistency.

l. Ensure that it is the sole entity to make payments to network providers for covered services, except in specific instances.

2. Program Integrity and Data Usage: The PIHP shall establish written policies, procedures, and standards of conduct that articulate the organization's

commitment to comply with all applicable data processing and safeguarding requirements and standards under the contract, and all applicable Federal and state requirements. This documentation must be kept current and be provided to the department upon request.

a. This requirement extends to all subcontractors to the extent that the subcontractor is delegated responsibility by the PIHP. The PIHP is responsible for ensuring that data usage agreements and procedures are in place with providers and contractors that facilitate complete, accurate and timely encounter submissions to the Department.

b. The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. The Department will ensure that the analysis does not violate the integrity of the reported data submitted by the PIHP.

3. Testing and Certification Requirements: The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production encounters or other documented encounter data must be used for the test data files.

   a. The PIHP must notify the Department of all significant personnel changes and system changes that may impact the integrity of the data, including new claims processing vendors and significant changes in personnel.

   b. A new PIHP must test the encounter data set until the Department is satisfied that the PIHP is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable. A new PIHP must become certified to submit compliant encounters within six months of their start date.

   c. The PIHP must provide a three month notice to the Department in advance of transition to a new claims processing system and/or third party administrator. The new system must become certified by the Department or its designee to submit compliant encounters within six months of its start date.

4. Data Exchange Requirements: All encounter submissions must be in a HIPAA compliant ASC X12 transaction format.

1. The PIHP must follow the data specifications defined in the Encounter User Guide and must submit encounters that conform to national standards as well as specific Departmental requirements.

2. The PIHP must enter itself as an other payer on the encounter, identifying the amount and the date the PIHP paid its provider.

3. The PIHP must process all the PIHP specific files as defined in the PIHP Report Matrix on ForwardHealth. All enrollment, encounters, response, capitation, provider, error reports and special program files must be processed in a timely and accurate manner.

5. Performance Requirements: The PIHP must submit accurate and complete encounter data that the Department can use for rate-setting, Federal Reporting, special programs and any other purpose deemed necessary by the Department. The PIHP must track metrics used by the Department to confirm that data is accurate and complete. Any deficiencies in the metrics must be reported to the Department within 15 days of the PIHP identifying the problem. The PIHP must complete a quarterly progress report due on April 30th, July 30th, October 30th and January 30th. The Progress Report and Template is posted to the Managed Care Section in ForwardHealth. The completed progress report and/or any deficiencies in the metrics should be submitted to DHSDMSBRS@dhs.wisconsin.gov.

6. The Chief Operating Officer or their designated authority must attest to the following metrics included on the report:

   a. Encounter Volume —The PIHP must submit encounters with a consistent volume from month to month. PIHPs provide expected average monthly volume on the quarterly progress report. An inconsistency is defined as a volume that is sustained for more than three months that is greater than 10 percent lower than the expected monthly volume.

   b. Pricing Percentage—The PIHP must achieve and maintain a consistent Pricing Percentage of 95 percent for a 12 month period over all Institutional, Professional and Dental claim types. The PIHP must report a deficiency in pricing percent that lasts greater than three months. Final reconciliation will be based on priced claims in encounter. The PIHP will not be reimbursed for claims not priced through PIHP encounter.

7. Non-Compliance Resolution Process: The Department shall have the right to audit any records of the PIHP and to request any additional information. If at any time the Department determines that the PIHP has not complied with any requirement in this section, the Department will issue a corrective action to the PIHP. The PIHP shall comply within the timeframe defined in the corrective action. If the PIHP fails to comply, the Department may pursue action against the PIHP as provided under Article XIV, Section C.

E. Coordination of Benefits (COB), Encounter Record, Member Grievances and Appeals, and Birth Cost Reporting Requirements

The PIHP agrees to furnish to the Department and to its authorized agents, within the Department's time frame and format, information that the Department requires to administer this Contract, including but not limited to the following:

1. Encounter Record for Each Member Service

   An encounter record for each service provided to members covered under this Contract. The encounter data set must include at least those data elements specified in the Encounter User Guide or elements required by the national standards.

2. Member Grievances and Appeals to the PIHP

   Copies of all member grievances and appeals and documentation of actions taken on each grievance.

F. Records Retention

The PIHP must retain, preserve and make available upon request all records relating to the performance of its obligations under the Contract, including paper and electronic claim forms, for a period of not less than ten years from the date of termination of this Contract. Records involving matters that are the subject of litigation or audit shall be retained for a period of not less than ten years following the termination of litigation or audit. Copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the microfilming procedures as reliable and supported by an effective retrieval system.

G. Reporting of Corporate and Other Changes

The PIHP must report to the Department through their Managed Care Analyst any change in corporate structure or any other change in information previously reported, such as through the application for certification process. The PIHP must report the change upon the submission of the Application for Change in Domestic Company Status with the Office of the Commissioner of Insurance.

1. Any change in information relevant to ineligible organizations.

2. Any change in information relevant to ownership and business transactions of the PIHP.

H. Provider and Facility Network Data Submission

1. The PIHP that contracts with the Department to provide FCMH services must submit a detailed provider network and facility file monthly and when the PIHP experiences significant change with respect to network adequacy (as defined in Art. V, F.), to the State's SFTP.

2. The provider network and facility file shall include only Medicaid-enrolled providers who are contracted with the PIHP to provide contract services to FCMH members.

3. PIHP must submit complete and accurate provider network and facility data. The Department will provide the PIHP with the required file format layout and data fields. The Department retains the right to conduct audits of provider and facility data for completeness and accuracy during the contract period. Incomplete or inaccurate provider and/or facility data will subject the PIHP to administrative sanctions outlined in Article XIII, Section C.

I. Contract Specified Reports and Due Dates

Weekly REPORTS		
PIHP Provider Network	List of all providers in the PIHP network, Submit via the SFTP. *(See the File Submission Specification Guide)*	Article V, F
Monthly REPORTS		
Supplier Diversity Report	Send monthly reports regarding the PIHPs subcontract with DOA certified MBEs and DVBs	Article XII, N
QUARTERLY REPORTS		

1ST QUARTER: (Jan-March); 2ND QUARTER: (April – June); 3RD QUARTER: (July – Sept); 4TH QUARTER: (Oct – Dec)		
Attestation Form	Send quarterly attestation form to the **BRS.** Email report to: DHSDMSBRS@dhs.wisconsin.gov Due date schedule is: 1st Quarter – April 30 2nd Quarter – July 30 3rd Quarter – Oct 30 4th Quarter – Jan 30	Article II D5 Forms are located in ForwardHealth.
Grievance and PIHP Appeal Summary Report	Send quarterly summary grievance and appeal reports to **BCS** by either hardcopy or password protected attached email. Report includes PHI. Due date is within 30 days of end of quarter.	Addendum V, C Use form in Grievance and Appeal Guide.
Access Payments	Send DMS BRS a summary of access payments for services incurred during the previous calendar year. Due date is the end of each quarter. Email report to: DHSDMSBRS@dhs.wisconsin.gov	Article XV, A.3
Detail Claims Report	Send DMS BRS a detail claims report identifying member services incurred during the previous calendar year. Due date is the end of each quarter. Email report to: DHSDMSBRS@dhs.wisconsin.gov	Article XV, A.3
ANNUAL REPORTS		
Performance Improvement Project (PIP) Final Project	Send to your **BCS** Care4Kids contract monitor and EQRO contact by password protected email attachment. Report due on the 1st business day of July.	Article X I
Annual PIHP Financial Reconciliation Report	PIHP certification of the encounter data for reconciliation due no earlier than twelve months after the end of the calendar year.	Article XVI A.3
Initial Performance Improvement Project (PIP) (PIP Proposal)	Send to your **BCS** managed care contract monitor and EQRO contact by password protected email attachment. Topic Selection on first business day of December.	Article X I
Financial Template	Report due to DMS BRS. Due date is no earlier than twelve months after the end of the Calendar Year. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI(A)3(b)2
Audited Financial Template	Report due to DMS BRS. Due date is no earlier than twelve months after the end of the Calendar Year. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI(A)3(b)2

Most recent complete year of encounter records	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Reconciliation of financials	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Alternate/Previous Medicaid IDs for enrolled members	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Access payments for prior year	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Statement of operations for the most recent complete year	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Vision Sub-payments for the most recent complete year	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Upcoming Rate Year Budget Projection	Report due to DHMS BRS. Due date is November 1st. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
OTHER REPORTS		
Affirmative Action Plan Submit every **3 years**	**AA/CRC Office** in the format specified on Vendor Net. Send to dhscontractcompliance@dhs.wisconsin.gov	Article XI C 4
Civil Rights Compliance Letter of Assurance and Plan	**AA/CRC Office** in the format specified in Article III, C.4.b. Send to AA/CRC Coordinator dhscontractcompliance@dhs.wisconsin.gov	Article I C 4 b
Encounter Data File in (**837I, 837P, 837D**) format.	**Send to Fiscal agent** on SFTP	Article XII E

Court Ordered Birth Cost Report.	Send report to your **BCS**, managed care contract monitor by password protected email attachment. This report contains PHI. **Submit on an as needed basis.**	Addendum IV B
Communicable Disease Reporting (by providers).	PIHP providers must send report to the **local health department**. Report of human immunodeficiency virus (HIV) will be made directly to the **State Epidemiologist. Providers should** submit **on an as needed basis.**	Article XII K
Fraud, Waste and Abuse Investigations.	The PIHP must report allegations of fraud, waste and abuse (both provider and member) to the Department within 15 days of the suspected activity coming to the attention of the PIHP. Submit **on an as needed basis.**	Article XII L 2
Abortions, Hysterectomies and Sterilizations.	The PIHP must comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations. Submit form with signatures **on an as needed basis.**	
Privacy and Security Incidents	Send information to your **BCS** managed care contract monitor the same day an incident occurs. Submit **on an as needed basis.**	Article XI, D
CMS Drug Utilization Review Report	PIHPs are required to submit timely responses to report and survey requests as required by federal and/or state law or program policy.	Article XI, A
Daily EVV Authorization File	PIHPs are required to submit a daily file for authorizations for personal care services.	Article IV(1)(15)
Daily EVV Visit File	PIHPs are required to utilize a daily file that contains all verified provider network EVV visits.	Article IV(1)(15)
COVID-19 Vaccination Reporting	Submit timely responses to report and survey requests as needed to your BCS managed care contract monitor.	

Any reports that are due on a weekend or holiday are due the following business day.

BCS= Bureau of Children's ServicesBRS = Bureau of Rate Setting

Report Mailing Addresses:

Department of Health Services
Bureau of Children's Services
P.O. Box 309
Madison, WI 53701-0309

Department of Health Services
Bureau of Rate Settings
P.O. Box 309
Madison, WI 53701-0309

Fiscal Agent
Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470

Department of Health Services
Affirmative Action/Civil Rights
Compliance Office
P.O. Box 7850
Madison, WI 53707-7850

The Department electronically produces multiple reports and resources for use by the FCMH PIHP, which are listed at the following website:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage

Any reports that are due on a weekend or holiday are due the following business day.

J. Communicable Disease Reporting

As required by Wis. Stats. 252.05, mandated providers affiliated with a PIHP shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any member treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable disease or death or as specified in Wis. Adm. Code DHS 145. Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the PIHP shall report to the local health department the identification or suspected identification of any communicable disease listed in Wis. Adm. Code DHS 145. Reports of HIV infections shall be made directly to the State Epidemiologist.

K. Program Integrity

1. Administrative and Management Arrangements

The PIHP must have documented administrative and management arrangements or procedures, and a mandatory compliance plan, that are

designed to guard against fraud, waste and abuse. The PIHP arrangements or procedures must include the following:

a. Written policies, procedures, and standards of conduct that articulate the PIHP's commitment to comply with all applicable federal and state laws and rules.

b. An organizational chart depicting the designation of a compliance officer and a compliance committee that is accountable to senior management.

c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the PIHP's compliance program and its compliance with contract requirements

d. A schedule for training and education for the Compliance Officer, the PIHP's senior management, and the PIHP's employees for the federal and state laws, rules, and requirements, including program integrity under the contract.

e. Documented effective lines of communication between the compliance officer, senior management and the PIHP's employees.

f. Enforcement of program integrity standards through well-publicized disciplinary guidelines.

g. The establishment and implementation of documented procedures and a system with dedicated staff for:
    1) Routine internal monitoring and auditing of compliance risks related to the provider network, including both prepayment and post-payment program integrity strategies;
    2) Prompt response to compliance issues, both internal and related to the provider network, as they are raised;
    3) Timely investigation of potential compliance problems, both internal and related to the provider network, identified in the course of self-evaluation and audits;
    4) Correction of such problems promptly and thoroughly to reduce the potential for recurrence;

5) Ongoing compliance with the requirements under the contract.

h. The identification of dedicated staff responsible for identifying, mitigating, and preventing fraud, waste, and abuse.
   1) The activities and performance are subject to audit/review by the DHS Office of the Inspector General (DHS OIG).
   2) The PIHP is required to respond to any corrective action or performance improvement activities specified in the written report to the PIHP within the timeframes specified

i. A documented process to ensure a prompt response to detected offenses, and for development of corrective action initiatives relating to the PIHP's contract.

j. A method for verifying, on a quarterly basis, whether services that have been reported for payment have been delivered by network providers and received by the appropriate Medicaid member.

   1) The PIHP must verify the provision of services with members for at least 100 paid encounters each quarter.
   2) The PIHP must maintain appropriate records of these verifications.
   3) DHS will verify compliance with this requirement.

k. If the PIHP makes or receives annual payments under the contract of at least $5,000,000, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about right of employees to be protected as whistleblowers.
   1) Whistleblowers should report program integrity concerns to the DHS OIG. Whistleblowers may make a report through the hotline (877-865-3432) or through the online portal (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx). The PIHP is responsible for ensuring employees have access to this information.

2. Fraud, Waste and Abuse Investigations

The PIHP must report all potential fraud, waste, and abuse, including credible allegations of fraud, directly to the DHS OIG within 15 business days of the PIHP's identification of the issue. The PIHP may make a report through the hotline (877-865-3432) or through the online portal (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx).

a. Reports of fraud, waste or abuse from a PIHP must not be made anonymously, and these reports may be subject to open records laws.
b. The PIHP must collect preliminary information including available data, statements from appropriate parties, and other materials supporting the allegations. The DHS OIG SharePoint site can be utilized as a secure method to upload preliminary information and documentation along with the original referral that was submitted to the online portal or hotline. Following the report of the alleged fraud, waste or abuse, the PIHP must continue to investigate the allegations of fraud unless otherwise directed by DHS OIG, Department of Justice Medicaid Fraud Control and Elder Abuse Unit, or other law enforcement or regulatory entity.
c. If the PIHP's investigation finds evidence of fraud, the PIHP must collaborate with DHS OIG to complete the credible allegation of fraud referral form (F-02296) and compile appropriate exhibits to the form.
d. The PIHP must report allegations of only Medicaid fraud to DHS OIG. It is unnecessary to report violations that occurred in the PIHP's commercial line of business, or otherwise did not result in the loss of Medicaid funds.
e. Failure on the part of the PIHP to cooperate with these directives or report fraud, waste, or abuse may result DHS taking in any applicable sanctions under Article XIV, Section D.
f. Pursuant to 42 CFR 455.23, the authority of determining credible allegations of fraud rests with the Department of Health Services. All reports of potential Medicaid fraud must first be made to the DHS OIG.
    1) If the PIHP forwards a report of potential Medicaid

fraud to any additional state or federal agency, the PIHP shall notify the DHS OIG of that referral.

3. Suspension of Provider Payments
    a. The PIHP agrees to cooperate with the Affordable Care Act (ACA) suspension of payment requirements. The PIHP is prohibited from paying for an item or service furnished by an individual or entity to whom the state has suspended payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments. The DHS Inspector General must review and authorize any request for a good cause exception.

    b. The PIHP must have a documented process outlining the PIHP's response to information in the provider file from the Department notifying the PIHP of suspension of payment. The provider file sent by the Department to the PIHP will have an added field that will indicate the outcome of the credible allegation of fraud investigation. The values are:
        1) A – ACA suspension of payment is currently active. The PIHP must suspend payment based on the effective date for the start of the investigation.
        2) C – The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.
        3) T – The provider has been terminated due to the outcome of the credible allegation investigation. The contract's termination date will be listed in the provider file.
    c. The PIHP must have a written process documenting its response to email notification of provider payment suspensions from the DHS OIG resulting from credible allegations of fraud, including but not limited to how the payments are suspended in the PIHP's claims processing system and any required internal communications.
    d. The PIHP must have clearly defined criteria, policies, and procedures in place for suspending providers within their network independent of payment suspensions issued by the DHS OIG. These policies and procedures must include

notification of DHS within 24 hours of the suspension of payments using the DHSOIGManagedCare@wisconsin.gov email address. PIHPs must also record these payment suspensions on the terminations/sanctions/suspensions tab of the Quarterly Program Integrity Report (F-02250)..

4. Termination of Exclusion of Provider

The PIHP must report providers terminated for cause by the PIHP, as well as providers the PIHP identifies as excluded, to OIG. The PIHP must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of the email should include the name of the provider, NPI and MA ID numbers, date of termination/exclusion, and reason for termination/exclusion.:

5. Treatment of Recoveries
    a. Pursuant to 42 CFR s. 438.608 (d), the PIHP must attempt to recover all overpayments made to network providers, including those overpayments attributed to fraud, waste, and abuse, identified by the PIHP. The PIHP recovers the payments and retains the funds for all overpayments identified by the PIHP, provider, or DHS OIG. Any overpayment identified by DHS OIG would be an estimated overpayment based on the max fee schedules. The PIHP would be responsible for determining the actual overpayment amount.

    b. The PIHP must have a documented process requiring the network providers to return any overpayments they received. The PIHP must share the documented process with all providers in the PIHP's network. The PIHP must require the network providers to return overpayments within 60 days of the provider receiving written notification of the overpayment or, if self-identified by provider, within 60 days of the provider's discovery of the overpayment. The PIHP must require the provider to notify the PIHP of the reason for the overpayment. The PIHP must appropriately reflect the recovery of all overpayments in the PIHP's encounter data and on Tab 3 of the Quarterly Program Integrity Report. Provider agreement language must require network providers to follow the same requirements when they self-identify an overpayment they have received.

    c. PIHPs must submit a monthly report of any payments in excess of amounts specified in the contract within sixty (60) calendar days of

identification as required by 42 CFR 438.608(c)(3). PIHPs must submit the report via DHS OIG's SharePoint site. The report must contain the following information:

1) The PIHP's name;
2) The member's Medicaid number;
3) The member's name;
4) The month or number of days if partial month;
5) The rate paid;
6) The correct rate;
7) The reason for overpayment, if known;
8) The original date the overpayment reported to DHS; and
9) The action taken by the PIHP, if any.

*This provision does not apply to any amount of recovery retained under the False Claim Act cases or through other investigations.

6. Network Provider Audits

DHS OIG and DHS OIG's contracted program integrity (PI) vendors will conducts audits of the PIHP's network providers. DHS OIG will utilize the fee-for-service max fee tables when assigning value to services provided in the audit. The PIHP must collaborate with DHS OIG and DHS OIG's contracted PI vendors on all matters related to these audits, including, but not limited to:

a. Coordinating relative to scope and sample to prevent a duplication of audit efforts between DHS OIG and the PIHP;
b. Sharing claims-level data for program integrity purposes;
c. Receiving copies of audit related communications between DHS OIG and contract PI vendors and the network providers;
d. Engaging in audit resolution which may include technical assistance to both the plan and provider, corrective action plans administered by DHS, referrals to MFCEAU or DSPS, termination of a network provider's Medicaid certification, financial sanctions administered by DMS, under Article XIV, Section D, or other means by which the audit findings can be addressed;
e. Ensuring audit findings are addressed across the PIHP'S entire network of providers, not just the provider(s) included in DHS OIG's audit;

f. Communicating recovery of any overpayments based on DHS OIG's audit findings:
    1) DHS OIG will not collect any overpayments based upon its audit but the PIHP may choose to use DHS OIG's estimated value of the audit findings and seek recovery of the overpayment from the audited network provider. The PIHP is entitled to keep the overpayment. Provider agreement language should be updated to reflect this activity if the PIHP elects to identify and pursue overpayments based on DHS OIG's audit findings.
    2) The PIHP must document the recovery of any overpayments associated with network provider audits conducted by DHS OIG or DHS OIG's contracted PI vendors on Tab 3 of the Quarterly Program Integrity Report by entering "OIG Audit (OIG case number)" in Column F "Reason for Recovery."
    3) Network providers may appeal overpayments through the process identified in the PIHP's provider agreement first, and subsequently follow the process outlined in Article VIII of this contract, if needed.
g. Ensuring that provider agreements require the PIHP's network providers to collaborate with DHS OIG and DHS OIG's contracted PI vendors in the following ways:
    1) Network providers must respond to requests for all records in a timely manner as specified in the record request letter.
    2) If a network provider would like to submit rebuttal to initial findings for consideration by DHS OIG or DHS OIG's contracted PI vendors, the network provider must submit the rebuttal documentation to DHS OIG or DHS OIG's contracted PI vendors by the date specified in the preliminary findings letter or amended preliminary findings letter.

7. Corrective Action Plans and Sanctions

   DHS will issue any formal corrective plans or sanctions related to non-compliance with this Article in accordance with Article XIV, Section D.

8. Quarterly Program Integrity Reporting Log
    a. The PIHP must submit the Quarterly Program Integrity Reporting Log (F-02250) to DHS OIG on a quarterly basis. The log must be

completed thoroughly and accurately and is due no later than the last business day of the month following the end of the calendar year quarter (April, July, October, and January). The Quarterly Program Integrity Reporting Log consists of the following four separate reporting categories:

1) Program Integrity Log: Captures complaints regarding fraud, waste, and abuse received by the PIHP warranting preliminary investigation.
2) Provider Education Log: Captures education given to network providers related to billing practices, billing errors, or fraud, waste, and abuse. PIHP's should differentiate between education that originates from a complaint, training requested by the provider and regular scheduled training opportunities. It is unnecessary to capture education regarding subject matter unrelated to program integrity.
3) Overpayment Recovery Log: Captures pertinent information regarding all overpayment recoveries, not just those recovered due to fraud, waste, and abuse, regardless of which entity identified the overpayment.
4) Termination/Sanctions/Suspension Log: Captures all terminations, sanctions, and payment suspension actions taken by the PIHP that impact Medicaid network providers.

b. The Quarterly Program Integrity report must be submitted to the Department via DHS OIG's SharePoint site. DHS OIG will evaluate the submitted reports and may follow up with the PIHP to obtain additional information, provide technical assistance, or request further action. DHS may impose a corrective action plan or a financial sanction for non-compliance with reporting requirements and deadlines.

9. Records Retention

The PIHP must retain records pertaining to all program integrity activities, including but not limited to audits, investigations, review, Quarterly Program Integrity Reports, and complaints as required in Article XII: Reports and Data, Section G: Records Retention in this contract. Article XII: Reports and Data, Section G: Records Retention requires documentation to be retained for a period of not less than ten years from the date of termination of this contract.

10. Annual Fraud, Waste, and Abuse (FWA) Strategic Plan

a. The PIHP is responsible for developing an annual FWA strategic plan which meets the requirements outlined in Addendum VII. The FWA strategic plan must be approved annually by DHS. Failure to submit a plan meeting the requirements outlined in Addendum VII may result in a corrective action plan and/or financial sanction under Article XIV, Section D.
b. The PIHP must document and be prepared to evidence completion of activities on the annual FWA strategic plan during DHS's annual audit of the FWA strategic plan. The PIHP must implement their first annual FWA strategic plan on January 1, 2023. DHS will begin auditing PIHP's compliance with their FWA strategic plans in the subsequent year. In addition, DHS will evaluate for the completeness and quality of all activities. PIHPs found to be out of compliance with their annual FWA strategic plan or in need of improvement will receive technical assistance following the first review by DHS. DHS may impose corrective action plan and/or financial sanction imposed under Article XIV, Section D for PIHPs who fail to engage in technical assistance or in DHS's audit process.
c. The PIHP must communicate any mid-year changes to the annual FWA strategic plan to DHS and submit an updated plan for DHS approval.
d. PIHPs must use the DHS OIG SharePoint site to submit all FWA strategic plans.

L. Non-Disclosure of Trade Secrets and Confidential Competitive Information

1. To the extent that encounter records, medical-loss ratio reports, or other submissions/reports include or have the capacity to reveal amount(s) paid by the PIHP to provider(s), the PIHP and the Department agree that those records, reports or submissions constitute trade secrets under the Wisconsin Uniform Trade Secrets Act, Wis. Stats., s. 134.90(1)(c), and must remain confidential to protect the competitive market position of the PIHP. The Department agrees such records, reports or submissions are thus exempt from disclosure under s. 19.36(5), Wis. Stats. regardless of whether said information is specifically, separately designated as such by the PIHP at the time of submission or reporting to the Department.

2. If the Department receives an open records request, subpoena, or similar request involving the information described in Paragraph 1, the Department

shall notify the PIHP of the request without unreasonable delay. Upon such request, the Department shall take all reasonable steps to prevent the disclosure of such information. In the event that disclosure of information is compelled pursuant to a writ of mandamus or other court order, the Department agrees to redact any otherwise proprietary, confidential, or trade secret information prior to said disclosure, subject to the terms of the order.

3. In the event the designation of the confidentiality of this information is challenged, the PIHP agrees to provide legal counsel or other necessary assistance to defend the designation of records, reports, or submissions as a trade secret. The Department shall, without charge to the PIHP, reasonably cooperate with such defense, to include providing legal counsel, testimony, and attestations regarding the protection of confidential and proprietary information that qualifies as a trade secret. Notwithstanding the foregoing, the PIHP shall have the sole right and discretion to direct the defense to settle, compromise, or otherwise resolve such defense. Should any order or judgment be issued against the Department, the PIHP will hold the Department harmless and indemnify the Department for costs and damages assessed against the Department as a result of designating records, reports, or submissions as trade secret(s).

   Notwithstanding the above, the amount(s) paid by the PIHP to provider(s) shall be stored within the Department's centralized data storage system, so as to allow the PIHP reconciliation procedures outlined in this Contract to be conducted by Department personnel. Such information shall still be considered trade secrets by the Department, but, in aggregate, will need to be included on various reports, including but not limited to communications with CMS about the operation of the Care4Kids program.

M. Annual Financial Report

The PIHP must submit its audited financial reports on an annual basis, starting with the PIHP's 2019 fiscal year. The audit must be conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards. The PIHP should include a Medicaid supplemental schedule along with the annual audited financial report. The Medicaid supplemental schedule will specifically segregate the financial results for the Foster Care Medical Home program contract from other lines of business for the required audit period and be reported on a GAAP basis. The audited Medicaid supplemental schedule will be provided to the Department in the

form of a "Statement of Operations and Changes in Net Assets" exclusive to the PIHP's Foster Care Medical Home contract. The statement must separately identify revenue and expenses covered by this Medicaid contract, other Medicaid contracts, and other non-Medicaid lines of business as applicable for the financial report.

The following example is a minimum requirement for the "Statement of Operations and Changes in Net Assets". The PIHP may provide an expanded statement with additional account categories at its discretion.

PIHP
Statement of Operations and Changes in Net Assets
For the Year Ended December 31, 20xx

	Foster Care Medical Home Medicaid Contract	All Other Medicaid Contracts	Other Non-Medicaid	Total
REVENUE				
Premium revenue				
Other revenue				
Total Revenue				
EXPENSES				
Medical expenses				
Claims adjustment expenses				
General administrative expenses				
Total Expenses				
NET INCOME/(LOSS)				

The PHIP will also submit its financial data for the Foster Care Medical Home Medicaid Contract on an annual basis on a Financial Template in order to restate medical expenses for paid claims and revenue for enrollment retroactively. The payment period will align with the encounters reported for the final reconciliation and will include a reconciliation of the Foster Care Medical Home Medicaid Contract reported on the audited Medicaid supplemental schedule. The PIHP shall report financial data that exclusively includes allowable services under this contract for eligible members. The Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

The following costs are excluded from rate setting:

- Advertising and Marketing, unless permissible as part of the HMO and PIHP Communication, Outreach, and Marketing Guide
- Lobbying
- Charitable Contributions and Donations
- Regulatory Fines and Penalties
- Travel Costs beyond those necessary to provide member healthcare services or economical administration of operate in the Wisconsin Medicaid program
- Entertainment

Unallowable costs must be segregated and excluded from allowable administrative costs in the PIHP's submitted budget projection. The department reserves the right to make adjustments to financial submissions for costs deemed unallowable based on Department or auditor review.

N. Supplier Diversity Reporting

Minority-Owned Business Enterprises (MBE) and Disabled Veteran-Owned Businesses (DVB) are certified by the Wisconsin Department of Administration (DOA). This program can be found at:
https://doa.wi.gov/Pages/DoingBusiness/SupplierDiversity.aspx

The State of Wisconsin is committed to the promotion of MBEs and DVBs in the State's purchasing program. The PIHP is strongly urged to use due diligence to further this policy by awarding Subcontracts to MBEs and DVBs or by using such enterprises to provide goods and services incidental to this Agreement.

The PIHP shall furnish appropriate monthly information about its efforts to subcontract with MBEs and DVBs, including the identities of such businesses certified by the Wisconsin Supplier Diversity Program, their contract amount, and spend for each period to DHS. A listing of certified MBEs and DVBs, as well as the services and goods they provide, is available at:
https://wisdp.wi.gov/Search.aspx

In accordance with WI Stats. Ch. 16.75 (3m), after completion of this contract, the Contractor shall report to DHS any amount of this contract that was subcontracted to DOA certified MBEs and DVBs.

DHS shall have the right to request any information regarding the use of subcontractors including, but not limited to, MBEs and DVBs. The PIHP shall

provide any such information as requested by DHS and within a time period that is specified by DHS.

The PIHP shall submit monthly reports of efforts to subcontract with MBEs, DVBs, and other diverse entities/suppliers to DHS. A link to the Supplier Diversity PowerForm for submitting these reports can be found on the DHS Compliance Documentation page found here: https://www.dhs.wisconsin.gov/business/compliance.htm

For the duration of this Agreement, the PIHP shall provide monthly reporting of efforts to subcontract with MBEs and DVBs no later than the 15th of the following month.

For questions about reporting, please contact DHS Contract Compliance at DHSContractCompliance@dhs.wisconsin.gov.

ARTICLE XIII: Functions and Duties of the Department

XIII. FUNCTIONS AND DUTIES OF THE DEPARTMENT

A. Utilization Review and Control

The Department will waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, , or other Medicaid restrictions for the provision of contract services provided by the PIHP to members, except as may be required by the terms of this contract.

B. Department Audit Schedule

The PIHP will be notified approximately 30 days prior to regularly scheduled, routine audits being conducted via a letter from the Department.

C. PIHP Review of Study or Audit Results

The Department will submit to the PIHP for a 30 business day review/comment period, any Medicaid and PIHP audits, PIHP report card, PIHP Member Satisfaction Reports, or any other Medicaid PIHP studies the Department releases to the public that identifies the PIHP by name. The PIHP may request an extension and the Department will exercise reasonable discretion in making the determination to waive the 30 business day review/comment requirement.

D. Vaccines for Children

The Department will assure that PIHP providers participate in the Vaccines for Children (VFC) program for administration of immunizations to PIHP members according to the policies and procedures in the Wisconsin Health Care Programs Online Handbook. The Department will reimburse the PIHP for the cost of new vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The reimbursement of the vaccine shall be the same as the Department reimburses FFS providers during the period of VFC availability. The PIHP retains liability for the cost of administering the vaccines.

E. Fraud, Waste, and Abuse Training

The Department will provide fraud, waste, and abuse detection training to the PIHP annually. The Department will provide training for PIHPs on implementation of suspension of payments to providers with a credible allegation of fraud.

F. Provision of Data to the PIHP

The Department will provide to the PIHP immunization information from the Wisconsin Immunization Registry, to the extent available.

G. Conflict of Interest

The Department will maintain state employee conflict of interest safeguards at least equal to federal safeguards (41 USC 423).

ARTICLE XIV: Contractual Relationship

XIV. CONTRACTUAL RELATIONSHIP

A. Delegations of Authority

The PIHP shall oversee and remain accountable for any functions and responsibilities that it delegates to any subcontractor. For all major or minor delegation of function or authority:

1. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate, or out of compliance with HIPAA privacy or security requirements.

2. Before any delegation, the PIHP shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

3. The PIHP shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once per contract period.

4. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor shall take corrective action.

5. If the PIHP delegates selection of providers to another entity, the PIHP retains the right to approve, suspend, or terminate any provider selected by that entity.

B. Subcontracts

This section does not apply to subcontracts between the Department and the PIHP. The Department shall have sole authority to determine the conditions and terms of such subcontracts. Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of the PIHP's contract with the Department of Health Services, hereinafter referred to as the Foster Care Medical Home Contract. Subcontract compliance with the Foster Care Medical Home Contract specifically includes but is not limited to the requirements specified below.

1. Subcontract Standard Language

The PIHP must ensure that all subcontracts are in writing and include the following standard language when applicable:

a. Subcontractor uses only Medicaid-enrolled providers in accordance with this Contract.

b. No terms of this subcontract are valid which terminate legal liability of the PIHP.

c. Subcontractor agrees to participate in and contribute required data to PIHP Quality Assessment/Performance Improvement programs.

d. Subcontractor agrees to abide by the terms of this Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the PIHP in accordance with this Contract.

e. Subcontractor agrees to submit PIHP encounter data in the format specified by the PIHP, so that the PIHP can meet the Department specifications required by this Contract. The PIHP will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

f. Subcontractor agrees to comply with all non-discrimination requirements.

g. Per 42 CFR 438.3(k), subcontractor agrees to comply with all audit and record retention and inspection requirements of 42 CFR 438.230(c)(3)(i-iv) and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements. Specifically, the State (including the OIG), CMS, The HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the PIHP's contract with the State. This right to audit will exist through ten

years from the final date of the contract period or from the date of completion of any audit, whichever is later.

h. Any PIHP or its subcontractor that enters into a contract with an entity outside the U.S. must clearly indicate Wisconsin law as jurisdiction for any breach of contract and ensure compliance with state and federal laws allowing for such contracts.

i. Per 42 CFR 438.230, subcontractor agrees to provide representatives of the PIHP, as well as duly authorized agents or representatives of the Department (including the OIG) and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the PIHP and the subcontractor), and administrative records. If the State (including the Office of the Inspector General), CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. Refusal will result in sanctions or penalties in Article XIV, Section C. against the PIHP for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

j. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in this Contract.

k. Subcontractor agrees to ensure confidentiality of family planning services.

l. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid benefits (e.g., COB recovery procedures that delay or prevent care).

m. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

n. Subcontractor agrees not to bill FCMH members for medically necessary services covered under this Contract and provided during the members' period of PIHP enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are eligible under the

Medicaid Program. This provision will remain in effect even if the PIHP becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the PIHP, PIHP provider, or PIHP subcontractor can bill.

The standard release form signed by the member at the time of services does not relieve the PIHP and its providers and subcontractors from the prohibition against billing a FCMH member in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to FCMH member liability must specifically state the admissions, services, or procedures that are not covered by Medicaid.

o. Within 15 business days of the PIHP's request subcontractors must forward medical records pursuant to grievances or appeals to the PIHP. If the subcontractor does not meet the 15 business day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

p. Subcontractor agrees to abide by the terms regarding appeals to the PIHP and to the Department regarding the PIHP's nonpayment for services providers render to members.

q. Subcontractor agrees to abide by the PIHP marketing/informing requirements. Subcontractor will forward to the PIHP for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its members concerning its PIHP affiliation(s), or changes in affiliation, or relating directly to the Medicaid population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the PIHP and the Department.

r. Subcontractor agrees to abide by the PIHP's restraint policy, which must be provided by the PIHP. Members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

2. Subcontract Submission Requirements

a. Changes in Established Subcontracts

1) The PIHP must submit changes in previously approved subcontracts to the Department for review and approval before they take effect. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services.

    a. Technical changes do not have to be approved.

    b. Changes in rates paid do not have to be approved, with the exception of changes in the amounts paid to PIHP management services subcontractors.

2) The Department will review the subcontract changes and respond to the PIHP within 15 business days.

b. New Subcontracts

The PIHP must submit new subcontracts to the Department for review and approval before they take effect.

3. Review and Approval of Subcontracts

The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the state Medicaid members, including but not limited to the proposed subcontractor's past performance. The Department will:

a. Give the PIHP:

    1) 120 days to implement a change that requires the PIHP to find a new subcontractor, and

    2) 60 days to implement any other change required by the Department.

b. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the PIHP.

c. Review and approve or disapprove each new subcontract before the Contract takes effect. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Contract.

d. Ensure that the PIHP has included the standard subcontract language as specified in Section B, 1 of this Article (except for specific provisions that are inapplicable in specific PIHP management subcontract).

4. Transition Plan

The PIHP may be required to submit transition plans when a primary care provider(s), mental health provider(s), gatekeeper or dental clinic terminates their contractual relationship with the PIHP. The transition plan will address continuity of care issues, member notification and any other information required by the Department to ensure adequate member access. The Department will approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

5. Notification Requirements Regarding Subcontract Additions or Terminations

The PIHP must:

a. Notify the Department of Additions or Terminations

The PIHP must notify the Department within 10 days of subcontract additions or terminations when those changes are substantial and impact member access. Those notifications could involve:

1) A clinic or group of physicians, mental health providers, or dentists,
2) An individual physician,
3) An individual mental health provider and/or clinic,
4) An individual dental provider and/or clinic.

This Department notification must be through the submission of an updated provider network to the SFTP server.

b. Notify the Department of a Termination or Modification that Involves Reducing Access to Care

The PIHP must notify the Department within 7 days of any notice by the PIHP to a subcontractor, or any notice to the PIHP from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could substantially reduce member access to care. This Department notification must be to both the PIHP's Contract Monitor and through the submission of an updated provider network to the SFTP server.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies pursuant to this Contract. These remedies include contract termination (notice to the PIHP and opportunity to correct are provided for), suspension of new enrollment, and giving members an opportunity to enroll in a different PIHP if one is available, or receive services through Medicaid FFS.

The PIHP must submit an updated provider and facility file when there has been a significant change with respect to network adequacy, as defined by the Department, in the PIHP's operations that would affect adequate capacity and services.

c. Notify Members of Provider Terminations

Not less than 15 days prior to the effective date of the in-network provider or gatekeeper termination, the PIHP must send written notification to the provider or gatekeeper's members. THE PIHP must use a template for this notification and obtain the Department's approval of the template before they it is sent to members. Any subsequent proposed changes to the template must be approved by the Department.

6. Management Subcontracts

The Department will review PIHP management subcontracts to ensure that:

a. Rates are reasonable.

b. They clearly describe the services to be provided and the compensation to be paid.

c. Any potential bonus, profit-sharing, or other compensation, not directly related to the cost of providing goods and services to the PIHP, is identified and clearly defined in terms of potential magnitude and expected magnitude during this Contract period. Any such bonus or profit-sharing must be reasonable compared to the services performed. The PIHP must document reasonableness. A maximum dollar amount for such bonus or profit-sharing shall be specified for the Contract period.

The requirements addressed in a. through c. are not required for non-Medicaid members if the PIHP wishes to have separate arrangements for non-members.

C. Memorandum of Understanding/Agreement

The PIHP is required to enter into or make every attempt to enter into an MOU with certain entities. The PIHP may include a provision within the MOU that will automatically renew MOUs with these entities. The MOU must include an opt out provision from the automatic renewal.

D. Sanctions, Financial Penalties and Remedial Actions for Violation, Breach, or Non-Performance of Contract

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny FCMH payments to the PIHP for members who enroll after the date on which the PIHP has been found to have committed one of the violations identified in the federal law. State payment for members of the contracting organization is automatically denied whenever, and for as long as, federal payment for such members has been denied as a result of the commission of such violations. The state may impose sanctions if the PIHP has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

In addition, the Department may pursue all sanctions and remedial actions with the PIHP that is taken with FFS providers if it determines, based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source, that an PIHP acts or fails to act as follows pursuant to 42 CFR 438.700:

- Fails substantially to provide medically necessary services that the PIHP is required to provide, under law or under this contract, to an enrollee covered under the contract.

- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to enroll a member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the Department.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans.
- Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or any implementing regulations.

Per 42 CFR 438.724, the State must give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed above. This notice must be given no later than 30 days after the State imposes or lifts a sanction and must specify the affected PIHP, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

1. Corrective Action Plan

   In addition to imposing sanctions or financial penalties, if the Department determines that the PIHP is not in compliance with one or more requirements of this contract, the Department can require the PIHP to complete a Corrective Action Plan (CAP). The CAP will outline the area(s) of non-compliance, follow-up recommendations/requirements, time frames for remedial action by the PIHP, and any other actions the Department deems necessary to remedy the non-compliance. The PIHP shall comply with all recommendations/requirements made in writing by the Department within the time frames specified by the CAP.

   Upon receipt of the CAP from the Department, the PIHP shall submit a written response to the Department detailing steps for compliance, including a timeframe(s) specified by the Department.

The Department may deny or postpone a service area expansion request from a PIHP on an active CAP.

The PIHP shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the contract.

2. Financial Penalties

The Department may pursue all financial penalties with the PIHP that are taken with FFS providers including any civil monetary penalties in the following specified amounts:

a. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to members, potential members or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.

b. A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the state.

c. A maximum of $15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

d. A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The state must deduct from the penalty the amount of overcharge and return it to the affected member(s).

e. If the PIHP fails to comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations, the Department may impose liquidated damages in the amount of $10,000. For additional details, see Article IV, Section E of the contract.

f. If the PIHP fails to comply with federal CLIA regulations as specified by 42 CFR Part 493, 42 CFR 263a, and Wisconsin Administrative Code, Chapter 105, DHS 105.42(1-2) and DHS 105.46 , sanctions in the amount of $10,000.00 may be imposed. For additional details, see Article XI, Section C (12) of the contract.

The Department will provide written notice of all financial penalties that explains the basis and nature of the penalties and any due process protections the state elects to provide.

3. Suspension and Reduction of Enrollment

   a. Suspension of New Enrollment

      Whenever the Department determines that the PIHP is out of compliance with this Contract, the Department may suspend the PIHP's right to receive new enrollment under this Contract. When exercising this option, the Department, must notify the PIHP in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the Contract. The Department may also notify members of the PIHP's non-compliance and provide an opportunity to enroll in another PIHP.

   b. Department-Initiated Enrollment Reductions

      The Department may reduce the maximum enrollment level and/or number of current members whenever it determines that the PIHP has failed to provide one or more of the Contract services required under the Contract or the PIHP has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the PIHP is providing contract services as required. The PIHP will have at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized.

   c. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll members in anticipation of the PIHP not being able to comply with federal or state law at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement.

4. Withholding of Payments and Orders to Provide Services

In any case under this Contract where the Department has the authority to withhold payments, the Department also has the authority to use all other legal processes for the recovery of damages.

Notwithstanding the provisions of this Contract, the Department may withhold portions of payments as liquidated damages or otherwise recover damages from the PIHP on the following grounds:

a. Medically Necessary Covered Services

Whenever the Department determines that the PIHP has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either order the PIHP to provide such service, or withhold a portion of the PIHP's payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

If the Department orders the PIHP to provide services under this section and the PIHP fails to provide the services within the timeline specified by the Department, the Department may withhold from the PIHP's payments an amount up to 150% of the Fee for Service amount for such services.

When it withholds payments under this section, the Department must submit to the PIHP a list of the participants for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

If the Department acts under this section and subsequently determines that the services in question were not covered services:

1) If the Department withheld payments, it will restore to the PIHP the full payment; or

2) If the Department ordered the PIHP to provide services under this section, it will pay the PIHP the actual documented cost of providing the services.

b. Payment Denials for New Members

Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

Specifically, the State may recommend that CMS impose the denial of payment for new members to a PIHP that has a contract to provide FCMH services if the State determines that the PIHP acts or fails to act pursuant to 42 CFR 438.700. The State's determination becomes CMS' determination for purposes of Section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days. When the State decides to recommend imposing the sanctions described in 42 CFR 438.730(e), this recommendation becomes CMS' decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days. If the State's determination becomes CMS' determination, the State will take the following options: (1) Give the PIHP written notice of the nature and basis of the proposed sanction; (2) Allow the PIHP 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction; (3) May extend the initial 15-day period for an additional 15 days if: (i) The PIHP submits a written request that includes a credible explanation of why it needs additional time; (ii) The request is received by CMS before the end of the initial period; (iii) CMS has not determined that the PIHP's conduct poses a threat to an enrollee's health or safety.

If the PIHP submits a timely response to the notice of sanction, the State: (i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation; (ii) Gives the PIHP a concise written decision setting forth the factual and legal basis for the decision; (iii) Forwards the decision to CMS. The State's decision will become CMS' decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS. If CMS reverses or modifies the State decision, the agency sends the PIHP a copy of CMS' decision.

c. Required Reports and Data Submissions

1) Encounter Data

If the PIHP fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of $1,500 per day for each day beyond the deadline that the PIHP fails to submit the data or fails to submit the data in the required form or format, such liquidated damages to be deducted from the PIHP's payments.

Additionally, if it is found that the PIHP failed to submit accurate and complete encounter data prior to the submission deadlines, the Department will be considered damaged. The PIHP may be held responsible for reimbursing the Department for the staffing and out-of-pocket costs incurred by the Department and its contractors associated with reviewing the delayed data submission, and developing and publishing revised rates.

The PIHP must meet the Department's aggregate standards for submitting encounter data as outlined in Article XII(D) or liquidated damages may apply based on "erred" data.

The term "erred encounter record" means an encounter record that failed an edit when a correction is expected by the Department, unless the record is otherwise priced and included in the PIHP encounter data. This does not apply to records for out-of-state emergency services that are not moved from the erred table due to the inability to match to the provider file. If the PIHP fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages of $5 per erred encounter record per month until the error has been corrected or the issue has been resolved to the Department's satisfaction. The liquidated damage amount will be deducted from the PIHP's payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis. If upon audit or review, the Department finds that the PIHP has removed an erred encounter record without the Department's approval, the

Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

a. The Department may assess $5 per record per month until the encounter record has been fixed, for each encounter record found to be different from the provider claim for the procedure code, units of service, diagnosis code, modifier code, charge field, and TPL paid amount.

   At a minimum, the PIHP must submit a consistent volume of encounters each month based on a calendar year average.

b. If it is found that the PIHP submitted inaccurate or incomplete encounter data that was used in the development of the current rates, the Department may assess damages associated with the reporting error and data that the PIHP failed to submit. The damages will be up to the priced amount of the inaccurate encounter records and the estimated amount or actuarial adjustment for the amount that the PIHP failed to submit.

   Failure to successfully report usable data using the ASC X12 837 HIPAA Compliant Transaction or the Financial Report information may result in a 1% withhold to the PIHP's administration rate. The amount will be withheld from the payment until the PIHP is able to submit usable data.

   If the PIHP is unable to submit usable data by the period of time defined by the Department when withholding the payment, the amount withheld will be forfeited.

   If either party terminates the contract during the period that payment is withheld, the amount will be automatically forfeited.

   Data is determined usable if it can be used in the rate-setting process in its entirety for the encounter data base years used to establish the rates.

   Whenever the Department determines that the PIHP has failed to perform the administrative functions, the Department may

withhold a portion of future payments sufficient to directly compensate the Department for the program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

2) Provider and Facility Network Data Submission

Incomplete or inaccurate provider and/or facility data will subject the PIHP to sanctions outlined in Article XIV, Section C.

3) Dental Claims

Per Article IV (A)(8)(g), the Department will conduct validity and completeness audits of dental claims. Upon request, the PIHP must submit paid claims to the Department along with any other records the Department deems necessary for the completion of the audit. Payment of incomplete or inaccurate claims will subject the PIHP to sanctions.

d. Procedures for Withholding Payments

Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of payments under the Contract, the following procedures will be used:

1) The Department will notify the PIHP's contract administrator no later than the second business day after the Department's deadline that the PIHP has failed to submit the required data or the required data cannot be processed.

2) Beginning on the second business day after the Department's deadline, the PIHP will be subject without further notification to liquidated damages per data file or report.

3) If the PIHP submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the HMO Encounter Data User Manual. The

Department will not edit the data until the process period in the subsequent month.

4) If the PIHP submits any other required data or report in the required format within five business days from the deadlines, the Department will rescind liquidated damages and immediately process the data or report.

5) If the PIHP repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the PIHP to develop a CAP to comply with the Contract requirements that must meet Department approval.

6) After the corrective action plan has been implemented, if the PIHP continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Section C, 3.a (Suspension of New Enrollment), or under Section C, 3.b (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.

7) If the PIHP notifies the Department that it will discontinue contracting with the Department at the end of a contract period, but reports or data are due for a contract period, the Department retains the right to withhold up to two months of payments otherwise due the PIHP that will not be released to the PIHP until all required reports or data are submitted and accepted after expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

e. Inappropriate Payment Denials

The PIHP that inappropriately fails to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, of payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure of denial was an isolated instance or a

repeated pattern or practice, and whether the health of a member was injured, threatened or jeopardized by the failure or denial. These sanctions apply not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal was made (i.e., the Department knows about the documented abuse from other sources).

f. Temporary Management

The state will impose temporary management, as provided in 42 CFR 438.706, when there is continued egregious behavior by the PIHP, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

1) There is substantial risk to members' health; or

2) The sanction is necessary to ensure the health of the PIHP's members while improvements are made to remedy violations under 438.700 or until there is an orderly termination or reorganization of the PIHP.

The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an PIHP has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act, or this section of the contract. The state must also grant enrollees the right to terminate enrollment.

The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.

The state may not terminate temporary management until it determines that the PIHP can ensure that the sanctioned behavior will not recur.

g. PIHP Subcontractors

Per Article XIV (B)(1)(i), PIHP must obtain subcontractor agreement to provide representatives of the PIHP, as well as duly authorized agents or representatives of the Department and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the PIHP

and the subcontractor), and administrative records. Refusal will result in sanctions and/or financial penalties in Article XIII, Section C against the PIHP for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

E. Modification and Termination of Contract

1. Modification

a. Mutual Consent

This Contract may be modified at any time by mutual written agreement of both the PIHP and the Department.

b. Unilateral Modification by the department:

This contract will be modified by the Department if changes in federal or state laws, rules, regulations or amendments to Wisconsin's CMS approved waivers or the state plan require modification to the contract. In the event of such change, the Department will notify the PIHP in writing. If the change materially affects the PIHP's rights or responsibilities under the contract and the PIHP does not agree to the modification, the PIHP may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination. (See Article XIV.E.2.e.2).

2. Termination

a. Mutual Consent

This Contract may be terminated at any time by mutual written agreement of both the PIHP and the Department.

b. Unilateral Termination by the Department

4) Authority to Terminate Contract:

The Department has the authority to terminate a PIHP's contract and provide members Medicaid benefits through other options included in the State Plan, if the Department determines that the PIHP has failed to do either of the following:

a) Carry out the substantive terms of this Contract; or

b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

5) Unilateral Modification by the Department

Before the Department terminates a PIHP contract for failing to carry out substantive terms of the contract or meet applicable requirement section 1932, 1903(m), or 1905(t) of the Social Security Act, the Department provide the PIHP a pre-termination hearing. The Department will give the PIHP written notice of its intent to terminate, the reason for termination, and the time and place of hearing.

6) Member Disenrollment During Termination Hearing Process:

Per 42 CFR §438.722, the Department may provide the PIHP's members with written notice of its intent to terminate the contract and allow members to disenroll from the PIHP immediately without cause.

a) The PIHP shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers.
b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new PIHP of the member's choosing.

7) Post-Hearing Notice:
After the hearing, the State will give the PIHP written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision,

the effective date of termination. For an affirming decision, the Department will give members of the PIHP notice of the termination and information, consistent with 42 CFR § 438.10, on their options for receiving Medicaid services following the effective date of termination.

c. Automatic Termination by the Department

1) Foreign Entity:
Pursuant to 42 C.F.R. § 438.602(i), the Department is prohibited from contracting with a PIHP located outside of the United States. In the event a PIHP moves outside of the United States, this contract will be terminated.

d. Unilateral Termination by the PIHP

1) Changes to payments:
This contract may be terminated by the PIHP due to dissatisfaction with the final payments offered. The PIHP must notify the Department within 30 days of notice of the final rates if the PIHP intends to terminate its contract with the Department. The PIHP must also notify the Department within 30 days if it intends to decrease its service area due to the final capitation rates. To assure the smooth transition of members, the termination of the Contract or the decrease in service area will be effective no less than 90 days, and no more than 120 days, after PIHP notification to DHS of the intent to terminate the Contract or decrease the PIHP's service area.
2) Changes in Reporting Requirements
If the Department changes the reporting requirements as specified in Article XII, Section K during the Contract period, the PIHP shall have 180 days to comply with such changes or to initiate termination of the Contract.

b. Termination by either party:
1) For Cause:
Either party may terminate this Contract at any time if it determines that the other party has substantially failed to

perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of its intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the PIHP.

2) Changes Mandated by Federal or State Law:
Either party may terminate this Contract at any time, due to modifications to the Contract mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this Contract. (See Article XIV.E.1.b). At least 90 days prior to the proposed date of termination, the party initiating the termination must notify the other party in writing of its intent to terminate this Contract.

3) Loss of Federal or State Funding:
   a) Permanent Loss of Funding
   Either party may terminate this Contract if federal or state funding of contractual services rendered by the PIHP becomes or will become permanently unavailable and such lack of funding would preclude reimbursement for the performance of the PIHP's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the PIHP will become unavailable, the Department shall immediately notify the PIHP in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will end.
   b) Temporary Loss of Funding
   In the event funding will become temporarily suspended or unavailable, the Department or PIHP may suspend performance of any or all of the PIHP's obligations

under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or PIHP shall attempt to give notice of suspension of performance of any or all of the PIHP's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the PIHP will resume the suspended services within 30 days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

c. Obligations of Contracting Parties Upon Non-Renewal or Termination

When non-renewal or termination of the Contract occurs, the following obligations must be met by the parties:

1) Transition Plan:
The PIHP shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to PIHP members and their successful transition to other applicable programs (e.g., Medicaid fee-for-service). The plan will include provisions for the transfer of all member related information held by the PIHP or its providers and not also held by the PIHP. Additional elements of the transition plan may include, but are not limited to, a communication plan; additional data-sharing reports for transitioning members; and timelines for outstanding financial reconciliation.
    a) Submission of the Transition Plan
    The PIHP shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the PIHP decides to not renew the contract; within ten (10) business days of notice of termination by the Department; or along with the PIHP's notice of termination.
    b) Management of the Transition

The PIHP shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

c) Continuation of Services
If the PIHP has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the PIHP shall continue operating as an PIHP under this contract until all members are successfully transitioned. The Department will determine when all members have been successfully transitioned to applicable programs.
If the Department determines it necessary to do so, the PIHP will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the PIHP remains responsible, and shall provide, the services in the benefit package, and all terms and conditions of the contract will apply during this period.

d) Costs of Transition Plan
The PIHP will be responsible for all expenses related to the transition plan, including, but not limited to costs associated with the Department's enrollment of the PIHP's members into other PIHPs or the provision of MA benefits to the PIHP's members through other options in the event of a unilateral termination by the Department under Article XIV.E.2.b.

2) Notice to Members and Providers

a. The Department will be responsible for developing the format for notifying all members of the date of non-renewal or termination and process by which the members will continue to receive contract services.
b. The Department will be responsible for the provision of any other necessary notifications to impacted members and providers. Such notifications may include, but are not limited to, mailed notices, ForwardHealth Member and/or Provider Updates and/or phone outreach.
c. Costs of Notice to Members and Providers
The PIHP will be responsible for all expenses related to said notifications under a) and b).

3) Return of Advanced Payment
   a. Any payments advanced to the PIHP for coverage of members for periods after the date of termination will be returned to the Department within the period of time specified by the Department.
   b. Transfer of Information: The PIHP will supply all information necessary for the reimbursement of any outstanding claims within the period of time specified by the Department.
   c. Recoupments: If a contract is terminated, recoupments will be handled through a payment by the PIHP to the Department within 90 days of contract termination.

F. Interpretation of Contract Language

When disputes arise, the Department has the right to final interpretation and/or application of the Contract language. The PIHP will abide by the interpretation and/or application.

XV. FISCAL COMPONENTS/PROVISIONS

A. Billing Members

For the FCMH Program, any provider who knowingly and willfully bills a member for a covered service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1) [42 U.S.C. 1320a-7b] of the Social Security Act and Wis. Stats. 49.49(3p). This provision shall continue to be in effect even if the PIHP becomes insolvent.

However, if a member agrees in advance in writing to pay for a service not covered by Medicaid, then the PIHP, PIHP provider, or PIHP subcontractor may bill the member. The standard release form signed by the member at the time of services does not relieve the PIHP and its providers and subcontractors from the prohibition against billing a member in the absence of a knowing assumption of liability for a Medicaid non-covered service. The form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services, or procedures that are not covered by Medicaid.

Except in emergency situations, the FCMH must use only Medicaid enrolled providers for the provision of covered services. The Department reserves the right to withhold from the capitation development the costs related to services provided by non-enrolled providers, at the FFS rate for those services, unless the FCMH can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was Medicaid enrolled at the time the FCMH reimbursed the provider for service provision.

B. Physician Incentive Plans

A physician incentive plan is any compensation arrangement between the PIHP and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the PIHP.

The PIHP shall fully comply with the physician incentive plan requirements specified in 42 CFR s. 417.479(d) through (g) and the requirements relating to subcontracts set forth in 42 CFR s. 417.479(i), as those provisions may be

amended from time to time. PIHP contracts must provide for compliance with the requirements set forth in 422.208 and 422.210.

The PIHP may operate a physician incentive plan only if no specific payment can be made directly or indirectly under such a plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If physician/group is put at substantial financial risk for services not provided by physician/group, the PIHP must ensure adequate stop-loss protection to individual physicians and conduct annual enrollee surveys.

The PIHP must provide adequate and timely information on its physician incentive plan to any member upon request.

If required to conduct a member survey, survey results must be disclosed to the State and, upon request, disclosed to members.

The disclosure to the State includes the following, and will be reported in a format determined by the Department:

- The PIHP must report whether services not furnished by a physician/group are covered by incentive plan. No further disclosure required if the PIP does not cover services not furnished by physician/group.

- The PIHP must report type of incentive arrangement, e.g. withhold, bonus, capitation.

- The PIHP must report percent of withhold or bonus (if applicable).

- The PIHP must report panel size, and if patients are pooled, the approved method used.

If the physician/group is at substantial financial risk, the PIHP must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

C. Payment Requirements/Procedures

The PIHP is responsible for the payment of all contract services provided to members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Rosters generated for the coverage period.

The PIHP is also responsible for the provision, or authorizing the provision of, services to all FCMH members with valid ForwardHealth ID cards indicating PIHP enrollment (via Electronic Voice Response or WiCall), without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the enrollment rosters must be reported to VEDSHMOSupport@wisconsin.gov for resolution. The PIHP must continue to provide and authorize provision of all contract services until the discrepancy is resolved, including members who were PENDING on the Initial Roster and held a valid ForwardHealth ID card indicating PIHP enrollment for the coverage period (via Electronic Voice Response or WiCall), but did not appear as a CONTINUE on the Final Roster.

If a member shows on the Initial enrollment roster as PENDING and later shows on the Final roster as a DISENROLL, the PIHP will not be liable for services after the date the disenrollment is effective.

1. Claims Retrieval

   The PIHP must maintain a claim processing system that can upon request identify date of receipt of the claim as indicated by its date stamp, adjudication action on all claims types (i.e., paid, denied, suspended, etc.), and date of adjudication. In addition, the claim processing system must identify, within the individual claim, the services provided and the diagnoses of the members using nationally accepted coding systems as specified in the Encounter User Guide. Finally, the claim processing system must be capable of identifying the provider of services National Provider Identifier (NPI), or atypical identifier if applicable, and their associated taxonomy numbers and CLIA numbers.

2. Thirty Day Payment Requirement

   The PIHP must pay at least 90% of adjudicated clean claims from subcontractors/providers for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent subcontractors/providers have agreed to later payment.

The PIHP agrees not to delay payment to a subcontractor/provider pending subcontractor/provider collection of third party liability unless the PIHP has an agreement with the subcontractor/provider to collect third party liability.

3. Payment of PIHP Referrals to Non-Affiliated Providers

   For PIHP approved referrals to non-affiliated providers, the PIHP must either establish payment arrangements in advance, or the PIHP is liable for payment only to the extent that Medicaid pays, including Medicare deductibles, or would pay, its FFS providers for services excluding Hospital Access Payments, and Hospital P4P Withhold,. Refer to Article VIII for policy on Provider Appeals.

   a. For Non-Affiliated Providers, the Department will adjudicate Provider Appeals according to FFS benefit policy and reimbursement, including PA requirements, emergency and post stabilization definition and other contract provisions. Refer to Article VIII, Provider Appeals.

   b. Should there be an appeal resolution determined by the Department to be in the Provider's favor, the PIHP must waive standard timely filing guidelines and allow the provider 60 days to rebill for services.

4. Health Professional Shortage Area (HPSA) Payment Provision

   The following provision refers to payments made by the PIHP. PIHP covered primary care and emergency care services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA must be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy or the equivalent. Specified PIHP-covered obstetric or gynecological services (see Wisconsin Health Care Programs Online Handbooks) provided to a member living in a HPSA or by a provider practicing in a HPSA must also be paid at the HPSA enhanced rates as outlined under Medicaid FFS policy or the equivalent. The specified enhanced payment amounts are available in the references made below.

   However, this does not require the PIHP to pay more than the enhanced FFS rate or the actual amount billed for these services. The PIHP shall ensure that the money for HPSA payments is paid to the physicians and is not used to supplant funds that previously were used for payment to the physicians. The

PIHP must develop written policies and procedures to ensure compliance with this provision. These policies must be available for review by the Department, upon request.

The specified enhanced payment amounts are available in the Monthly Max Fee Extract for the relevant HPSA procedure codes (BAF codes beginning with H). The procedure codes that qualify for the HPSA incentive are available on ForwardHealth.

5. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

   If the PIHP contracts with a Medicaid enrolled FQHC or RHC for the provision of services to its members, the PIHP must pay at a minimum the Medicaid FFS rate or the equivalent aggregate FFS rate by provider. The PIHP must retain records demonstrating that they are meeting this requirement. The records must be available within 30 days of the Department's request for information and be made available to CMS upon request.

   The PIHP must pay as least 90% of adjudicated clean claims from FQHC or RHC providers for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent that providers have agreed to later payment.

6. Hospitalization at the Time of Enrollment or Disenrollment

   The PIHP will not assume financial responsibility for members who are hospitalized at the time of enrollment in the PIHP (effective date of coverage) until date of the hospital discharge. The Department is responsible for paying on a FFS basis all Medicaid covered services for such hospitalized members during hospitalization.

   Hospitalization in this section is defined as an inpatient stay at a Medicaid enrolled hospital as defined in Wis. Adm. Code DHS 101.03(76). Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

   Members, including newborn members, who are hospitalized at the time of disenrollment from the PIHP, shall remain the financial responsibility of the

PIHP. The financial liability of the PIHP shall encompass all contract services. The PIHP's financial liability shall continue for the duration of the hospitalization, except where:

a. Loss of Medicaid eligibility or death occurs.

b. There is a voluntary Disenrollment from the PIHP as a result of one of the conditions in Article II, B(1) in which case the PIHP's liability shall terminate upon disenrollment being effective.

c. There is disenrollment due to just cause

In these three exceptions, the PIHP's liability shall not exceed the period for which it is capitated. When calculating the PIHP liability for the member, the PIHP should take the total stay allowed divided by the total number of days hospitalized to determine a daily rate. The daily rate would then be multiplied by the number of days the member was enrolled in the PIHP.

7. Members Living in a Public Institution

The PIHP is liable for the cost of providing all medically necessary services to members who are living in a public institution during the month in which they first enter the public institution. Members who remain in public institution after the last day of the month are no longer eligible for Medicaid and the PIHP is not liable for providing care after the end of the first month.

Members who are living in a public institution and go directly from the public institution to a medical facility, court ordered or voluntarily, are no longer living in a public institution and remain eligible for Medicaid. The PIHP shall be liable for the provision of medically necessary treatment if treatment is at the PIHP's contracted facilities, or if unable to itself provide for such treatment.

8. Payment to Provider Pending Credentialing Approval

The PIHP must pay a Medicaid-enrolled provider for services provided to a member of the PIHP while the provider's complete application for credentialing is pending approval by the PIHP. If the provider's application is ultimately denied by the PIHP, the PIHP is not liable for the services provided. This provision does not apply to PIHPs who are NCQA-accredited.

9. Calculation of Non-listed Max Fee Rate

   When a rate is not listed on the FFS max fee schedule, the PIHP may determine their own payment methodology for determining the rate for affiliated and non-affiliated providers. The Department may request documentation of methodology if a provider appeal is submitted based on this derived payment amount.

10. The PIHP is prohibited from making payment to a provider for provider-preventable conditions (42 CFR s. 438.6(f)(2)(i)).

    All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made must be reported by all providers to the PIHP per 42 CFR 438.6(f)(2)(ii).

    Refer to Article X, B.7 for a comprehensive listing of provider-preventable conditions.

11. 2022 American Rescue Plan Rate Increase

    The 2022 American Rescue Plan Rate Increase is subject to the Wisconsin Legislature Joint Finance Committee approval.

    The Department will make payments to the PIHP for American Rescue Plan Act (ARPA) eligible services, which the PIHP shall distribute to ARPA eligible service providers, under the following terms and conditions:

        a. For purposes of this section, "ARPA eligible service provider" are providers of:
            i. Alcohol and other drug abuse (AODA) services,
            ii. AODA Day Treatment,
            iii. Home health services,
            iv. House counseling,
            v. Mental health day treatment,
            vi. Mental health services,
            vii. Nursing provided in the home,
            viii. Occupational therapy provided in the home,
            ix. Personal care,
            x. Physical therapy provided in the home,

xi. Respiratory care,
xii. Respite,
xiii. Skilled nursing services (RN/LPN).
xiv. Speech and language pathology services provided in the home, and
xv. Transportation as defined in Wi. Admin. Code DHS § 107.23, excluding ambulance.

b. Providers of services with non-negotiated rates and providers not listed, including but not limited to retail providers, nursing homes and common carrier transportation providers are not ARPA service providers under this section. PIHPs are also not eligible service providers.
c. PIHPs are required to provide a unit rate increase to all eligible providers equal to 5% of each eligible provider's rates for the services identified in part a. effective January 1, 2022.
d. PIHPs are required to complete issuing payments for this increase by April 1, 2022.

XVI. FINANCIAL REQUIREMENTS AND REIMBURSEMENT

Reimbursement for the FCMH Program will be done under the authority of 42 CFR 438.2. This is a non-risk contract between the State of Wisconsin and the PIHP providing a Foster Care Medical Home to children in out-of-home-placement.

A. Reimbursement Method

The Department will develop a monthly non-risk prepayment rate based on historical spending for the Medicaid out-of-home-placement population and/or C4Ks program history. Additional adjustments may be made based on Care4Kids service delivery requirements included in this contract. The PIHP will receive a monthly per member per month non-risk prepayment for each enrolled individual. After the end of each calendar year, the Department will reconcile payments made to the PIHP with the cost of those services provided repriced against the Medicaid fee schedule, and will either recoup from or make additional reimbursements to the PIHP based on the results of the reconciliation. In addition, the Department will provide administrative funding.

1. Non-risk Prepayment Rates

   In consideration of full compliance by the PIHP with contract requirements, the Department agrees to make monthly non-risk prepayments to the PIHP based on the non-risk prepayment rates specified in this contract. The non-risk prepayments include adjustments for care coordination costs and adjustments for approved "in-lieu of" service costs. It does not include services that are not covered under the State Plan.

   The Department will make payments for members enrolled for a partial month based on a daily rate. The daily rate is calculated by multiplying the monthly prepayment rate by 12 months and dividing that amount by 365 days (366 for leap years). This is the daily rate that will be used for midmonth enrollments.

2. Annual Review of Non-risk Prepayment Rates

   The monthly non-risk prepayment rates set forth in this article are recalculated on an annual basis.

   a. DHS will incorporate CY2021 capitation rates into this contract via an amendment. The CY2020 capitation rates will remain in effect until the CY2021 rates are implemented.

b. The PIHP will have 30 days from the date of the written notification to accept the new payment rates in writing or to initiate termination or non-renewal of the Contract.

c. A non-response after 30 days constitutes acceptance of the rates.

d. The payment rates are not subject to renegotiation by the PIHP once they have been accepted.

e. The Department may elect to renegotiate rates as required by changes in federal or state laws, rules or regulations.

f. The Department may adjust payment rates to reflect the implementation of material provider rate changes. The rate adjustment would be certified as actuarially sound and approved by CMS in the form of a contract amendment.

3. Reconciliation & Quarterly Financial Review

a. Quarterly Financial Review

The Department will perform a quarterly financial review to determine the adequacy of the non-risk prepayment rates. Within 45 days of the end of the quarter the PIHP will submit a financial statement to the Department for the PIHP program. If the PIHP program sustains an operating loss of more than 10% for two consecutive quarters, the Department will provide an additional payment to the PIHP in the amount of the year to date operating loss. Email financial statements to DHSDMSBRS@dhs.wisconsin.gov.

b. Final Reconciliation

Final reconciliation for each calendar year period will be initiated twelve months after the end of the calendar year period and completed no later than three months thereafter. This process will not be initiated earlier than twelve months after the end of the calendar year period in order to allow a sufficient claims run out time.

1) Quarterly Detail Claims and Access Payment Reports – The PIHP must submit a quarterly detail claims report to the Department identifying member services incurred during the previous calendar year. These data files must include unique member identifiers, unique claim number identifiers, service codes, dates of service and paid amounts. These files will be supplemental to encounter submissions

and used by the Department to track the completeness of encounter reporting.

The PIHP must also submit a quarterly report to the Department identifying access payments for services incurred during the previous calendar year. These reports should be in the same format specified in Article XV, A.3.b(4)

2) Service Costs - The reconciliation amounts will be calculated by comparing the amounts paid to providers against the services reported in the encounter system re-priced at the Medicaid fee-for-service paid amount. Encounters submitted and repriced in the encounter system by the end of the thirteenth (i.e. January 31st) month after the calendar year will be included in the final reconciliation. The Department will send all service year encounters in the MMIS to the PIHP by the middle of the 14th month (i.e. February 15th). The final reconciliation amount will include a missing data adjustment up to two percent of total allowable costs to account for missing encounters, as well as encounters that were submitted but not accepted by the Medicaid Management Information System.

   This adjustment will be developed based on a comparison of the total PIHP paid amounts in the encounter data and the total member service costs reported in the PIHP's audited financial data. The total member service costs reported in the PIHP's audited financial data will be divided by the total PIHP paid amounts in the encounter data. A factor of one (1) will be subtracted from this percentage. This final percentage will be multiplied by the total repriced paid amounts in the encounter data to determine the missing data adjustment dollar amount.

   The missing data adjustment will not exceed the lesser of either two percent of total allowable costs or the missing data adjustment dollar amount derived from dividing the total member service costs reported in the PIHP's audited financial data by the total PIHP paid amounts in the encounter data, subtracting one (1) and multiplying by the total repriced paid amounts in the encounter data.

Example of Missing Data Adjustment Calculation:

	a	b	c (a/b) - 1	d	e c * d	f 2% * a	g Lesser of e or f
	Total allowable member service costs reported in the PIHP's audited financial data	Total PIHP paid amounts in the encounter data	Missing data adjustment formula	Total repriced paid amounts in the encounter data	Missing data adjustment amount	Two percent of total allowable costs	Lesser of missing data adjustment or two percent of total allowable costs
Example 1	$1,000,000	$950,000	5.263%	$930,000	$48,947.37	$20,000	$20,000
Example 2	$1,000,000	$990,000	1.010%	$970,000	$9,797.98	$20,000	$9,797.98

The resulting total service costs for allowable services provided to eligible enrollees will be compared to the non-risk prepayment rates, less the administrative component, paid to the PIHP for the same period of time. If, in aggregate, the amount spent as reported in this manner is greater than the amount paid in non-risk prepayment rates by the Department, an additional payment will be made to the contracting provider. If, instead, the amount reported is less than the Department provided in non-risk prepayments, a recoupment will be processed. The PIHP will submit the Financial Template and signed encounter attestation by the end of the fifteenth month (i.e. March 31st). The corrected amount calculated will be provided, or recouped by the Department, by the end of, the seventeenth month (May 31st) after the end of the calendar year period in question.

3) PIHP Certification - A letter from the PIHP certifying the encounter data accurately reflects actual utilization shall be submitted to the Department no later than the fourteenth day of the fourteenth month after the end of the calendar year. This letter shall be submitted to CMS by the Department as part of the required CMS reconciliation documentation. The letter shall be signed by an officer or director of the PIHP and shall contain:

- Contract year being certified.
- Total dollar amounts of claims paid for dates of service within the contract year being certified. The dollar amount shall include billable care management. The contract year will be determined by the from date on the claim.
- Total count of unique claim numbers for paid claims with the from date of service occurring within the contract year being certified.

This includes claims where the liability of the PIHP may be zero due to payments made by other health insurance.

- Total access payments paid for contract year
    - Inpatient Hospital – Total access payments paid for claims with an admit date during the contract year being certified.
    - Outpatient Hospital – Total access payments for claims with a from date of service during the contract year being certified.
- Statement attesting to the accuracy and completeness of the data.

Email annual certification and access payment detail to DHSDMSBRS@dhs.wisconsin.gov.

4) Access Payment Costs – Included with the PIHP certification, the PIHP shall submit detailed information for access payments for the certification year.

    a) Inpatient hospital admissions and outpatient visits - The detail shall include the following fields for hospital inpatient admissions and outpatient visits:

        i. MA ID of provider

        ii. NPI of provider

        iii. Hospital name

        iv. Number of qualifying inpatient admissions paid to the individual hospital for admissions with a from date of service within the contract year being certified

        v. Access payment rate per inpatient discharge

        vi. Total access payment to hospital for inpatient discharges

        vii. Total number of outpatient visits paid to hospital for visits with a from date of service within the contract year being certified

        viii. Access payment rate per outpatient visit

        ix. Total payment to hospital for outpatient discharges.

5) Administrative Cost – Administrative Costs will not be reconciled.

c. Interim Payments for High Cost Members

The non-risk prepayment rate will be established to reflect the anticipated benefit cost of the Care4Kids population. However, due to the distribution of these costs over the annual period and the small number of members, benefit costs may vary if there are unanticipated high cost members. The PIHP may request an interim payment from the Department. The PIHP may make a request to the Department for an interim financial payment no more than once every 30 days. The PIHP must submit a claim to the Department in accordance to current billing standards and include a statement or explanation of benefits (EOB) showing the amount of reimbursement paid. In the case of extended hospitalizations, the PIHP may submit interim payment requests to the Department if interim payments were made to the hospital.

The PIHP is still required to submit all claims in accordance with the encounter reporting requirements. Any additional payments made to the PIHP will be accounted for in the reconciliation process. All interim financial payments to cover on-going high-cost member expenses will be subject to department approval.

B. Coordination of Benefits (COB), and Third Party Liability (TPL)

In order to maintain the confidentiality of children in out-of-home care and consistent with Medicaid policy, the PIHP is not required to coordinate benefits.

For purposes of both COB and TPL, and pursuant to the federal Deficit Reduction Act (P.L. 109-171, Sec. 6035), the PIHP shall use cost avoidance when possible, except as otherwise permitted herein. Specifically, the PIHP is prohibited from referring members to publicly supported health care resources in order to avoid costs. While the PIHP cannot recoup payment pending third party liability recovery, it may request additional information from a provider or member prior to payment.

C. Recoupments

In addition to recoupments that may arise from the reconciliation process of this non-risk contract, the Department will recoup the PIHP's monthly payments in the situations described below:

1. The Department will recoup the PIHP's non-risk prepayment for the following situations where a member's PIHP status has changed for which a non-risk prepayment has been made:

    a. The member moves out of the PIHP's service area.

    b. The member enters an ineligible setting including residential care centers and secure facilities.

    c. The member dies.

    d. The member voluntarily disenrolls.

    e. Correction of a computer or human error, where the person was never enrolled in the PIHP.

2. The Department will recoup the PIHP non-risk prepayment for situations where the Department initiates a change in a member's PIHP status on a retroactive basis, reflecting the fact that the PIHP was not able to provide services. In these situations, recoupments for multiple months' payments are possible.

3. If a PIHP member moves out of the PIHP's service area, the member will be disenrolled from the PIHP on the date s/he moved as verified by the eligibility worker. Any non-risk prepayments made for periods of time after disenrollment will be recouped.

4. The effective date of a voluntary disenrollment may be any day of the month. Payments for members who disenroll mid-month or lose program eligibility (e.g. by transferring to an ineligible setting such as a residential care center) will be appropriately recouped based on a daily rate in a subsequent financial cycle.

D. Hospital Access Payments

The non-risk prepayment rates paid to the PIHP include funds for access payments. Consistent with reconciling after benefit costs to the Medicaid fee schedule these payments made to the PIHP as part of the non-risk prepayment rates will be reconciled to the Medicaid fee for service payment rates after the end of the contract year.

The PIHP shall make payments to Acute Care Hospitals or Critical Access Hospitals (CAH) based on the number of qualifying inpatient discharges and outpatient claims in the previous month. To ensure consistency with the reconciliation, the PIHP should pay the previous month's access payments at the fee for service access payment amount for the appropriate dates of service. Fee for service access payment information can be found on the Department's website. The PIHP shall make payments to the hospitals no later than 15th of the following month.

These payments are in addition to any amount the PIHP is required by agreement to pay the hospital for provision of services to PIHP members.

An "acute care hospital" means a Wisconsin hospital that is not a critical access hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital.

An "eligible CAH" means a Medicaid enrolled Wisconsin CAH that is not an acute care hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital.

A list of qualifying hospitals is available from the Department upon request.

"Qualifying discharges and outpatient claims" are inpatient discharges and outpatient claims for which the PIHP made payments to eligible providers in the preceding month, for services to the PIHP's members, other than members who are eligible for both Medicaid and Medicare or Childless Adult (CLA) plan members. The PIHP shall exclude all members who are dually-eligible and all dual-eligible claims and members of CLA plans. If a third party pays the claim in full, and the PIHP does not make a payment, the claim shall not count as a qualifying claim for the hospital access payment. If the PIHP pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for hospital access payments.

1. Quarterly reporting requirements

   At the end of each quarter, the PIHP must submit the report in Addendum V, D to the Department. The spreadsheet shall contain the information identified in Article XV, Section A.3.b(4).

2. Noncompliance

The Department shall have the right to audit any records of the PIHP to determine if the PIHP has complied with the requirements in this section. If at any time the Department determines that the PIHP has not complied with any requirement in this section, the Department will issue an order to the PIHP that it comply and the PIHP shall comply within 15 calendar days after the Department's determination of noncompliance. If the PIHP fails to comply after an order, the Department may terminate the contract as provided under Article XIV, C.

Upon request, the PIHP must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

If the PIHP fails to send payment to the hospital within the payment timeframe, the PIHP will pay a fine to the Department equal to three percent of the delayed payment.

3. Payment disputes

   If the PIHP or a hospital dispute the monthly amount that the PIHP is required to pay the hospital, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The PIHP or hospital may request a contested case hearing under Ch. 227 on the Department's determination.

4. Resolution of Reporting Errors

   The PIHP shall adjust prior hospital access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient claims.

E. Unauthorized Programs or Activities

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the PIHP must do no work on that part after the effective date of the loss of program authority. The state must adjust payments to remove costs that are specific to any program or activity that is no longer authorized by law. If the PIHP works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the PIHP will not be paid for that work. If the state paid the PIHP in

advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the PIHP worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the PIHP, the PIHP may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

F. Payment Method

All payments, recoupments, and debit adjustments for payments made in error, distributed by the Department to the PIHP, will be made via Electronic Funds Transfer (EFT) via enrollment through the secure Forward Health Portal account.

PIHPs are responsible for maintaining complete and accurate EFT information in order to receive payment. If a PIHP fails to maintain complete and accurate information and DHS makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment.

All arrangements between the financial institution specified for EFT and the PIHP must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the PIHPs via their secure ForwardHealth Portal accounts constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and if any such information is false, criminal or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to PIHP in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

ARTICLE XVII: PIHP Specific Contract Terms

XVII. PIHP SPECIFIC CONTRACT TERMS

A. Documents Constituting Contract

1. Current Documents

In addition to this base agreement, the Contract between the Department and the PIHP includes existing Medicaid provider publications addressed to the PIHP, the terms of the most recent PIHP certification application issued by this Department prior to PIHP contracts, any questions and answers released pursuant to said PIHP certification application by the Department, and the PIHP's signed application. In the event of any conflict in provisions among these documents, the terms of this base agreement will prevail. The provisions in any question and answer document will prevail over the PIHP certification application. The PIHP certification application terms shall prevail over any conflict with the PIHP's actual signed application.

2. Future Documents

The PIHP is required by this Contract to comply with all future Wisconsin Health Care Programs Online Handbooks and Contract Interpretation Bulletins issued pursuant to this Contract. The documents listed in this section constitute the entire Contract between the parties. No other oral or written expression constitutes any part of this Contract.

B. Disclosure Statement(s) of Ownership or Controlling Interest in a PIHP and Business Transactions

1. Ownership or Controlling Interest Disclosure Statement(s)

a. Pursuant to 42 CFR § 455.104 the PIHP, and subcontracted disclosing entities and fiscal agents, must provide the following disclosures to the Department:

- The name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box.

- Date of birth and Social Security number (in the case of an individual).
- Other tax identification number (in the case of a corporation) with ownership or control interest in the disclosing entity (or fiscal or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.

  Calculation of 5% Ownership or Control is as follows:

  a) The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

  b) The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the PIHP, the person owns 8% of the PIHP.

  c) The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the PIHP's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the PIHP's assets, the person owns 6% of the PIHP.

- Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity is a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

- The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
- The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

b. Disclosure from any provider or disclosing entity is due at any of the following times:
   1) Upon the provider or disclosing entity submitting the provider application.

   2) Upon the provider or disclosing entity executing the provider agreement.

   3) Upon request of the department during the re-validation of the enrollment process.

   4) Within 35 days after any changes in ownership of the disclosing entity.

c. Disclosure from fiscal agents are due at any of the following times:
   1) Upon the fiscal agent executing the contract with the Department.

   2) Upon renewal or extension of the contract.

   3) Within 35 days after any changes in ownership of the fiscal agent.

d. Disclosure from the PIHP is due at any of the following times:
   1) Upon the PIHP executing the contract with the Department.

   2) Upon renewal or extension of the contract.

   3) Within 35 days after any change in ownership of the managed care entity.

   The PIHP must disclose all ownership and controlling interest to the Department upon request or as federally required. The PIHP may supply this information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

   As directed by the CMS Regional Office (RO), the Department must provide documentation of this disclosure information as part of the prior approval process for contracts. This documentation must be submitted to the Department and the RO prior to each contract period. If the PIHP has not supplied this information, a contract with the PIHP is not considered approved for this period of time and no FFP is available for the period of time preceding the disclosure.

A managed care entity may not knowingly have as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's a person who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under the Federal Acquisition Regulation or who has an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the state.

If the Department finds that the PIHP has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

a) Must notify the Secretary of the noncompliance.

b) May continue an existing agreement with the PIHP unless the Secretary directs otherwise.

c) May not renew or otherwise extend the duration of an existing agreement with the PIHP unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement."

2. Business Transaction Disclosures

The PIHP must report to the Department information related to business transactions in accordance with 42 CFR § 455.105. The PIHP must be able to submit this information within 35 days of the date of written request from the Department.

a. The ownership of any subcontractors with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b. Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

If the FCMH PIHP Contract is being renewed or extended, the PIHP must disclose information on those business transactions that occurred during the prior contract period. If the Contract is an initial contract, but the

PIHP has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving Medicaid enrollment. All of these PIHP business transactions must be reported.

3. Disclosure by providers: information on persons convicted of crimes

   In accordance with 42 CFR 455.106:

   a. The PIHP must disclose to the Department the identity of any person who:
      1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider, and
      2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or title XX service program since the inception of those programs.

   b. The PIHP shall report to the Department within 20 working days of receipt of the following:
      1) Any information regarding excluded or convicted individuals or entities, including those in paragraph (C)(a) above;
      2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a provider.

   c. Denial or termination or provider participation
      1) The Department may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX service Program.
      2) The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (C)(a) of this section.

C. Miscellaneous

1. Indemnification

The PIHP agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages and expenses, including reasonable attorney's fees that are related to or arise out of:

a. Any failure, inability, or refusal of the PIHP or any of its subcontractors to provide contract services.

b. The negligent provision of contract services by the PIHP or any of its subcontractors.

c. Any failure, inability or refusal of the PIHP to pay any of its subcontractors for contract services.

2. Independent Capacity of Contractor

The Department and the PIHP agree that the PIHP and any agents or employees of the PIHP, in the performance of this Contract, will act in an independent capacity, and not as officers or employees of Department.

3. Omissions

In the event either party hereto discovers any material omission in the provisions of this Contract that is essential to the successful performance of this Contract, said party may so inform the other party in writing. The parties hereto will thereafter promptly negotiate the issues in good faith in order to make all reasonable adjustments necessary to perform the objectives of this Contract.

4. Choice of Law

This Contract is governed by and construed in accordance with the laws of the State of Wisconsin. The PIHP shall be required to bring all legal proceedings against the Department in Wisconsin state courts.

5. Waiver

No delay or failure by either party hereto 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 will impair that right or power or be construed as 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 will not be construed as a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein.

6. Severability

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

7. Survival

   The terms and conditions contained in this Contract that by their sense and context are intended to survive the completion of performance shall so survive the completion, expiration or termination of the Contract. This specifically includes, but is not limited to recoupments and confidentiality provisions.

8. 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. Headings

   The article and section headings used herein are for reference and convenience only and do not affect its interpretation.

10. Assignability

    Except as allowed under subcontracting, the Contract is not assignable by the PIHP either in whole or in part, without the prior written consent of the Department. Notwithstanding the foregoing or any provision to the contrary, the Department authorizes the PIHP to assign to its wholly owned subsidiary, Children's Community Health Plan, Inc. through a subcontract, the right and obligation to receive all monthly non-risk prepayments and all quarterly and

year-end reconciliation payments from the Department hereunder, as the PIHP's delegate, to administer payments and pay claims.

11. Right to Publish

    The PIHP must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

12. Media Contacts

    The PIHP agrees to forward to the Department all media contacts regarding the FCMH Program or its members.

D. PIHP Specific Contract Terms

1. Initial Contract Period

   The respective rights and obligations of the parties as set forth in this Contract shall commence on January 1, 2022, and unless earlier terminated, shall remain in full force effective through December 31, 2023. The specific terms for enrollment and rates are as specified in the Contract.

2. Renewals

   By mutual written agreement of the parties, there may be one one-year renewal of the term of the Contract. An agreement to renew must be effected at least 30 days prior to the expiration date of any contract term. The terms and conditions of the Contract shall remain in full force and effect throughout any renewal period, unless modified under the provision of the Contract.

3. Specific Terms of the Contract

   a. The counties in the PIHP's designated service area are: Milwaukee, Waukesha, Racine, Kenosha, Washington and Ozaukee.

   b. Maximum Enrollment Limit: (5,000). The number of members may exceed the maximum by up to 5% on a temporary basis. The Department does not guarantee any minimum enrollment level.

c. The non-risk prepaid rates in this contract will be paid for the covered population as follows:

1) Initial rate for January 1, 2019 to (December 31, 2019) for the eligible members.

2) Initial rate will be reconciled as specified in Article XIV, Section A.3.

E. Noncompliance

The Department shall have the right to audit any records of the PIHP and to request any information to determine if the PIHP has complied with the requirements in this section. If at any time the Department determines that the PIHP has not complied with any requirement in this article, the Department will issue an order to the PIHP to comply. The PIHP shall comply within 15 calendar days after receipt of the order. If the PIHP fails to comply after an order, the Department may pursue action against the PIHP as provided under Article XIII. Additionally, the PIHP may be required to forfeit the reimbursement.

F. Payment Disputes

The Department shall have the right to adjust the reimbursement outside the information provided by the PIHP in the guide or template.

The PIHP may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the PIHP waives the right to dispute the reimbursement amount.

G. Resolution of Reporting Errors

If the PIHP discovers a reporting error, the Department's Bureau of Rate Settings in the Division of Medicaid Services must be contacted in writing within 15 days of the discovery.

Errors discovered after the retroactive monthly prepayment rate amendment is issued will be applied to the following year's reimbursement.

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

PIHP Name	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I: Standard Member Handbook Language

The Care4Kids Standard Member Handbook is located in the HMO and PIHP Communication, Outreach and Marketing Guide, Updated December 2021.

ADDENDUM II: Comprehensive Initial Health Assessment Requirements

Each child shall have a Comprehensive Initial Health Assessment within 30 days of enrollment in the PIHP. Ideally, the pediatric nurse practitioner or a primary care physician who performs the comprehensive initial health assessment continues to follow the child throughout his/her stay in foster care. The child/adolescent, out-of-home care provider(s), Division of Milwaukee Child Protective Services (DMCPS) or county child welfare agency caseworker, health care coordinator and birth parent(s) should be encouraged to attend the comprehensive initial health assessment whenever possible.

B. Proposed components of the Comprehensive Initial Health Assessment include:

   c. A review of the child's available medical, behavioral, developmental, and social history (including results from the Child and Adolescent Needs and Strengths if available) to guide the provision of health care services.

   d. A standard medical review of systems.

C. Complete unclothed physical examination (including genital examination) in compliance with the enhanced HealthCheck (Wisconsin's Early Periodic Screening, Diagnosis and Treatment) schedule in Article III, L of the contract.

D. Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment. Those primary care practitioners with limited experience in this area should refer to the child protective center as necessary if a physical or sexual abuse exam is indicated.

E. Developmental screen for younger children (those ≤ 5 years of age).

   Measurement tools are not specified because they will vary depending upon the child's age and developmental stage. However, a developmental screening should include measurement of the following domains using whatever standardized tool the practitioner deems most appropriate

   1. Gross motor skills.
   2. Fine motor skills.
   3. Cognition.
   4. Expressive and receptive language skills.
   5. Social interactions.
   6. Activities of daily living (ADL) skills.

A developmental assessment by a pediatric therapist(s) (physical, occupational, speech) should occur as soon as possible if problems are suspected. Children under three years of age can be referred to the Birth to 3 Early Intervention Program for evaluation.

Ongoing developmental surveillance should be incorporated at every well-child preventive visit to identify developmental concerns that may have surfaced since the child entered foster care. In addition, it is strongly recommended that a valid developmental screening test be administered regularly at the 9-, 18-, and 30-month visits.

F. Behavioral/mental health screen for children over five years of age and adolescents.

MH screening tools are not specified because they will vary based on the child's age.

*Note: the Child and Adolescent Needs and Strengths (CANS) will be administered by the child welfare case manager to all children within 30 days of entering out of home care. If available at the time of the comprehensive initial health assessment, the results from the CANS should be reviewed. This review should including any requests for consideration of further behavioral health evaluation, treatment or therapy based on either the results of the CANS, or on identified behavioral/mental health concerns of the child welfare agency, child, family or foster caregiver.

G. Growth and nutritional assessment including measurement of height, weight, BMI (and head circumference for children <3 years old).

H. Immunization review.

I. Hearing/vision screen with referral as indicated.

J. Dental/oral inspection with referral as indicated.

K. Adolescent survey (discussion with adolescents) to include at a minimum:

1. Family relationships (foster and birth).
2. Alcohol/drug/tobacco use.
3. Sexual activity/sexual orientation.

4. Pelvic examination and family planning counseling services for sexually active females as soon as possible.
5. Prevention of sexually transmitted diseases (STDs) and birth control.
6. School performance.
7. Educational/career plans.
8. Physical activity/exercise/hobbies.

L. Screening lab tests based on the age and condition of the child (e.g., CBC, lead level, U/A, HIV testing if positive risk assessment and consent obtained).

M. Anticipatory guidance including education and counseling on topics specific to out-of-home care:
   1. General adjustments to new home, grief and loss issues.
   2. Behavioral problems that may have surfaced (adjustment reactions, opposition behavior, depression, anger, attention or impulse control problems, etc.).
   3. Sleep problems.
   4. Appetite/unusual eating habits.
   5. Enuresis/encopresis.
   6. School problems behavioral/academic.
   7. Interaction with other children in the home.
   8. Contact with birth family including difficulties around visits.

M. Referrals to dental, mental health, Birth to Three, or other medical services as appropriate.

N. Assess “goodness of fit” between the child and the out-of-home care family.

O. Review of all current medications, with distinct identification and documentation of any psychotropic medications, including clear identification of antipsychotic medications.

Based in part on AAP, District II, NYS

ADDENDUM III: Coordination of Developmental and Mental/Behavioral Health Services

Summary

Coordination of developmental and mental/behavioral health services is critical to ensure appropriate and timely service delivery and to communicate service specific information to the Division of Milwaukee Child Protective Services (DMCPS) or the county child welfare agency, out-of-home care family, birth family, and primary care medical home providers. The health care coordinator, who oversees all aspects of health care for a child in out-of-home care, is responsible for ensuring frequent, effective communication and collaboration with the DMCPS or the county child welfare agency, out-of-home care family, birth family, and other service providers.

A. Coordination Goals

1. To review the results of either the developmental or mental/behavioral health screens as they relate to the Comprehensive Initial Health Assessment for each child, based on his/her age and history, including any prior evaluations.

2. To coordinate and arrange for all developmental or behavioral health assessment and/or treatment services recommended from the out-of-home care health screen, the Child and Adolescent Needs and Strengths (CANS), comprehensive initial health assessment, or other periodic re-examination.

3. To ensure that all periodic reassessments and reviews are done according to protocol, including any additional developmental and mental health services needed as the result of changes in placement.

4. To ensure that the out-of-home care family (and birth family when appropriate) is educated regarding the child's developmental and mental health needs.

5. To facilitate coordination and communication among developmental and mental health providers involved in an individual child's care.

6. To communicate and coordinate developmental and behavioral/mental health services with the DMCPS or county child welfare agency.

7. To assure that identification and ongoing oversight of children who are prescribed psychotropic medications is occurring regularly, including recommended metabolic testing for children on antipsychotic medication.

B. Treatment Service Options

1. Developmental services may include but are not limited to:

    a. Head Start
    b. Early intervention; B-3 and/or community-based PT, OT, or Speech therapies
    c. Pre-school or school-age therapy services;
    d. Speech and language therapy;
    e. Occupational therapy;
    f. Physical therapy.

        a. Mental/behavioral health services may include but are not limited to:

    a. Psychotherapies (individual, group, cognitive-behavior, social skills training);
    b. Psychoeducational services
    c. Infant mental health services
    d. Psychopharmacological treatment;
    e. Substance abuse treatment;
    f. Peer support for children/adolescents specifically related to issues of foster care placement such as separation and loss, loss of autonomy and control, etc.
    g. In-Home Therapy services

Based in part on AAP, District II, NYS

ADDENDUM IV: Example Memorandum of Understanding

BETWEEN [PIHP NAME] [or its subcontractor] AND THE (INSERT DIVISION OF MILWAUKEE CHILD PROTECTIVE SERVICES OR COUNTY CHILD WELFARE AGENCY)

Purpose

This document represents an agreement between PIHP and the {insert child welfare agency name]. Specifically, this memorandum is written to identify roles and responsibilities between the PIHP and the [Insert County Agency] who have entered into an agreement for the purpose of providing and paying for services to Members enrolled in Care4Kids program under the State of Wisconsin Foster Care Medical Home (FCMH), and for the further specific purpose of promoting coordinating and continuity of preventative health services and other medical care and to ensure prompt and appropriate payment for services provided between agencies.

The [insert child welfare agency name] works with families to ensure the safety and well-being of children. With its many community partners, [insert agency name] provides service to families in crisis that help keep children safely in the home. When it is necessary, [insert agency name] looks to foster and adoptive families to provide appropriate temporary and permanent homes for children who cannot live with their parents.

The PIHP is responsible for the management of the complex medical, dental, vision, psychosocial, and developmental needs of children in out-of-home care including those with special health care needs. The PIHP will establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care.

Definitions

Care Coordination: The integration of all processes in response to a child's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.

Child in Out-of-Home Care: Refers to a child taken into custody and determined by a judge to meet the need for continuation of custody under s. 48.21(4)(b) or a parent/legal guardian signs a Voluntary Placement Agreement with DMCPS or the county Child Welfare Agency. A child in out-of-home care may reside in a variety of different placement settings, including a foster home, a group home, or a relative's home.

Comprehensive Initial Health Assessment: A comprehensive initial health assessment is required for all children entering out-of-home care who are enrolled in the foster care medical home program and must occur within 30 days of removal. This assessment should be comprehensive with respect to the identification of possible acute and chronic physical health, behavioral/mental health, oral health, and developmental problems; and, must be in compliance with Wisconsin Health Check requirements. This assessment should include components of both developmental and behavioral/mental health screenings as indicated for each child based on his/her age and history, including any prior evaluations. This assessment should be performed by a clinician who is knowledgeable about the trauma-informed evaluation and treatment of children in out-of-home care.

Member: A child in out-of-home care who has been certified by the state as eligible to enroll under this Contract, and whose name appears on the Enrollment Reports that the Department transmits to the PIHP according to an established notification schedule. Children born to members of the PIHP will be enrolled in the PIHP if covered under the out-of-home care court order unless disenrolled at the request of the parent.

Out-of-Home Care Health Screen: The screening is completed no later than 2 business days after the child enters out-of-home care. The purpose of the screen is to identify any immediate medical, urgent mental health, or dental needs the child may have and any additional health conditions of which the out-of-home providers and child welfare caseworker should be aware of. This screen may also be referred to as the "Foster Care Health Screen".

Out-of-Home Care Provider: The Care4Kids program will serve children placed with providers that are Court Ordered Kinship, Level 1 – Level 5 Foster homes and Group Homes.

Parent/Legal Guardian: Biological parent, parent by adoption, or has a person named by the court having the duty and authority of guardianship.

A. PIHP Rights and Responsibilities:

e. PIHP will provide contact information for the Lead Care Coordinator who will serve as the primary contact for the agency for care coordination issues on behalf of individual members.

f. PIHP will provide contact information for the Health Care Coordinator(s). Each child will be assigned a Health Care Coordinator at the time of his or her enrollment in the medical home. The Health Care Coordinators will serve as the clinical specialist who oversees all aspects of the child's health care.

g. PIHP will provide all Medicaid-covered mental health and substance abuse services to children identified as clients of the [insert agency]. Disputes in the medical necessity of services identified in the Family Treatment Plan will be adjudicated using the dispute process outlined in this MOU, except that the PIHP will provide court ordered services in accordance with the contract.

h. PIHP's responsibilities related to the enrollment process includes the following activities:
    a. Review eReports from eWiSACWIS daily to identify children enrolled in the Care4Kids program.
    b. Send informational packets to the parent/legal guardian and the out-of-home care provider within 5 business days of the receipt of enrollment.
    c. Coordinate with the child welfare worker to obtain any necessary consent(s) for screenings and evaluation from the parent/legal guardian
    d. Other activities required by the contract.

6. PIHP's responsibilities related to the Out-of-Home Care Health Screening includes the following:
    a. If needed, PIHP will provide support in identifying CAC's and scheduling the Out-of-Home Care Health Screen.
    b. Ensures transfer of Out-of-Home health screen finding to the primary care provider who will perform the Comprehensive Initial Health Assessment.
    c. Other activities required by the contract.

7. PIHP's responsibilities related to the Comprehensive Initial Health Assessment includes the following:
    a. Following up with the Out-of-Care provider to assist with scheduling the Comprehensive Initial Health Assessment
    b. PIHP will obtain the child's past medical history, available health records and ensures the primary care provider has timely access to existing health information prior to the Comprehensive Initial Health Assessment.
    c. Other activities required by the contract.

8. PIHP's responsibilities related to the Comprehensive Health Care Plan
    a. Development of the Comprehensive Health Care Plan with input from the child/youth, the parent/legal guardian, caseworker, out-of-home care providers and medical professionals. Ensures the results of the Comprehensive Initial Health Assessment form the basis for the Comprehensive Health Care Plan.

b. Ensure that the initial Comprehensive Health Care plan is developed within 60 days of enrollment in the Care4Kids program.
c. Ensure that the child's primary care physician and child welfare caseworker are primary participants in the development and periodic reviews of the comprehensive care plan. The child's primary care physician is the lead for the child's overall health care needs, and the child welfare caseworker has the overall responsibility for all aspects of the child's care.
d. Identifying the responsible team member for each of the health care needs outlined in the Comprehensive Health Care Plan.
e. Provide an opportunity for the parents/legal guardians an opportunity to review and sign off on the care plan. Evidence of this action will be reflected in the care plan.
f. Other activities required by the contract.

9. PIHP's responsibilities related to the Mental Health Screening and Evaluation includes the following:
   a. Review the Out-of-Home Care Health Screen, the recommendations from the CANS, and the mental health screen from the Comprehensive Initial Health Assessment for any identified mental health needs.
   b. Provides support in identifying and scheduling appointments with mental health providers in a timely manner, as needed
   c. Works with mental health provider in developing the Comprehensive Health Care Plan, including a crisis plan if indicated.
   d. Sharing the crisis plan with the team.
   e. Other activities required by the contract.

10. PIHP's responsibilities related to the comprehensive Oral Evaluation include;
    a. Provide support in identifying and scheduling appointments with dental providers in a timely manner.
    b. Ensure that each child 12 months of age and above receives a comprehensive oral evaluation by a dentist.
    c. Ensures that the oral evaluation happens within 3 months of enrollment, or a re-call exam if a comprehensive oral examination was conducted within 6 months prior to enrollment.
    d. Works with the dental provider in developing the Comprehensive Health Care Plan.
    e. Other activities required by the contract.

11. PIHP's responsibilities related to the Ongoing Monitoring of Care4Kids member success includes the following:
    a. Hold regular, and as needed meetings with the child, parent/legal guardian and out-of-home care provider, child welfare caseworker, health care provider staff and others involved in the delivery of services to the child to monitor and evaluate progress/success, prioritize necessary services for the child including care that will be obtained external to the PIHP network (e.g. County-based services).
    b. Assists new Out-of-Home care providers with identifying and scheduling needed appointments with a new primary care provider if needed.
    c. Establishing measurable healthcare goals and periodically re-evaluating progress towards established goals and outcomes.
    d. Development of a system to track changes in the health care status of the child which are reflected through periodic review and updating of the health care plan at least every six months.
    e. Monitoring the child's case in eWiSACWIS to keep informed of the child's ongoing needs.
    f. Monitor the child's continued enrollment in Care4Kids.
    g. Annual metabolic screening and measurement of growth parameters (including BMI) for any child who is prescribed one or more antipsychotic medications.
    h. Monitoring of the rate and types of psychotropic medication usage among members, stratified by age and number of medications prescribed.
    i. Other activities required by the contract.

12. PIHP's responsibilities related to the Discharge from Out-of-Home Care includes the following:
    a. Prior to discharge from out-of-home care, the PIHP will work with the team including the parent/legal guardian to create a transition health care plan.
    b. Ensure that health information is transferred to a new primary care provider when a child is discharges from out-of-home care.
    c. Monitor the child's continued enrollment in Care4Kids.
    d. Other activities required by the contract. ‘

13. PIHP's responsibilities related the 12-month extension include:
    a. Monitor the status of the 12-month extension.
    b. Prior to the end of the extension, work with the parent/legal guardian to develop a transition health care plan.

14. PIHP's liaison, or other appropriate staff as designated by PIHP, will participate in case conference with [insert agency] upon the request of [insert agency]. The planning session may be done through telephonic or other means of communication when attending a formal case conference is not feasible.

15. The PIHP liaison and [insert the agency] will determine who will be responsible for ensuring that the Member receives the services authorized and provided through PIHP. PIHP will have a mechanism in place for notifying [insert the agency] of missed appointments, or crisis situations that could potentially lead to a change in placement by [insert the agency]. The notification will be within three business days for missed appointments or sooner if possible and as soon as possible for crisis situations.

16. PIHP agrees to participate in dispute resolution using the following process:
    a. PIHP will provide the agency with contact information for the designated personnel who will respond to disputes.
    b. The [Insert agency name] and PIHP designated personnel will meet or teleconference to discuss the case and attempt to resolve issues of dispute.
    c. If the [insert agency name] designees and the PIHP designees (known as the team) are unable to resolve the issues, the [insert agency name] and the PIHP will schedule a meeting or a teleconference of representatives with expertise in the area of dispute to look at outstanding issues within two days of the teleconference, or sooner if indicated.
    d. If the team is unable to resolve the issues to both parties' satisfaction, either party may appeal to the Department. It will be the disputing parties' responsibility to supply the necessary documentation for the Department to adjudicate the dispute.

17. PIHP will work with the [insert agency name] in developing lists of providers and fostering a provider network which has expertise in:
    a. Working with children in out-of-home care effectively.
    b. Working with children who may have developmental, behavioral health or other special health care needs effectively.
    c. Recognizing the interrelationship of the problems [insert agency name] children in out-of-home placement experience and therefore, the value of close collaborative relationships among the various service providers working with the caregivers and child.

18. PIHP will share with the [insert agency name] the process and procedure for prior authorization and out-of-plan referrals.

19. Annually and when requested by the [insert agency name], PIHP will provide training to [insert agency name] staff and contract providers on a variety of subjects related to the Care4Kids program. Subject areas may include but are not limited to, PIHP's provider network, how the out-of-home care provider can appropriately access services including any referral and/or prior authorization processes and Member/caregiver grievances.

20. PIHP will participate in the [insert agency name] site managers' meetings when requested by [insert agency name].

21. The PIHP will share client specific information to assist [insert agency name] in any court-related proceedings.

B. [Insert agency name] Rights and Responsibilities:

1. [Insert agency name] will provide contact information for the staff person who will serve as the primary contact for the agency for care coordination issues on behalf of individual members.

2. [Insert agency name] will ensure the accurate contact information for the supervisors and the caseworkers who will be working with the Health Care Coordinator assigned to each child will be updated timely in eWiSACWIS.

3. It is the [insert agency name]s' responsibility to initiate contact with the PIHP regarding children in need of immediate services. [Insert agency name] will provide (through court order and/or signed release of information) completed assessment information which supports the request for PIHP services.

4. [insert agency name] will involve PIHP in the development of a comprehensive child welfare case plan, which identifies the outcomes to be achieved, the services to be provided and the measures to be used for evaluation. [Insert agency name] will be responsible for developing and periodically updating the child welfare case plan.

5. [Insert agency name] will utilize PIHP's provider network for routine services and will attempt to utilize PIHP's provider network for emergency services. [Insert agency name] will obtain criteria from the PIHP concerning [insert agency name]'s ability to utilize non-participating providers and the mechanism for authorizing non-participating providers.

6. [Insert agency name]'s responsibilities related to the enrollment process includes the following activities:
    a. Provide Care4Kids informational handout to the child's parent/legal guardian.
    b. Enter the child's placement into eWiSACWIS within 5 calendar days of placement.
    c. Complete the Enrollment process outlined in the Enrollment policy.
    d. Obtain any necessary consent(s) for screening and evaluation.
    e. Other activities agreed upon by [insert agency name] and the PIHP.

7. [Insert agency name] responsibilities related to the Out-of-Home Care Health Screening includes the following:
    a. Ensure that the child is scheduled for and completes the Out-of-Home Health Screening within 2 business days of entering out-of-home care.
    b. Ensure that the child receives the Out-of-Home Health Screening at a Child Advocacy Center when possible.
    c. If the Out-of-Home Health Screening is not completed within 2 business days, [Insert agency name] will document the reason in eWiSACWIS.
    d. Other activities agreed upon by [Insert agency name] and the PIHP.

8. [Insert agency name]'s responsibilities related to the Comprehensive Initial Health Assessment includes the following:
    a. Ensure the child is scheduled for comprehensive initial health assessment within 30 days of entering care.
    b. Ensure eWiSACWIS is up to date with all medical information and documentation of removal reasons when possible.
    c. Other activities agreed upon by [Insert agency name] and the PIHP.

9. [Insert agency name]'s responsibilities related to the Comprehensive Health Care Plan
    a. Identifies key team members to participate in the development of the Comprehensive Health Care Plan, including the child welfare worker.
    b. Scans initial and updated Comprehensive Health Care Plan's into eWiSACWIS
    c. Ensures the health care needs identified in the Comprehensive Health Care Plan are being executed.
    d. Other activities agreed upon by [Insert agency name] and the PIHP.

10. [Insert agency name] responsibilities related to the Mental Health Screening and Evaluation includes the following:

a. Complete CANS within 30 days of out-of-home care placement.
b. Ensure child is scheduled for and completes mental health evaluation if needed.
c. Other activities agreed upon by [Insert agency name] and the PIHP.

11. [Insert agency name] responsibilities related to the comprehensive Oral Evaluation include;
    a. Ensures all children 12 months or older are scheduled for a comprehensive oral evaluation within 30 days of entering care.
    b. Ensures that within 3 months of enrollment, all children 12 months or older complete a comprehensive oral evaluation or a re-call exam if a comprehensive oral evaluation was completed within the last six months.
    c. Other activities agreed upon by [Insert agency name] and the PIHP.

12. [Insert agency name] responsibilities related to the Ongoing Monitoring of Care4Kids member success includes the following:
    a. Notify the Health Care Coordinator of any new health concerns or changes in child's health status.
    b. Works with team to ensure that recommended follow up appointments are attended.
    c. Update eWiSACWIS with any change of placements and determines if the child remains eligible for Care4Kids, following enrollment policy.
    d. Informs the Health Care Coordinator of any court-ordered health services and assists in the scheduling of services.
    e. Assists the Health Care Coordinator with any issues affecting the child's ability to receive appropriate health services such as the parent/legal guardian being unresponsive or the Comprehensive Health Care Plan not being followed.
    f. Monitors child's continued enrollment in Care4Kids, per Enrollment Policy.
    g. Other activities agreed upon by [Insert agency name] and the PIHP.

13. [Insert agency name] responsibilities related to the Discharge from Out-of-Home Care includes the following:
    a. When possible, prior to discharge, notifies the Health Care Coordinator of the discharge plan.
    b. Update placement information in eWiSACWIS.
    c. Participate in the development of the transition health care plan.
    d. Monitor the child's continued enrollment in Care4Kids, per the enrollment policy.

14. [Insert agency name] responsibilities related the 12-month extension include:
    a. Monitors the child's active participation in health care plan during the time the case remains open.
    b. Coordinates with Health Care Coordinator to assist in transition planning prior to case closure to ensure child's identified health care needs will be addressed.
    c. Other activities agreed upon by [Insert agency name] and the PIHP.

15. [Insert agency name] agrees to participate in dispute resolution using the following process:
    a. [Insert agency name] and PIHP designated personnel will meet or teleconference to discuss the case and attempt to resolve issues of dispute.
    b. If the [Insert agency name] designees and PIHP designees (known as the team) are unable to resolve the issues the [Insert agency name] and PIHP will schedule a meeting of representatives to look at outstanding issues within two days of the meeting or teleconference (or sooner if indicated).
    c. If the team is unable to resolve the issues to both parties' satisfaction, either party may appeal to the Department. It will be the disputing party's responsibility to supply the necessary documentation for the Department to adjudicate the dispute.

16. [Insert agency name] will assist PIHP in providing outreach to caregivers who are non-compliant with the child's treatments, Health Check, medication regimes, or who have multiple missed appointments for a child in out-of-home care.

17. [Insert agency name] agrees to provide training to PIHP staff or PIHP's provider network on child welfare issues at the request of the PIHP.

This Memorandum of Understanding (MOU) is in effect from [insert date] through [insert date] unless revised by mutual agreement. In the event that changes in Federal or State requirements impact the current MOU, [PIHP] and the [Agency] agree to renegotiate the pertinent section within 90 days of receiving new instructions from the State.

Name	Title	Agency	Date

Name	Title	Agency	Date

THIS DOCUMENT IS TO BE USED AS A SAMPLE. Nothing in this document precludes CCHP or the Agency from adding other requirements to this MOU if it is in the best interest of the children they have in common, and does not violate any of the agreements between the State agency and the PIHP.

ADDENDUM V: Report Forms and Worksheets

A. Court Ordered Birth Cost Requests

County Child Support Agencies (CSA) obtain court orders requiring fathers to repay birth costs that have been paid by FFS as well as the PIHP. In some counties, judges will not assign birth costs to the father based upon average costs. Upon request of the Fiscal Agent Contract Monitor, the PIHP must provide actual charges less any payments made by a third party payer for the use by the court in setting actual birth and related costs to be paid by the father. Birth cost information must be submitted to the Bureau of Children's Services within 14 days from the date the request was received by the PIHP.

The birth cost report forms follows this page.

CARE4KIDS BIRTH COST REQUEST

PART 1: Local Child Support Agency Portion

PART 1: To be completed by the Local Child Support Agency. Please type or print, in a legible manner.

1. **PIHP Name**

2. **Mother's Name**

(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

____

Address

(Street Address)

(City) (State) (Zip Code)

3. **Newborn's Name** _____

(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Date of Birth _____ Sex _____

Note: In cases of multiple births, a form must be completed for each newborn. In addition, the form(s) should not be submitted to the Bureau of Children's Services until 60 days after the birth.

4. **I certify this information is accurate to the best of my knowledge.**

Name of Local Child Support Agency	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

5. **Mail To:**
Bureau of Children's Services

ATTN: Birth Costs, Room 350
P.O. BOX 309

FAX To:
Bureau of Children's Services

ATTN: Birth Costs
(608) 266-1096

MADISON, WI 53701-0309

PART II: PIHP Portion

Part II: To be completed by the PIHP. Please type or print in a legible manner.

1. **The actual payment for birthing costs for the mother and her baby.**

Mother's Name _____ID#_____

Baby's Name _____ID#_____DOB_____

Hospital/Birthing Center Payment (Mother) $_____

Hospital/Birthing Center Payment (Newborn) $_____

Physician Payment (Mother) $_____

Physician Payment (Newborn) $_____

Amount Paid by Other Insurance $_____

2. **Comments: (i.e., retroactively disenrolled from [PIHP NAME] effective [DATE], services denied)**

[State Denial Reason]: _____

3. **I certify this information is accurate to the best of my knowledge.**

Name of PIHP	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

4. **Mail or FAX Part I and Part II within 14 days of receipt to:**

Mail To:
Bureau of Children's Services

FAX To:
Bureau of Children's Services

ATTN: Birth Costs, Room 350
P.O. Box 309
Madison, WI 53701-0309

ATTN: Birth Costs
(608) 266-1096

B. PIHP Newborn Report

The newborn report should be completed for infants born to mothers who are Foster Care Medical Home eligible and enrolled in the PIHP at the time of birth of the infant. The FCMH is encouraged to use the online form to submit newborn information, which will be received and processed more quickly and processed more quickly than forms sent by fax or mail. When newborn information is submitted online, ForwardHealth may be able to establish eligibility and FCMH enrollment for the newborn faster.

The requirements for the Newborn Report are included in the ForwardHealth online handbook. The handbook includes instructions for online submitting, links to the form and submission instructions.

C. Member Complaint and Grievance Reporting Forms

The PIHP is required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F, as contained in the *Member Grievances and Appeals Guide*, Dated December 2021.

D. Summary Hospital Access Payment Report to Department of Health Services

This report will be provided to the PIHP electronically in the current PIHP contract for completion. Hospital Access Payments must be sent to the hospitals within 15 calendar days after the PIHP receives the monthly amounts from the Department. The PIHP must submit to the Department the following information for each paid hospital within 15 calendar days of receipt of payment from the Department:

Hospital Access Payment

PIHP Name	
Month, Year payment was received from the Department	
Month, Year from which hospital discharge and claims data is being reported (i.e. previous month)	
Date the last hospital access payment was sent	
*** Grand Total Payment**	

*****The distribution of these funds by the PIHP to hospitals shall be based on eligible discharges and claims in the prior month paid by the PIHP to eligible hospitals.

1 2 3 4 5 6 7 8 9 10 11 12 13

MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of Hospital Qualifying Inpatient Discharges Paid to the Individual Hospital	Number of Total Inpatient Discharges Paid by PIHP to All Eligible Hospitals	Percent of the Hospital's Total Inpatient Discharges Paid by the PIHP(Column 5 / Column 6)	Payment to Hospital for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of Hospital Qualifying Outpatient Claims Paid to the Individual Hospital	Number of Total Outpatient Claims Paid by PIHP to All Eligible Hospitals	Percent of the Hospital's Total Outpatient Claims Paid by PIHP (Column 10 / Column 11)	Payment to Hospital for Outpatient Claims (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____

(Signature) (Date)

E. Summary Critical Access Hospital (CAH) Access Payment Report to Department of Health Services

This report will be provided to the PIHP electronically in the current PIHP contract for completion. Payments must be sent to the hospitals within 15 calendar days after the PIHP receives the monthly amounts from the Department. PIHPs must submit to the Department the following information for each paid CAH

Critical Access Hospital (CAH) Access Payment

PIHP Name	
Month, Year payment was received from the Department	
Month, Year from which CAH discharge and claims data is being reported (i.e. previous month)	
Date the last CAH access payment was sent	
*** Grand Total Payment**	

* Total payments made to all CAH(s) should be equal to the total amount the PIHP received from the Department. The distribution of these funds by the PIHP to CAH(s) shall be based on eligible discharges and claims in the prior month paid by the PIHP to eligible CAH(s):

1 2 3 4 5 6 7 8 9 10 11 12 13

MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of CAH Qualifying Inpatient Discharges Paid to the Individual CAH	Number of Total Inpatient Discharges Paid by PIHP to All Eligible CAHs	Percent of the CAH's Total Inpatient Discharges Paid by the PIHP (Column 5/ Column 6)	Payment to CAH for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of CAH Qualifying Outpatient Claims Paid to the Individual CAH	Number of Total Outpatient Claims Paid by PIHP to All Eligible CAH(s)	Percent of the CAH's Total Outpatient Claims Paid byPIHP (Column 10 / Column 11)	Payment to CAH for Outpatient Claims (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____

(Signature) (Date)

G. Attestation

I_____, have reviewed the following data:
(Name and Title)

- ☐ Encounter Data for (quarter)_____(year) 20___.
- ☐ Vent Report for (quarter)_____for (year) 20___.
- ☐ PIHP Network Submission (submitted monthly) for (quarter) __(year) 20__.
- ☐ Maternity Kick Payment Newborn Report for (quarter) _____(year) 20__.
- ☐ Other _____ (Specify Report)

After conducting a reasonably diligent review of the data, documentation and information, I attest that it is accurate, complete and truthful. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under the applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Plan's agreement or contract with the Wisconsin Department of Human Services (DHS). This form must be signed by the PIHP CEO,CFO, or their designated authority in order to be considered a valid signature.

_____ _____
(Title) (PIHP Name)

_____ _____
(PIHP Signature) (Date)

ADDENDUM VI: Benefits and Cost Sharing Chart

For current information about Wisconsin Medicaid covered services and allowable cost-sharing, please refer to the ForwardHealth Online Handbooks, Provider Updates, and interChange. A summary of covered servicesis available in Appendix B of the ForwardHealth Enrollment and Benefits Handbook (available at https://www.dhs.wisconsin.gov/library/p-00079.htm).

ADDENDUM VII: Fraud, Waste, and Abuse (FWA) Strategic Plans

A. Fraud, Waste, and Abuse (FWA) Strategic Plans General Guidelines
   1. The FCMH must submit their annual FWA strategic plans to the DHS Office of Inspector General (OIG) for review by November 15 using the DHS OIG SharePoint site.
      a. The FCMH may consult with their DHS OIG representative throughout the calendar year while developing their annual FWA strategic plan to ensure a successful approval process.
   2. The DHS OIG auditor will review the FWA strategic plan according to the rubric below and provide feedback to the FCMH regarding any necessary changes.
      a. The FCMH must make the necessary edits and submit the plan to the DHS OIG SharePoint site for additional review. This cycle will continue until a compliant FWA strategic plan is submitted.
      b. The FCMH must ensure that DHS OIG's feedback, including any requested corrections or revisions, are incorporated into their strategic plans.
   3. The FCMH are required to have approval of their annual FWA strategic plan prior to December 31.

B. FWA Strategic Plan Components

   The strategic plan must be structured as follows:

      1. Data Analysis - Overview of the data analysis that will be conducted to determine which FWA issues the FCM will prioritize in their FWA strategic plan. The FMCH is responsible for conducting the data analysis and determining risk.
      2. Program Integrity Initiatives – Identify a minimum of three program integrity initiatives to be implemented during the calendar year to address the identified FWA issues identified in the data analysis. A program integrity initiative is the plan or action that will be implemented during the calendar year to address the identified FWA issue.
         a. Each program integrity initiative must:
            i. Identify the program integrity issue or risk the FCMH is attempting to address with each initiative
            ii. Identify the goal of each initiative
            iii. Identify the expected results of the initiative
            iv. Identify the objectives or strategies that will be used to achieve the goal of each initiative
            v. Describe the planned tasks for each quarter that are intended to achieve the identified goal.
            vi. Identify the anticipated completion date of the initiative

vii. Identify the personnel responsible for the completion of the initiative
viii. Identify the method by which the FCMH will measure compliance or return on investment on the initiative.

3. Additional Required Components – The following list can be used as an individual initiative or as a strategy within another initiative. All the additional required components must ben included in the strategic plan.
   a. Prepayment activities.
   b. Post-payment activities. These post-payment activities must include audits of medical records, including reviewing for appropriate coding and medical necessity. Post-payment audits are only one example of post-payment activities, and the FCMH must consider all post-payment activities when developing their plan.
   c. Verification of the provision of services to members:
      i. Includes the planned number of verifications. Must be equal to or greater than 100 verifications per quarter;
      ii. Includes methodology for verifying services – explanation of benefits, phone calls, etc.
      iii. Includes methodology for tracking related reports of fraud and subsequent overpayment recoveries.
   d. Plan to increase the quantity of credible allegations of fraud identified.
   e. Planned provider education related to fraud, waste, and abuse

C. FWA Strategic Plan Approval Process

DHS OIG and the PIHPs will engage in the following process to review and approve the annual FWA strategic plans:

1. PIHPs will draft their annual FWA strategic plans in accordance with the requirements of the addendum.
2. PIHPs must submit their annual FWA strategic plan through the DHS OIG SharePoint site no later than November 15.
3. DHS OIG will use the FWA Strategic Plan Evaluation Rubric to evaluate compliance with the requirements of this addendum.
4. DHS OIG will either approve the FWA strategic plan or return the plan to the PIHP for changes based on DHS OIG feedback from the rubric assessment.
5. DHS OIG will upload the FWA Strategic Plan Feedback Form to the SharePoint site indicating whether the plan has been approved or needs additional work completed.
6. If the FWA Strategic Plan needs correction, the PIHPs will incorporate DHS OIG's feedback and resubmit the FWA strategic. DHS OIG will

provide the due date for returning the draft for the next review as part of the feedback to ensure the plan receives approval by December 31.

7. Steps 4-6 are to be repeated until DHS OIG approves the FWA strategic plan.
8. Each PIHP must have an FWA strategic plan approved by DHS OIG by December 31.

STRUCTURE				
	Exceeds Criteria	Meets Criteria	Requires Additional Work	
Structure – Overview of Data Analysis	PIHP documented a thorough data analysis which clearly demonstrates the thought process behind the selected initiatives, objectives, and strategies.	PIHP documented a basic data analysis which clearly demonstrates the thought process behind the selected initiatives, objectives, and strategies.	PIHP documented a review of data that does not have a clear connection to the selected initiatives, objectives, and strategies. *Resubmit plan with a more thorough analysis and clear connections.*	PIHP did not include any information related to data analysis. *Resubmit with data analysis that clearly demonstrates the thought process behind the selected initiatives, objectives, and strategies.*
Structure – Number of Initiatives	FWA strategic plan includes more than three initiatives.	FWA strategic plan includes three initiatives	FWA strategic plan includes 1-2 initiatives. *Resubmit plan with at least three initiatives.*	FWA strategic plan includes zero initiatives. *Resubmit plan with at least three initiatives.*
Structure – Quality of Initiatives	FWA strategic plan articulates thoughtful, well-structured, and innovative initiatives.	FWA strategic plan articulates acceptable initiatives.	FWA strategic plan does not articulate initiatives clearly or does not articulate relevant initiatives. *Resubmit with clearly identified initiatives that will likely be impactful to the PIHP's PI oversight.*	FWA strategic plan does not contain initiatives. *Resubmit with clearly identified initiatives that will likely be impactful to the PIHP's PI oversight.*
Structure – Quality of Objectives	FWA strategic plan clearly articulates measurable objectives that align with the initiative that demonstrate an anticipated high impact to the	FWA strategic plan clearly articulates measurable objectives that align with the initiative.	FWA strategic plan contains objectives but they either are not measurable or do not align with the initiative. *Resubmit with clearly identified objectives that are measurable and align with the corresponding initiative.*	FWA strategic plan does not contain objectives. *Resubmit with clearly identified objectives that are measurable and align with the corresponding initiative.*

	PIHP's PI oversight.			
Structure – Quality of Strategies	Strategies are innovative and articulate a clear plan to achieve the objectives and initiatives with an anticipated high impact to the PIHP's PI oversight.	Strategies articulate a clear plan to achieve the objectives and initiatives.	Strategies are unclear or do not appear as though they will result in the PIHP achieving the objective or initiative. *Resubmit with more detail or improved alignment.*	FWA strategic plan does not contain strategies. *Resubmit plan with clearly defined strategies that align with the objectives and initiatives.*
Structure – Quarterly Breakout	Initiatives, objectives, and strategies are broken out by quarter in a manner that is visually appealing and easy for the reader to follow.	Initiatives, objectives, and strategies are broken out by quarter.	Initiatives, objectives, and strategies are not broken out by quarter. *Resubmit plan with initiatives, objectives, and strategies broken out by quarter.*	
Structure – Date of Completion	Strategies include anticipated dates of completion that demonstrate a dynamic yet attainable pace.	Strategies include anticipated dates of completion.	One or more strategies do not include anticipated dates of completion. *Resubmit plan with anticipated dates of completion for all strategies.*	None of the strategies include anticipated dates of completion. *Resubmit plan with anticipated dates of completion for all strategies.*
Structure – Responsible Personnel	Identifies responsible personnel and supporting personnel assigned to each strategy.	Identifies person responsible for completion of each strategy.	One or more strategies do not identify the person responsible. *Resubmit plan with the responsible personnel identified.*	None of the strategies identify the person responsible. *Resubmit plan with the responsible personnel identified.*
Structure – Measuring Compliance and ROI	Identifies methods of measuring compliance or return on investment that are innovative, impactful, and easy to monitor.	Identifies method of measuring compliance or return on investment for each strategy that is able to be monitored and	One or more strategies are missing the identified methodology or the provided methodology does not align with the strategy. *Resubmit plan with the method of measuring*	None of the strategies identify the method of measuring compliance or return on investment. *Resubmit plan with the method of measuring compliance or return*

		aligns with the strategy.	*compliance or return on investment identified.*	*on investment identified.*

D. FWA Strategic Plan Implementation Process

The PIHP will implement their approved FWA strategic plan each year on January 1. DHS OIG will monitor the Quarterly Program Integrity Report and other methods the PIHPs indicate that they will be measuring their compliance with their FWA strategic plan. DHS OIG representative will contact the PIHP periodically during the year to offer support and technical assistance, and to ensure the PIHP is on track with their FWA strategic plan. If an updated FWA strategic plan is needed, DHS OIG can assist the PIHP in making the needed updates.

E. DHS OIG Audit of PIHP Compliance with the FWA Strategic Plan

DHS OIG will audit the PIHP's compliance with their approved FWA strategic plan. DHS OIG will use technical assistance, corrective action plans, and financial sanctions to address as remedies for FWA strategic plan review audit findings. DHS OIG may request financial sanctions when:

1. A PIHP has refused to engage in technical assistance provided by DHS OIG in response to a determination that the PIHP is out of compliance with their FWA strategic plan; or
2. A PIHP has refused to engage in the audit process

ADDENDUM VIII: Rates

Exhibit 4
Wisconsin Department of Health Services
CY 2023 Care4Kids Non-Risk Prepayment Rate Development
CY 2023 Non-Risk Prepayment Rates

		Milwaukee Adjustment			Southeastern Adjustment					
	Regional Variation	1.124	1.124	1.124	0.804	0.804	0.804			
		CY 2023 Milwaukee PMPMs			CY 2023 Southeastern PMPMs			CY 2023 PMPMs		
	Age Group	Title IV-E	Non Title IV-E	Total	Title IV-E	Non Title IV-E	Total	Title IV-E	Non Title IV-E	Total
CY 2023 PMPM	Age 0	$765.07	$1,916.83	$1,353.09	$546.94	$1,370.32	$967.31	$680.59	$1,705.17	$1,203.68
	Ages 1-5	340.54	478.91	410.90	243.45	342.37	293.75	302.94	426.03	365.53
	Ages 6-14	398.08	466.67	438.94	284.58	333.62	313.79	354.12	415.14	390.47
	Ages 15-20 F	448.76	540.55	518.51	320.82	386.43	370.67	399.21	480.86	461.25
	Ages 15-20 M	321.92	636.62	560.38	230.13	455.11	400.61	286.37	566.32	498.50
CY 2023 PMPM Total		**$398.99**	**$579.24**	**$502.54**	**$285.23**	**$414.09**	**$359.26**	**$354.93**	**$515.28**	**$447.05**
PMPM Non-Service Costs	Age 0	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20
	Ages 1-5	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
	Ages 6-14	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
	Ages 15-20 F	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
	Ages 15-20 M	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
PMPM Non-Service Costs Total		**$83.20**	**$83.20**	**$83.20**	**$83.20**	**$83.20**	**$83.20**	**$83.20**	**$83.20**	**$83.20**
Access Payments Add-On	Age 0	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97
	Ages 1-5	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
	Ages 6-14	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
	Ages 15-20 F	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
	Ages 15-20 M	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
Access Payments Add-On Total		**$59.97**	**$59.97**	**$59.97**	**$59.97**	**$59.97**	**$59.97**	**$59.97**	**$59.97**	**$59.97**
Non-Risk Prepayment Rates	Age 0	$908.24	$2,060.00	$1,496.26	$690.11	$1,513.49	$1,110.48	$823.76	$1,848.34	$1,346.85
	Ages 1-5	483.71	622.08	554.07	386.62	485.54	436.92	446.11	569.20	508.70
	Ages 6-14	541.25	609.84	582.11	427.75	476.79	456.96	497.29	558.31	533.64
	Ages 15-20 F	591.93	683.72	661.68	463.99	529.60	513.84	542.38	624.03	604.42
	Ages 15-20 M	465.09	779.79	703.55	373.30	598.28	543.78	429.54	709.49	641.67
Non-Risk Prepayment Rates Total		**$542.16**	**$722.41**	**$645.71**	**$428.40**	**$557.26**	**$502.43**	**$498.10**	**$658.45**	**$590.22**