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, 2014 – December 31, 2015

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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

I. 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 client or member practices that result in unnecessary costs to the Department of Health Services.

ACA/PPACA: PPACA and ACA are interchangeable acronyms. PPACA is the abbreviation for the 2010 federal law, the Patient Protection and Affordable Care Act. This law is commonly referred to as ACA or the Affordable Care Act.

ACA Primary Care Rate Increase Fee Schedule – A separate fee schedule (from the Wisconsin BadgerCare Plus maximum allowable Fee Schedule) which outlines the codes and amount the PIHP must pay to qualifying providers for the PPACA Primary Care Rate Increase. The ACA Primary Care Rate Increase Fee Schedule is based on the Medicare Fee Schedule for the corresponding dates of service. The fee schedule will be updated annually. The fee schedule can be found at the following link:

https://www.forwardhealth.wi.gov/WIPortal/Max%20Fee%20Home/tabid/77/Default.aspx

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service.

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

Amount Distributed to Provider – The total payment the PIHP made to the provider related to each specific detail on the PPACA Primary Care Report for the encounter.

Appeal: A request for review of an action.

Authorized Representative: For the purposes of filing a complaint, grievance, or appeal, an individual appointed by the member, including a provider or estate representative, may serve as an authorized representative with documented consent of the member

BadgerCare Plus: The state's comprehensive health insurance program for low income children, families and childless adults. The health care benefits for children in out-of-home care are the same as those services covered under the state's Medicaid program.

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.

Bureau of Milwaukee Child Welfare (BMCW): The state agency responsible for child protective services in Milwaukee County.

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

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 outcomes and the effectiveness of services.

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

CFR: Code of Federal Regulations.

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 BMCW 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. Althought this contract uses the term "Foster Care Medical Home" the reference applies to all children place 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.

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.

Complaint: A general term used to describe an oral expression of dissatisfaction with the PIHP from a member. It can include access problems such as difficulty getting an appointment or difficulty receiving appropriate care; quality of care issues such as long waiting times in a provider's office, rude providers or staff; or denial or reduction of a service. A complaint may become a grievance or appeal if it is subsequently submitted in writing.

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, behvavioral/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 Agreement, 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:

i. Personally identifiable information;
ii. Individually identifiable health information;
iii. 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
iv. Information designated as confidential in writing by the State.

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

A. Any reports that the Department may reasonably require, and
B. At least the following services to eligible HealthCheck members formally enrolled with the provider as enumerated in 42 CFR 441.60(a)(1)-(5):

1. Screening, diagnosis, treatment, and referrals for follow-up services;

2. Maintenance of the member's consolidated health history, including information received from other providers;

3. Physician's services as needed by the member for acute, episodic or chronic illnesses or conditions;

4. Provision or referral for dental services; and

5. Transportation and scheduling assistance.

Contract: The agreement executed between the PIHP and the Department to accomplish the duties and functions, in accordance with the rules and arrangements specified in this document.

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

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

Corrective Action Plan: 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 system (such as a PIHP), a health care clearinghouse, or a health care provider or HMO that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162.

Cultural Competency: 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.

Department of Health Services (DHS): The State agency responsible for the Foster Care Medical Home Program, referred to as the Department in this contract.

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:

- An emphasis on a family centered approach.
- Consumer involvement throughout the process.
- Building resources on natural and community supports.
- A strength based approach.
- Providing unconditional care.
- Collaborating across systems.
- Using a team approach across agencies.
- Being gender, age and culturally responsive.
- Promoting self-sufficiency focus on education and employment where appropriate.
- A belief in growth, learning and recovery.
- Being oriented to outcomes.

Emergency Medical Condition:

A. 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:

1. 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;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

B. With respect to a pregnant woman who is in active labor:

1. Where there is inadequate time to effect a safe transfer to another hospital before delivery; or
2. Where transfer may pose a threat to the health or safety of the woman or the unborn child.

C. A psychiatric emergency involving a significant risk of serious harm to oneself or others.

D. A substance abuse emergency exists if there is significant risk of serious harm to an enrollee or others, or there is likelihood of return to substance abuse without immediate treatment.

E. 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 Service: Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition.

Encounter:

A. 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

B. 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.

C. A service or item not directly provided by the PIHP, and one 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 the 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 Paid Amount – FFS Max Fee Schedule rate the encounter was priced at after cost sharing for the dates of services and appears on the PPACA Primary Care Report.

Encounter Record: An electronically formatted list of encounter data elements per encounter as specified in the current Encounter Data User Manual. 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, Member, Consumer and Participant: See Member.

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 Foster Care Medical Home Program compared to the standard fee-for-service benefit package. Enrollment activities refers to distributing, collecting, and processing enrollment materials.

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 HFS 107.035(1) and (2), Wis. Adm. Code, as determined by the Department.

External Quality Review Organization (EQRO): An independent entity that contracts with the Department to conduct quality reviews of managed care organizations or prepaid inpatient health plans that serve Medicaid members.

Formally Enrolled with a Continuing Care Provider (as cited in 42 CFR 441.60(d)): A member (or member's guardian) agrees to use one continuing care provider as the regular source of a described set of services for a stated period of time.

ForwardHealth interChange: ForwardHealth interChange handles claims, prior authorizations, and other services for many of the state health care programs within a single system. The system is also referred to as "interChange."

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 by a member or authorized representative of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system of grievances and appeals handled by the PIHP. Possible grievance subjects 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. The member or authorized representative may file a grievance either orally or in writing and must follow an oral filing with a written, signed grievance (unless the member requests expedited resolution according to 42 CFR 438.402(b)(3)(ii)).

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 an RN nursing degree, a social worker meeting at a minimum the "Advanced Practice Social Worker" licensure requirements as defined in s. MPSW 6 Wisconsin Administrative Code, or a nurse practitioner. 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 CCHP.

Health Care Professional: A physician or any of the following: a 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, and certified respiratory therapy technician.

Health Check/EPSDT: HealthCheck is Wisconsin's name for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Under federal Medicaid law, states must provide EPSDT services to all children under the age of 21.

Federal law also states that states must cover other "necessary health care, diagnostic services, treatment, and other measures" that fall within the federal definition of medical assistance (as described in Section 1905(a) of the Social Security Act that are needed to "correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services."

EPSDT services must be based on a nationally recognized pediatric periodicity schedule. For children enrolled in the PIHP, the Department is requiring an enhanced periodicity schedule.

To be recognized as a comprehensive HealthCheck screen, the following components must be assessed and documented:

- 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 inspection plus referral to a dentist beginning at age 1
- Appropriate immunizations based on age and health history;
- Appropriate lab tests (including age-appropriate blood lead level testing).

HHS: The federal Department of Health and Human Services.

HHS Transaction Standard Regulation: The 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.

Individually Identifiable Health Information (IIHI): Patient demographic information, claims data, insurance information, diagnosis information, and any other information the relates to the past, present, or future health 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.

Local Health Department (LHD): An agency of local government established according to Chapter 251, Wis. Stats. Local health departments have statutory obligation to perform certain core functions, including assessment, assurance, and policy development to protect and promote the health of their communities.

Marketing: Any unsolicited contact by the PIHP, its employees, affiliated providers, subcontractors, or agents to a potential member or potential member's legal guardian or family members for the purpose of persuading such persons to enroll with the PIHP.

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

Medicaid: The Wisconsin BadgerCare Plus and Medicaid SSI Program operated by the 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 well being 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 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 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.

Member-Centric Care: Member-centric care explicitely 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.

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.

Net PPACA Supplement – The difference between the Encounter Paid Amount and PPACA Paid Amount and appears on the PPACA Primary Care Report.

Newborn: A member less than 100 days old.

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 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.

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 Foster Care Medical Home will be responsible for serving children placed with providers in out-of-home settings other than secure detention, corrections, institutions, and residential care centers.

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

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:

a. The individual's Social Security number;
b. The individual's driver's license number or state ID number;
c. The individual's date of birth;
d. 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;
e. The individual's DNA profile; or
f. 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 HMO 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.

PIHP Paid Amount – The total amount of money the PIHP paid to the provider after cost sharing and prior to PPACA Primary Care Rate Increase being applied to the encounter. This definition is used with the PPACA Primary Care Rate Increase, Article VI, Section L.

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

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

PPACA Paid Amount – ACA Primary Care Rate Increase Fee Schedule rate for specified dates of services and appears on the PPACA Primary Care Report.

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.

Primary Care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP): Primary care providers include, but are not limited to FQHCs, RHCs, tribal health centers, and physicians, nurse practitioners, nurse midwives, physician assistants and physician clinics with specialties in general practice, family practice, internal medicine and pediatrics.

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

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, jails, and juvenile secure detention facilities. This does not include in-patient psychiatric facilities covered under Article III, F.

Recovery: Refers to an approach to care which has as its goal a decrease in dysfunctional symptoms and an increase in maintaining the person's highest level of health, 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.

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, mailings, 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.

State: The State of Wisconsin.

Subcontract: Any written agreement between the PIHP and another party to fulfill the requirements of this Contract. However, such term does not include insurance purchased by the PIHP to limit its loss with respect to an individual enrollee, provided the PIHP assumes some portion of the underwriting risk for providing health care services to that member.

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 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.

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: Care and services that if not fulfilled could result in an emergency room visit or inpatient admission.

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

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

Terms that are not defined above shall have their primary meaning identified in Wis. Adm. Code DHS 101-108.

ARTICLE II

II. 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:

- 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.

- Before any delegation, the PIHP shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.

- 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.

- If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor shall take corrective action.

- 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.

ARTICLE III

III. FUNCTIONS AND DUTIES OF THE PIHP

A. Statutory Requirement

In consideration of the functions and duties of the Department contained in this Contract, the PIHP shall retain at all times during the period of this Contract a valid Certificate of Authority issued by the State of Wisconsin Office of the Commissioner of Insurance.

B. 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 and Title XXI, SCHIP, 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, unless 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. 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 that 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 be determined by the Department. This section does not limit the Department's ability to modify this Contract due to changes in the state budget.

The PIHP is not 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. Rules and regulations

prescribed by the U.S., Department of Labor in accordance with 41 CFR Chapter 60.

C. 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). a) through e) 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 ownership 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 judiciary 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, and 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 that 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 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.

2. Key Personnel

The health system must designate key personnel for this contract. Key personnel do not have to be full-time but should be available in sufficient numbers to meet the requirements of this contract. One person could also perform more than one function of the key personnel as long as the FCMH has sufficient staff to meet the requirements of this program.

Key personnel for this contract are:

a. Chief Executive Officer.
b. Medical Director
c. Contract Representative (Administrator)
d. Quality Improvement Officer
e. Chief Financial Officer
f. Encounter Data and Systems Manager
g. Member (Child) Advocate
h. Lead Care Coordinator.

3. 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.

4. 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 at the time of submission. This includes encounter data or any other data regarding claims the PIHP paid. The PIHP must use the Department's attestation form in the contract, Addendum V. The

attestation form must be submitted quarterly to the PIHP's Managed Care Analyst in the Bureau of Benefits Management (Article VII, J reference)

5. 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 (AA) Plan

1) For contracts where the PIHP has 50 employees or more and will receive over $50,000 in funding, the PIHP must complete and file an 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 a written document committing the contractor to a program designed to achieve a balanced work force. It contains, at a minimum, sections for a policy statement, a workforce analysis, program goals, an internal monitoring system, and dissemination of the AAP. To comply with this requirement , the PIHP should visit the link provided below to obtain the instructions and forms: http://vendornet.state.wi.us/vendornet/doaforms/doafrm.ASP

2) When the PIHP complies with the State of Wisconsin's Contract Compliance Law requirements, the contractor may be included in the "Contract Compliance Program (CCP) Contractor Directory", and identified in the directory as an eligible contractor for three years. The AA Plan must be submitted to:

Department of Health Services
Division of Enterprise Services
Bureau of Strategic Sourcing/Contracting Section

1 West Wilson St., Room 655
P.O. Box 7850
Madison, WI 53707

b. Civil Rights Compliance (CRC) Plan

1) The PIHP must file a Civil Rights Compliance (CRC) Letter of Assurance (LOA) to comply with DHS civil rights compliance requirements. PIHPs with over fifty (50) employees and who receive over $50,000 in funding must complete a CRC Plan compliant with DHS CRC requirements. The CRC Plan must be kept on file and produced when requested by an official representative of DHS. Instructions and templates to comply with these requirements are accessible at: http://dhs.wisconsin.gov/civilrights/Index.HTM.

The CRC LOA must be submitted to the Office of Affirmative Action and Civil Rights Compliance. For technical assistance on all aspects of CRC, the PIHP is to contact the Department's AA/CRC Office at:

The Department of Health Services
Office of Affirmative Action and Civil Rights Compliance
1 West Wilson St., Room 656
P.O. Box 7850
Madison, WI 53707-7850
(608) 266-9372 (voice)
(608) 266-0583 (Fax)
(888) 701-1251 (TTY)

2) PIHPs extending federal or state funds to other entities assume the responsibility for assuring sub-contractors' compliance with DHS AA Plan and CRC requirements.

6. Non-Discrimination in Service Delivery

a. The PIHP agrees to not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion, sex/gender, sexual identity or sexual orientation. 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

b. The PIHP agrees to comply with Federal and State civil rights laws applicable to service delivery.

c. 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.

d. The PIHP agrees to cooperate with the Department in developing, implementing and monitoring corrective action plans that result from complaint investigations or monitoring efforts.

7. Non-Discrimination in Employment

The PIHP agrees to comply with federal and state laws applicable to non-discrimination and equal employment opportunity. These laws require that no otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age (over 40), arrest record, conviction record, color, creed/religion, disability, genetic testing, honesty testing, marital status, military service, pregnancy/childbirth, race/ethnicity, national origin/ancestry, sex, sexual orientation, sexual identity, or use of legal products during non-work hours outside of the employer's premises, except as otherwise authorized by applicable statutes. Federal and State employment law prohibits retaliation.

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 PIHP further agrees to take affirmative action to ensure equal employment opportunities. The PIHP 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. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

With respect to provider participation, reimbursement, or indemnification, the PIHP will not discriminate against any provider who is acting within 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 prohibit the PIHP from including providers to the extent necessary to meet the needs of the Medicaid population or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities. 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.

8. Provision of Services to all 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. 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.

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 beneficiary.

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.

9. Access to Premises

The PIHP must allow duly authorized agents or representatives of the state or federal government access to the PIHP's or its subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the PIHP's or its 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 its 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 its 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.

10. 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 prepayment. This provision will remain in effect even if the PIHP becomes insolvent.

11. 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 X.

12. 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 Benefits Management. 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 careand 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 Bureau of Milwaukee Child Welfare 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 BMCW, 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 III, F, 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 departments if those agencies provide services to children in out-of-home care or their families.

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.

f. School-Based Services (SBS) Providers

The PIHP must use its best effort to have 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.

g. 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. The Department distributes a statewide list of certified TCM agencies to the PIHP and will periodically update that list.

h. County Birth to 3 (B-3) Agencies

The PIHP must use its best effort to develop MOUs with county Birth to Three Program agencies in their service area. Wisconsin's Birth to 3 Program (http://www.dhs.wisconsin.gov/children/birthto3/) is a federally mandated program with oversight by the U.S. Department of Education, Office of Special Education Programs (OSEP) under Part C of the Individuals with Disabilities Act. The Birth to 3 Program provides early intervention services for children ages birth to 36 months with developmental delays and disabilities and is available in all 72 counties; the Department of Health Services (DHS) contracts with each county to establish and maintain a Birth to 3 Program. The goal of the program is to support and educate

parents so they can support their child's growth and development. Early intervention and supports can lessen the effects of developmental delays and may decrease the need for future services. Eligibility for the program is based on a diagnosed disability or significant delay in one or more areas of development. Births to 3 Program services include developmental education services, occupational therapy, physical therapy, and speech therapy, family education, related health services, and targeted case management.

HMOs can find a list of county contacts for Birth to Three programs at: www.dhs.wisconsin.gov/children/birthto3/contacts/countycontacts.asp

i. Hospitals/ Urgent Care Centers for the Provision of Emergency Services

The PIHP may have a contract or an MOU with hospitals or urgent care centers within the PIHP's service area to ensure prompt and appropriate payment for emergency services.

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 paremeters of sharing confidential child welfare records. The PIHP shall identify appropriate staff to access eWiSACWIS and the eReports.

13. 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 CLIA regulations as specified by 42 CFR Part 493.1. "Laboratory Requirements and Basis and Scope." Those laboratories with certificates must provide only the types of tests permitted under the terms of their certification. The PIHP shall comply with the following federal compliance requirements for the services listed below:

1. Standards and Certification, 42 CFR 493 -- Laboratory Requirements.

2. Clinical Laboratory Improvement Amendments, 42 CFR 263a – Laboratory

Requirements.

3. Wisconsin Administrative Code, Chapter 105, DHS 105.42(1-2) and DHS 105.46 – Medical Assistance.

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

D. Payment Requirements/Procedures

The PIHP is responsible for the payment of all contract services provided to all FCMH members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Rosters provided by the Department for the coverage month. The PIHP is responsible for the provision, or authorizing the provision of, services to all FCMH members with valid ForwardHealth ID cards indicating PIHP enrollment, without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between eligibilityand the enrollment rosters must be reported to the Department for resolution. The PIHP must continue to provide and authorize provision of all contract services until the discrepancy is resolved.

1. Claims Retrieval

The PIHP must maintain a claim retrieval system that can, upon request, identify date of receipt, action taken (i.e., paid, denied, other) and date the action was taken on all claims. The PIHP must have procedures in place that will show the date a claim was received whether the claim is a paper copy or an electronic submission. In addition, the PIHP must maintain a claim retrieval system that can identify, within the individual claim, the services provided and the diagnoses of the member using nationally accepted coding systems: HCPCS including Level I CPT codes and Level II and Level III HCPCS codes with modifiers, current ICD diagnosis and procedure codes, and other national code sets such as place of service, type of service, and EOB codes. Finally, the claim retrieval system must be capable of identifying the provider of services by the appropriate Wisconsin Medicaid provider ID number and/or National Provider Identifier (NPI), if applicable, assigned to all in-plan providers.

2. Thirty Day Payment Requirement

The PIHP must pay at least 90% of adjudicated clean claims from subcontractors 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 have agreed to later payment. The PIHP agrees not to delay payment to a subcontractor pending

subcontractor collection of third party liability unless the PIHP has an agreement with the subcontractor to collect third party liability.

3. Payment to a Non-PIHP Provider for Services Provided to a Disabled Participant Less Than Three or for Services Ordered by the Courts

   The PIHP must pay for covered services provided by a non-PIHP provider to a disabled participant less than three years of age, or to any participant pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-PIHP provider, and extending until the PIHP issues a written denial of referral. This requirement does not apply if the PIHP issues a written denial of referral within seven days of receiving the request for referral.

4. 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 or would pay, its FFS providers. This condition does not apply to cases where there are specific subcontract agreements, MOUs or other binding agreements entered into before the referral.

5. Health Professional Shortage Area (HPSA) Payment Provision

   The following provision refers to payments made by the PIHP. The 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 the ForwardHealth Online Handbooks) provided to a member living in a 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. The specified enhanced payment amounts are available in the ForwardHealth Provider Updates.

   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 Department will supply a list of the services affected by this provision, the maximum FFS rates, and HPSAs. 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.

6. Payment of Physician Services to Enrolled Members

The PIHP must adequately fund physician services provided to FCMH members, so that they are paid at rates sufficient to ensure that provider participation and services are as available to the FCMH population as they are to the general population in the PIHP service area.

7. Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

If the PIHP contracts with a Medicaid certified 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 for services.

8. Immunization Program

As a condition of certification as a FCMH provider, the PIHP must share member immunization status with Local Health Departments and other non-profit HealthCheck providers upon their request without the necessity of member authorization. The Department also requires that 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.

9. 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, and pancreas transplants.

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

10. 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 (effective date of coverage) until an appropriate hospital discharge. The Department is responsible for paying

on a FFS basis all Medicaid covered services for such hospitalized members during hospitalization (Article VIII, E).

Hospitalization in this section is defined as an inpatient stay at a certified 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 for these hospitalizations 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. Disenrollment occurs because there is a voluntary disenrollment from the PIHP as a result of one of the conditions in Article VIII in which case the PIHP's liability shall terminate upon disenrollment being effective.

In these two exceptions, the PIHP's liability shall not exceed the period for which it has received prepayment. 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.

11. 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 a 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 facilities, or if unable to itself provide for such treatment.

E. Covered FCMH Services

The PIHP must provide FCMH services to the extent outlined below, but it is not restricted to only providing Medicaid services. Sometimes the PIHP finds that other treatment methods may be more appropriate thanMedicaid covered services, or result in better outcomes.

None of the provisions of this Contract that are applicable to Medicaid covered services apply to other services that the PIHP may choose to provide, except that abortions, hysterectomies and sterilizations must comply with 42 CFR 441 Subpart E and 42 CFR 441 Subpart F.

The Department will authorize the PIHP to substitute an appropriate alternative service for a covered service if the service meets four criteria: the service must be medically necessary; the service must be health-related; the service must be an appropriate substitute for a covered service; and the service must be cost-effective when compared to the covered service. These alternatives must be reported in the encounter reporting system using codes defined by the Department.

Whether the service provided is a Medicaid covered service or an alternative service, the PIHP or PIHP provider is not allowed to bill the member for the service. Cost sharing is prohibited in the Foster Care Medical Home project.

1. Provision of Contract Services

   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), Wis. Adm. Code DHS 107 and the State Plan Amendment approved on July 10, 2012 as applicable to the particular member and as further clarified in all ForwardHealthOnline Handbook and Contract Interpretation Bulletins, Provider Updates, through the interChange Portals, and as otherwise specified in the Contract except:

   a. Chiropractic Services

   b. Community Recovery Services (CRS).

   c. Community Support Programs (CSP).

   d. Comprehensive Community Services (CCS).

   e. Crisis intervention services.

   f. Directly observed therapy for individuals with tuberculosis.

   g. Medication therapy management.

h. Non-emergency medical transportation services.

i. Prescription and over-the-counter drugs and diabetic supplies dispensed by the pharmacy.

j. Provider-administered drugs and their administration, as discussed in the Provider-Administered Drugs (topic #4382), and Synagis (topic #1951) topics of the Submission section of the Claims chapter and the Administration Procedure Codes for Provider-Administered Drugs topic (topic #6717) of the Codes section of the Covered and Noncovered Services chapter of the ForwardHealth Online Handbook.

k. School-based services.

l. Targeted case management.

2. Key Components of Health Care Service

General Requirements

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.

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

- 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.

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

- 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.

- Required Components:

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

The PIHP is not required to provide an Out-of-Home Care Health Screen for the following scenarios:

- Newborns, children who are detained from an inpatient hospital setting, and children with an out-of-home care placement date prior to January 1, 2014. There are no other allowable categorical exemptions.

- Children who are taken into protective custody at the time of a forensic evaluation. The exam should include the following elements:
  - ✓ Triage score
  - ✓ Necessary medication refills
  - ✓ Recommendations related to needed medical and/or mental health follow up

- Children who are taken into custody subsequent to the completion of a forensic exam, if a child welfare worker confirms the following:

  - ✓ The child welfare worker contacted the Child Protection Center intake staff to review forensic exam results
  - ✓ The Child Protection Center determined upon review of the completed forensic evaluation that an additional Out-of-Home Care Health Screen is not necessary.

The PIHP must reduce verbal requests to writing and make sure the documentation includes, the date of the request, the name of the child welfare worker making the request, and the date of the forensic evaluation.

The PIHP must retain documentation that clearly shows that the child meets one of the criteria outlined above.

b. The assignment of a health care coordinator to each child enrolled in the PIHP;

c. Comprehensive Initial Health Assessment ;
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 both behavioral/mental health screenings as indicated for each child based on age and history, including any prior evaluations.

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

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:

- Comprehensive Initial Health Assessment
- Standardized screening (developmental, mental health)
- Referrals for early intervention, mental health evaluations as indicated
- Subspecialty referrals, including dental
- Ongoing primary care well child exams
- Transition health planning

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:

- Child and Adolescent needs and Strengths (CANS)
- Out-of-Home Care Health Screen or other medical assessment
- Crisis service intervention team
- Any medical, human service, or educational professional working with the child
- 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 (refer to Addendum TBD);

j. Monitoring of the rate and types of psychotropic medication usage among enrollees, stratified by age and number of medications prescribed (refer to Addendum TBD);

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:

i. To the Department and enrollment specialist;
ii. With the PIHP certification application;
iii. Whenever the PIHP adopts the policy during the term of the contract;
iv. Must be consistent with 42 CFR 438.10;
v. Must be provided to potential members before enrollment;
vi. Must be provided to members within ninety (90) calendar days after adopting the policy with respect to a particular service; and
vii. 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.

3. Medical Necessity

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. Decisions to provide or not to provide or authorize medical services shall be based solely on medical necessity and appropriateness as defined in DHS 101.03(96m). Disputes between PIHP and members about medical necessity can be appealed through the PIHP grievance system, and ultimately to the Department for a binding determination; the Department's determinations will be based on whether Medicaid would have covered that service on a FFS basis (except for certain experimental procedures). Alternatively, disputes between the PIHP and members about medical necessity can be appealed directly to the Department.

Specify what constitutes "medically necessary" in a manner that:

a. Is no more restrictive than that used in the Medicaid Program as indicated in state statutes and regulations, the State Plan, and other state policy and procedures; and

b. Addresses the extent to which the PIHP is responsible for covering services related to the following:

1) The prevention, diagnosis, and treatment of health impairments;
2) The ability to achieve age development;
3) The ability to attain, maintain, or regain functional capacity;
4) Coordinating health care services for children with related systems such as child welfare, schools, and public health.

The Department encourages the PIHP, when determining the provision of any services, to consider Pediatric Medical Necessity, defined as: health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the American Academy of Pediatrics, to promote optimal growth and development in a child, and to prevent, detect, diagnose, treat ameliorate or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities. (American Academy of Pediatrics. "Essential Contractual Language for Medical Necessity in Children".(2013, August) *Pediatrics*, 132 (2), 398-401.)

4. Physician and Other Health Services

Services required under Wis. Stats., s. 49.46(2), and Wis. Adm. Code 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.

Provider-administered drugs (as defined by the Department in the maximum allowable fee schedule), are not covered through the nonrisk prepayment rate.

5. 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.

6. 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 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 timeframe as described in the contract. Failure will constitute the PIHP agreement to pay the appealed claim in full.

7. Non-Emergency Medical Transportation

Non-emergency Medical Transportation (NEMT) is coordinated by Department of Health Services' NEMT manager, Medical Transportation Management, Inc. (MTM Inc.). As the NEMT manager, MTM Inc. 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 ambulance, rides in specialized medical vehicles (SMV), or rides in other types of vehicles depending on a member's medical and transportation needs, as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and 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 Non-emergency Medical Transportation webpage at: http://www.dhs.wisconsin.gov/badgercareplus/NEMT/index.htm for more information.

8. 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 107.7, 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. 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, except as required in Subsection c) following.

c. 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.]

d. The PIHP must cover emergency dental care.

e. 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.

f. 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 XI.

g. Requirements to Dental Service Providers

If the PIHP subcontracts with a dental benefits administrator, the dental benefits administrator has the right to appeal to both the PIHP and the 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.

The PIHP must pay providers rendering dental services, at a minimum, the Medicaid fee-for-service rates for dental services.

RESPONSIBILITY FOR PAYMENT OF ORTHODONTIC AND PROSTHODONTIC TREATMENT WHEN THERE IS AN ENROLLMENT STATUS CHANGE DURING THE COURSE OF TREATMENT

	Who pays for completion of orthodontic and prosthodontic treatment* when there is an enrollment status change		
	1st PIHP	**2nd HMO**	**FFS**
Person converts from one status to another: 1. FFS to a PIHP covering dental.		N/A	X
2a. PIHP covering dental to an HMO 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 HMO 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 PIHP or another HMO covering dental and the person's residence remains within 50 miles of the residence when in the first PIHP.	X		
3b. PIHP covering dental to the same PIHP or to HMO 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

* Orthodontic treatment is only covered by Medicaid for children under 21 as a result of a HealthCheck referral (HFS 107.07(3)).

9. 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 emergency, 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 working days of the change.

b. Coverage and 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) calendar 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) 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 PIHP may not deny payment based on the emergency room provider, hospital or fiscal agent not notifying the member's primary care provider or the PIHP of the member's screening and treatment within ten (10) days of the member's presentation for emergency services.

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

6) 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:

a) 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 in 42 CFR 422.113(c).

b) 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:

1) A network physician assumes responsibility for the member's care at the treating hospital or through transfer;
2) The treating physician and PIHP reach agreement; or
3) The member is discharged.

2) The PIHP's financial responsibility for post-stabilization care services that 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, be liable for payment only to the extent that Medicaid pays or would pay FFS providers for services to the Medicaid populations. 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:

- Cases where prior payment arrangements were established;
- Specific subcontract agreements.

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

The PIHP may have a contract or an MOU with hospitals 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 in this contract. In 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.

10. 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 assigned to the member.

b. The member may choose to receive family planning services at any Medicaid certified family planning clinic. Family planning services provided at Medicaid certified 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 including those of a minor shall be kept confidential.

11. Pharmacy Coverage

a) Pharmacy coverage, including provider-administered drugs under Article III, is carved out of the nonrisk prepayment rate for the FCMH Program and will be paid on a fee-for-service basis

b) Pharmacy Services Lock-In Program

The DHS Division of Health Care Access and Accountability (DHCAA) 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, DHCAA 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

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

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

- DHCAA 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.

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

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

- DHCAA 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.

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

- DHCAA 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.

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

2) PIHP Responsibilities

- PIHP 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.

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

- 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 DHCAA or its designated representative.

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

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

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

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

- PIHP must communicate with DHCAA or its designated representative.

- DHCAA 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.

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

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

    - Member convicted within one year of a crime related to restricted medications. Crimes include: forgery, theft, distribution, etc.

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

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

    - 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.

12. School-Based Services (SBS)

School-Based Services (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.

13. 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.

F. 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 enrollee for the service.

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

On the effective date of this contract, the PIHP must be in compliance with Wis. Stats., s.632.89;

a. Be certified according to DHS 105.21, 105.22, 105.23, 105.24, 105.25 and/or 105.255, to provide mental health and/or substance abuse services; or

b. Have contracted with facilities and/or providers certified according to DHS 105.21, 105.22, 105.23, 105.24, 105.25, and/or 105.255, to provide mental health and/or substance abuse services.

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 a certified 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.

Regardless of whether a. or b., above, is chosen, such treatment facilities and/or providers must provide arrangements for covered transitional treatment in addition to other outpatient mental health and/or substance abuse services. Such transitional treatment arrangements may include, but are not limited to Child/Adolescent Day Treatment and Substance Abuse Day Treatment.

In compliance with said provisions: The PIHP must further guarantee that FCMH members have access to all medically necessary outpatient mental health/substance abuse and covered transitional 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. No Limitations on Treatment

No limit may be placed on the number of hours of outpatient treatment that the PIHP must provide or reimburse where it has been determined that treatment for mental illness and/or substance abuse or covered transitional treatment is medically necessary. The PIHP shall not establish any monetary limit or limit on the number of days of inpatient hospital treatment where it has been determined that this treatment is medically necessary. Additional information on covered services is available through the ForwardHealth Provider Updates and online handbooks.

3. Mental Health/Substance Abuse Assessment Requirements

The PIHP must assure that authorization for mental health/substance abuse treatment for its members is governed by the findings of an assessment performed promptly by the PIHP upon request of a client or referral from a primary care provider or physician in the PIHP's network. Such assessments must be conducted by qualified staff in a certified program, who are knowledgeable about trauma-informed care and are experienced in mental health/substance abuse treatment. All denials of service and the selection of particular modalities of service shall be governed by the findings of this assessment, the effectiveness of the therapy for the

condition, 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 rational for withholding or limiting treatment of a member. The PIHP will use Wisconsin Uniform Placement Criteria (WI-UPC), or placement criteria developed by the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in 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 members 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; 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 ensure that all persons employed by or under contract to the PIHP who are required by law to report suspected child abuse and neglect 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 providing assessments under the Children's Code, Wis. Stats., s. 48.295 and is responsible for reimbursing for the provision of medically necessary treatment if unable to itself provide such treatment court-ordered by ajudge. 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 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. Stats., Ch. 343, and Wis. Adm. Code DHS 62. The medial 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 PIHP's receipt of a written request 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 and online handbooks. If medically necessary, coverage limitations can exceed FFS levels.

7. Crisis Intervention Benefit

The PIHP must assign a medical representative to interface with the designees of crisis intervention agencies certified under Wis. Adm. Code DHS 34 that provide services within the PIHP service area. The PIHP must work with the certified Crisis Intervention Agency to coordinate the transition from the crisis intervention care to ongoing Medicaid covered mental health and substance abuse care within the PIHP's network. The PIHP is not responsible for payment of services provided to its members by certified Crisis Intervention Agencies. Those services are to be billed directly to FFS. In addition, the PIHP is not required to pay for services directed by the certified Crisis Intervention Agency outside the PIHP network, unless the PIHP has authorized those services. The PIHP must communicate to its members how to access crisis intervention care.

8. Emergency Detention and Court-Related Mental Health Services

The PIHP is liable for 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.

9. 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.

10. 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.

11. Memorandum of Understanding (MOU) Requirement and Relations with other Human Service Agencies

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.

G. FCMH Health Care Management

1. 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.

A. 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 BMCW 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, 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.

- 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.

- 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.

- 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 BMCW 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 BMCW 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.

B. 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 serves as a clinical specialist who oversees all aspects of the child's health care. The PIHP must ensure that:

a. The HCC has 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.

Other staff, under the supervision of the HCC, may assist with duties related to service coordination such as the scheduling of appointments. There are no specific training and experience requirements for these individuals, but they should be provided with training specific to children in out-of-home care.

b. HCCs are allowed adequate time to be effective case managers.

While this contract does not include specific caseload standards, the PIHP must have strategies in place to monitor workload and to assure that each HCC's caseload is such that

the HCC is 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:

- Workload – the complexity of the cases (refer below to, Guidelines for Determining Levels of Care Management Needs)
- The potential need for face-to-face contacts with the child and others instrumental to meeting needs of the child.
- Management duties which include,
  - Time to gather and ensure all medical history is provided to the primary care provider prior to the 30-day comprehensive health assessment.
  - The need to provide necessary documentation timely to BMCW and child welfare agencies for court proceedings (which are sometimes scheduled with little lead time) or other case-related meetings.
  - Time to adequately document case management activities.

C. 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.

D. The PIHP must establish a process that ensures that the HCC is informed of the results of assessments, evaluations and screenings that would necessitate an update or review of the child's care plan.

E. 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.

F. The PIHP must ensure that children with emotional, behavioral, mental, or substance abuse problems have a 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 those who know the child best and must be distributed to all critical service/support providers in the child'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.

G. The PIHP must have a process for prioritizing the care management needs of each child.

H. 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.

2. Guidelines for Determining Levels of Care Management Needs

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 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.

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

- Level I – Information sharing (short-term technical assistance, information, and/or referral);
- Level II – Significant but not necessarily long-term assistance in planning and coordinating multiple services;
- Level III – 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 BMCW 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, after a change in placement, at reunification, at time of discharge from out-of-home care, or during transition to adolescence or adulthood.

3. Duties of Health Care Coordinators

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.

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

1. Case identification
2. Comprehensive assessment and planning
3. Referral and intervention
4. Monitoring outcomes

The duties of the health care coordinator include the following:

- 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.

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

- Collaborating with a multidisciplinary team of providers to develop, implement, and maintain a single coordinated care plan for each child.

- 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.

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

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

- Holding meetings as needed with the child and the child's parent/legal guardian and out-of-home care provider to monitor and re-evaluate the individualized plan of care.

- Holding meetings as needed 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.

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

- Developing a separate transitional health care plan with the child prior to their disenrollment from the PIHP. The transitional health care plan must indicate the identified permanent placement and peer and natural support systems.

4. Information Gathering (Assessment)

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,

- The need for immediate appointment scheduling and referrals
- The need for immediate medication management
- The need for open and flexible scheduling, including the need to go beyond the PIHP's provider network
- The need for stabilization services for mental/behavioral health concerns

To ensure that the care plan is a comprehensive reflection of the child's needs, the HCC must do the following prior to completing the care plan:

- Obtain information related to the child's medical history and current medications
- To ensure continuity of care, where possible, obtain information regarding current providers
- Review the recommendations from the CANS assessment and any other behavioral/mental health screen for mental health and other behavioral health concerns
- 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
- Obtain input from the child's primary care provider to determine the need for additional referrals, diagnostic or treatment services
- 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 health care needs.

5. Comprehensive Health 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:

A. 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,

- The names of all individuals who are instrumental to the child's care and treatment
- The names of external supports (e.g., school nurse, public health nurse, community-based case managers)
- The enhanced schedule for comprehensive HealthCheck exams
- The tracking and timely follow up on referrals
- Short and long-term treatment goals
- Barriers to care
- An action plan for behavior management (if appropriate)
- An action plan for exacerbation of a chronic condition
- 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
- Patient self-management, anticipatory guidance for caregivers, and home care (if appropriate)
- 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

B. 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.

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

- The child, as appropriate
- The child's out-of-home care provider
- The child's parent/legal guardian
- 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.

D. 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.

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

6. 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.

Ongoing monitoring includes:

- 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.

- 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.

- 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.

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

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

- 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.

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

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

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

H. Provider Appeals

1. The PIHP must inform providers in writing (either electronically or hard copy) of the PIHP's decision to pay or deny the original claim. PIHPs who use the HIPAA 835 transaction set to notify providers of payment

determination must include the below elements in their contract or MOU with providers or in their provider manual, or through written notification for non-contracted providers. Written notification of payment or denial must occur on the date of action when the action is denial of payment and include the following information:

1. A specific explanation of the payment amount or a specific reason for the nonpayment.

2. A statement regarding the provider's rights to appeal to the PIHP.

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

4. An explanation of the process the provider should follow when appealing the PIHP's decision to the PIHP, which includes the following steps:

    a. Include a separate letter or form clearly marked "appeal."

    b. Include the provider's name, date of service, date of billing, date of payment and/or nonpayment, member's name and Badger Care Plus and/or Medicaid SSI ID number.

    c. Include the reason(s) the claim merits reconsideration.

    d. If the provider's complaint is medical (emergency, medical necessity and/or prior authorization), the PIHP must indicate if medical records are required and need to be submitted with the appeal.

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

    f. Send the appeal within 60 days of the initial denial or payment notice.

    g. A statement advising the provider of the provider's right to appeal to the Department if the PIHP fails to respond to the appeal within 45 days or if the provider is not satisfied with the PIHP's response to the request for reconsideration. All BadgerCare Plus and Medicaid SSI providers must appeal first to the PIHP and then to the Department if they disagree with the PIHP's payment or nonpayment of a claim. Appeals to the Department must be submitted in writing within 60 days of the PIHP's final decision or, in the case

of no response, within 60 days from the 45 day timeline allotted the HMO to respond. Providers must use the Department's form when submitting a provider appeal for State review. All elements of the form must be completed and all of the required documents (i.e. copy of the claim, copy of the payment denial remittance, copy of the appeal letter and response, and medical records for appeals regarding medical necessity) must be included with the appeal or it will be returned to the provider.

The form is available at the following website: http://dhs.wisconsin.gov/forms/F1/F12022.doc.

Appeals to the Department must be sent to:

BadgerCare Plus and Medicaid SSI
Managed Care Unit
P.O. Box 6470
Madison, WI 53716-0470
Fax Number: 608-224-6318

The PIHP must include provider appeal procedures in their provider handbooks and incorporate them into subcontracts with providers at the time of the next renewal.

2. The PIHP must accept written appeals from providers submitted within 60 days of the PIHP's initial payment and/or nonpayment notice. The PIHP must respond in writing within 45 days from the date of receipt of the request for reconsideration. If the PIHP fails to respond within 45 days, or if the provider is not satisfied with the PIHP's response, the provider may seek a final determination from the Department.

3. In exceptional cases, the Department may override the PIHP's time limit for the submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making a final decision. PIHPs must return a copy of the Department's Request for Information letter with their response and any additional documentation to assist in the determination of the appeal.

   The Department may send an official Request for Additional Information notice to the provider and PIHP when additional information is needed to make a decision on an appeal; this request may be sent via US mail or email. The Additional Information notice and requested documents can be

returned to the Department at the address listed above via US mail, fax or electronically if sent over a secure network.

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 under certain circumstances where an error has been made or there was a misrepresentation of facts.

4. The PIHP must perform ongoing monitoring of provider appeals, and perform provider outreach and education on trends to prevent future denials/partial payments, thus reducing future provider appeals. The Department will provide the PIHP with data on provider appeals received by the Department and summarize trends in appeals, including data on numbers of appeals that were either overturned or upheld.

I. Provider Network and Access Requirements

The PIHP must provide medical care to its FCMH members that is as accessible to them, in terms of timeliness, amount, duration, and scope, as those services are to non-enrolled Medicaid members within the area served by the PIHP.

1. Use of Medicaid Certified Providers

Except in emergency situations, the PIHP must use only providers who have been certified by the Medicaid program for covered services. The Department reserves the right to withhold from the monthly payments the monies related to services provided by non-certified providers, at the FFS rate for those services, unless the PIHP can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was certified by the program at the time the PIHP reimbursed the provider for service provision. The Wis. Adm. Code, Chapter DHS 105, contains information regarding provider certification requirements. The PIHP must require its health care providers to have a Medicaid Provider Number or National Provider Identifier (NPI).

2. Protocols/Standards to Ensure Access

The PIHP must have written protocols to ensure that members have access to screening, diagnosis and referral, and appropriate treatment for those conditions and services covered under the FCMH Program.

The PIHP's protocols must include methods for identification, outreach to and screening/assessment of members with special health care needs,

including mental health and substance abuse. The PIHP must identify and provide care coordination to those children with no formally diagnosed medical condition who are nevertheless "at increased risk" for chronic physical, developmental, behavioral or emotional conditions. The health care professionals involved in this process must be trained in trauma-informed care and must have expertise in the care of children with chronic conditions.

3. Written Standards for Accessibility of Care

The PIHP must have written standards for the accessibility of care and services. These standards must be communicated to providers and monitored by the PIHP. The standards must include the following:

- Waiting times for care at facilities;
- Waiting times for appointments;
- Statement that providers' hours of operation do not discriminate against FCMH members;
- Whether or not the provider speaks the member's language.

The PIHP must take corrective action if its standards are not met.

4. Monitoring Compliance

The PIHP must develop policies and procedures regarding wait times for appointments and care.

The PIHP shall conduct surveys and site visits to monitor compliance with standards for waiting times for care and waiting time for appointments and shall make this available to DHS upon request. If issues are identified, either by the PIHP or by the Department, the PIHP must take corrective action so that providers meet the PIHP's standards and improve access for members. The Department will investigate complaints received of the PIHP that exceed standards for waiting times for care and waiting time for appointments.

5. Access to Selected Providers and/or Covered Services

a. Dental Providers

The PIHP must have a dental provider within a 25-mile radius of each zip code in the service area. There must be a sufficient number of dentists to ensure that each child receives a dental assessment within 3 months of FCMH enrollment or a follow-up

visit if an assessment was conducted within six months prior to enrollment in the FCMH.

b. Mental Health or Substance Abuse Providers

The PIHP must have a sufficient number of child psychiatrists in the network who are board certified or board eligible to see patients as needed to conduct face-to-face evaluations and for consultation about specific children or their families with primary care and mental health/substance abuse treatment providers.

The PIHP network must include a sufficient number of mental health and substance abuse professionals with experience working with children with emotional, behavioral and mental and substance abuse disorders. These providers must be located throughout the service areas.

The PIHP must ensure that all providers who serve children in the FCMH program receive in-service training on trauma-informed care. The PIHP must document that the in-service training has occurred with sample curricula and attendance logs or certificates for attendees.

c. High Risk Prenatal Care Services

The PIHP must provide medically necessary high risk prenatal care within two weeks of the member's request for an appointment, or within three weeks if the request is for a specific PIHP provider, who is accepting new patients.

d. PIHP Referrals to Out-of-Network Providers for Services

The PIHP must provide adequate and timely coverage of services provided out of network, when the required medical service is not available within the PIHP network. The PIHP must coordinate with out-of -network providers with respect to payment and ensure that the cost to the member is no greater than it would be if the services were furnished within the network. (42 CFR. §. 438.206(b)(v)(5)). S.S.A. 1932(b)(2)(D)].

Emergency services provided out of network must not have a cost to the member greater than if the emergency services were provided in-network. The PIHP must reimburse for emergency services provided to members in Canada or Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. Non-emergency services

in Canada or Mexico may be covered by the PIHP per the PIHP's prior authorization policies, provided the financial institution receiving payment is located within the United States.

e. Primary Care Providers

Primary Care Providers are defined to include, but are not limited to physicians and physician clinics with specialties in pediatrics, family practice, obstetrics and gynecology, FQHCs, RHCs, nurse practitioners, physician assistants and tribal health centers.

The PIHP may define other types of providers as primary care providers. If they do so, the PIHP must define these other types of primary care providers and justify their inclusion as primary care providers during the pre-contract review phase of the PIHP certification process.

The PIHP must have a sufficient number of primary care providers in the network with pediatric board certification or eligibility and experience working with children with special health care needs so that each child is served. In Milwaukee County, there must be a sufficient number of primary care providers in all zip codes in the county. In other counties, primary care providers must be within a 20 mile radius of each zip code in the service area to serve children in those zip codes.

f. Second Medical Opinion

The PIHP must upon member request, provide members the opportunity to have a second opinion from a qualified network provider subject to referral procedures approved by the Department. If an appropriately qualified provider is not available within the network, the PIHP must arrange for a second opinion outside the network at no charge to the member.

g. Women's Health Specialist

In addition to a primary care provider, a female member may have a women's health specialist. The PIHP must provide female enrollees with direct access to a woman's health specialist within the network for covered women's routine and preventive health care services.

h. Urgent Care Centers or Walk-in Clinics

The PIHP must have policies and procedures to provide members access to urgent care centers or walk-in clinics which will reduce emergency department utilization by providing ambulatory care for members with a sudden illness or an injury that needs medical care right away. The PIHP must include in its network urgent care centers, walk-in clinics, or other medical facilities that are available to members for after-hours care from 5pm to 7pm during weekdays and open to members during weekends. A hospital emergency department may not serve to meet this requirement.

All urgent care centers, walk-in clinics, and physician offices open extended hours must accept and advertise that walk-in appointments are accepted. The PIHP is encouraged to contract with urgent care providers that meet these criteria:

- X-ray on site
- Phlebotomy services on site
- 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
    - Perform minor procedures (ex. sutures, splinting) on site
- The following equipment and staff trained in its use:
    - Automated external defibrillator (AED)
    - Oxygen, ambu-bag/oral airway
- At least two exam rooms.

The PIHP must have a process to communicate urgent care access information to members via the Provider Directory (either mailed or online) and submit the urgent care and walk-in clinics list to the Department in the provider and facility files.

1. The centers or clinics must be within a 20 mile distance from any member residing in the PIHP service area, unless there is no such clinic within the specified distance. In that case, the travel distance shall be no more than for a non-enrolled member. All urgent care centers and walk-in clinics do not have to be open for extended hours or weekends, but there shall be at least one such clinic that is open within 20 miles from each member for the specified amount of time each day.

i. Hospitals

The PIHP must include a sufficient number of hospitals in its network so that the following requirements are met:

1. The PIHP must include a non-specialized hospital within a 20-mile distance from any member residing in the PIHP service area. If there is no hospital within the specified distance, the travel distance shall be no more than for a non-enrolled member.

   As it applies to this requirement, the Department defines a hospital specializing in Pediatrics as a *non-specialized* hospital. In all other instances, the Department defines a non-specialized hospital as one which is not exclusive to a single category of service or specialty including, but not limited to, behavioral health, cardiology or orthopedics.

j. Access to Tribal Health Providers

For Native American members enrolled in the PIHP, the PIHP must ensure access to an Indian Health Care Provider or Service (Indian Tribe, Tribal Organization, or Urban Indian Organization, or I/T/U), when available. If such a provider agrees to serve in the network as a PCP and has capacity, the member must be allowed to select that provider as her or his PCP. If no such provider is contracted, the PIHP must allow the member to see the provider out of network. The Department encourages PIHPs to contract with any Indian Health Care Providers or Services within the PIHP's service area.

The PIHP must pay all Indian Health Care Providers or I/T/Us, whether participating in the network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Native American members.

Native American members can be identified through any of the following:

- ForwardHealth medical status code;
- Letter from Indian Health Services identifying the individual as a tribal member;
- Tribal enrollment/membership card;
- Written verification or a document issued by the Tribe indicating tribal affiliation;
- Certificate of degree of Indian blood issued by the Bureau of Indian Affairs;

- Tribal consensus document; or
- Medical record card or similar documentation that is issued by an Indian health care provider that specifies an individual as an Indian.

6. Network Adequacy Requirements

The PIHP must ensure that its delivery network is sufficient to provide adequate access to all services covered under this contract. In establishing the network, the PIHP must consider:

a. The anticipated FCMH enrollment;

b. The expected utilization of services, considering characteristics and health care needs of children in out-of-home placement enrolled in the FCMH;

c. The number and types of providers (in terms of training experience and specialization) required to furnish the contracted services;

c. The number of network providers not accepting new patients;

d. The geographic location of providers and enrollees, distance, travel time, normal means of transportation used by members and whether provider locations are accessible to members with disabilities;

e. The experience of providers in caring for children in out-of-home placement in order to assure access to timely and adequate mental health and substance abuse services performed by qualified persons with experience treating children in out-of-home care;

f. Its ability to provide trauma-informed care in one or more treatment modalities as specified in "Creating Trauma-Informed and Developmentally Appropriate Systems of Care in Child Abuse and Neglect Prevention: Guiding Principles of Practice" prepared by the Wisconsin Children's Trust Fund;

h. The requirement that it have a written policy for contracting on an ad hoc basis with non-network providers, including a process for assuring that the providers are Medicaid-certified and clear procedures for billing and payment.

The PIHP must provide documentation and assurance of the above network adequacy criteria as required by the Department in the pre-

contract certification process or upon request of the Department. In addition, the PIHP must update the documentation and assurance to the Department with respect to network adequacy whenever there has been a significant change, as defined by the Department, in the PIHP's operations that would affect adequate capacity and services, including changes in PIHP benefits, geographic service areas, provider network, payments, or enrollment of a new population in the PIHP (42 CFR, §.438.207(c)(2)(i-ii)).

The PIHP must notify the Department of any geographical service area reductions 120 days before the intended decertification date unless DHS agrees to a shorter time period based on extraordinary circumstances beyond the control of the PIHP. The PIHP must submit a member communication/transition plan for all service area reductions.

7. Use of Non-Medicaid Providers

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

8. Online Provider Directory

The PIHP must post a provider directory specific to the FCMH program on their website for members, network providers, and the Department to access. The file must include, the following information:

- Provider full name and phone number;
- Clinic Address;
- Specialty;
- Languages spoken; and
- If they are accepting new patients.

J. Responsibilities to Members

The PIHP must employ a FCMH Member Advocate during the entire contract term. The advocate must work with both members and providers to facilitate the provision of FCMH benefits to members, and the advocate is responsible for making recommendations to the PIHP 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 PIHP 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, advocacy organizations, and members.

    b. Monitor formal and informal grievances for purposes of identification of trends or specific problem areas of access and care delivery. The monitoring function includes ongoing participation on the PIHP grievance committee.

    c. Recommend policy and procedural changes to PIHP management including changes 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.

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

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

    f. Work with the Department's staff person assigned to the PIHP on issues of access to medical care and quality of medical care. This includes working with the Enrollment Specialist and Ombudsmen on issues of access to medical care, quality of medical care, and enrollment/disenrollment.

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

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

    i. 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. Participate in the

development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

j. Review and approve all PIHP informing materials to be distributed to member to assess clarity and accuracy.

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

l. 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.

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 PIHP must give the Advocate the authority to perform the functions and duties listed in Section 1, a-l, 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, 1)-12) 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 workplan, with the timelines and activities specified, and must maintain and modify it as necessary, throughout the contract term.

3. 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:

a. Provide written information at the time of FCMH enrollment to all adults receiving medical care through the PIHP regarding:

1) 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

2) The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements; and

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

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

c. 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.

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

e. Provide education for staff and the community on issues concerning 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.

4. Primary Care Provider Assignment

The PIHP must have a process in place to assure each child is assigned a Medicaid certified primary care provider (PCP) who is board eligible or board certified in general or subspecialty pediatrics or family practice or who has pediatric nurse practitioner status. The process shall include a defined method to notify the member of such an assignment. The PIHP may choose to allow members an initial choice of primary care provider assignment.

a. HMO primary care provider assignment strategy

The strategy the PIHP uses to assign members to a primary care provider must take into account the health care needs of the member.

The PIHP must ensure members are assigned a primary care provider 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 assignment strategy, the PIHP must include the following:

i. A process for assigning all members to an appropriate primary care provider 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.

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

iii. DHS encourages the PIHP to evaluate the effectiveness of their primary care provider assignment strategy to ensure quality of care.

b. Changing and lock-in PCP assignments

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 being defined as lack of access to quality, culturally appropriate, health care. Such just cause will be handled as a formal grievance.

c. Data sharing with PCP

The PIHP must provide information on members to their assigned primary care provider on a monthly 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.

5. Choice of Health Care Professional

The PIHP must offer each member covered under this Contract the opportunity to choose a primary health care professional affiliated with the PIHP, to the extent possible and appropriate. If the PIHP assigns members to primary care providers, then the PIHP must notify enrollees of the assignment. The PIHP must permit FCMH members to change primary providers at least twice in any year, and to change primary providers more often than that for just cause, just cause being defined as lack of access to quality, culturally appropriate, health care. Such just cause will be handled as a formal grievance. If the PIHP has reason to lock in an enrollee to one primary provider in cases of difficultcare coordination, the PIHP must submit a written request in advance of such lock-in to the Bureau of Benefits Management 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.

6. Coordination and Continuation of Care

Have a system in place to ensure well-managed patient care, including at a minimum:

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

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

c. 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.

d. 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.

e. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and/or 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.

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

g. 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.

h. The PIHP must ensure that the care of new members is not disrupted or interrupted. To ensure continuity of care the PIHP must authorize coverage of services with the member's current providers, including out-of-network providers, for the first 90 days of enrollment. After 90 days, the PIHP will make case by case

determinations for ongoing continuity of care needs on a member by member basis. Rates of payment for out-of-network services will be determined between the PIHP and the provider. Out-of-network providers, with the exception of emergency services providers, must be Medicaid-enrolled.

7. Cultural Competency

The PIHP must address the special health needs of members who are low income or members of specific population groups needing specific culturally competent services. The PIHP must incorporate in its policies, administration and service, practices that:

a. Recognize its members' beliefs;
b. Address cultural differences in a competent manner; and
c. Foster in its staff and providers behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds.

The PIHP must have specific policy statements on these topics and communicate them to subcontractors as well as provide reports on its effectiveness 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 providers based on the provider's ability to deliver services in a culturally competent manner. Members may submit grievances to the PIHP and/or the Department regarding to their inability to obtain culturally appropriate care, and the Department may, pursuant to such a grievance, permit an member to disenroll from that PIHP and enroll in another PIHP if one is available, or if another PIHP is not available, receive health care on a FFS basis.

8. Member Handbook, Education and Outreach for Newly Enrolled Members

a. Within 10 days of final enrollment notification to the PIHP, annually thereafter and whenever the enrollee, guardian or authorized representatives request, the PIHP must mail to each member or member's out-of-home care provider and legal guardian or parent an enrollee handbook which is at the sixth grade reading comprehension level and which at a minimum will include information about:

1) The telephone number that can be used for assistance in obtaining emergency care or prior authorization for urgent care;

2) Contract services offered by the PIHP;

3) Location of facilities;

4) Hours of service;

5) Informal and formal grievance procedures, including notification of the member's right to a fair hearing;

6) Grievance appeal procedures;

7) HealthCheck;

8) Family planning policies;

9) Policies on the use of emergency and urgent care facilities;

10) Providers and whether the provider is accepting new members including information regarding languages spoken by the provider;

11) Contact information for the 24/7 crisis intervention agencies certified under Wis.Adm. Code DHS 34 that provide services within the PIHP service area.

12) Policies on member's right to disenroll from the PIHP at any time for any reason.

The PIHP must notify all members annually that the handbook is available online and that a hardcopy can be mailed upon request. With Department approval, the PIHP may send member handbooks, provider directories, newsletters, and other new member information (which does not contain PHI) electronically to members that provide an e-mail address to the PIHP, provided the PIHP meets the timeframes above regarding distribution of member handbooks. PIHPs my also choose to send the annual materials electronically to members that have provided an e-mail address. PIHPs must document these plans in the Member Outreach and Communication Plan submitted to the Department for approval.

b. The PIHP must provide periodic updates to the handbook and explain changes to the information listed above, as needed. Such changes must be approved by the Department prior to printing.

c. When the PIHP reprints their member handbooks, they must include all of the changes to the standard language as specified in this Contract.

d. Member handbooks (or other member information approved by the Department that explains FCMH services and how to use the PIHP) must be made available upon request within a reasonable timeframe in at least: Spanish, Russian and Hmong if the PIHP has enrollees who are conversant only in those languages. The handbook must tell members or member representatives how to obtain a copy of the handbook in those languages. The PIHP may use the translated standard handbook language as appropriate to its service area. However, the PIHP must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The PIHP must arrange for translation into any other dialects appropriate for its enrollees, and it must arrange for the member handbook to be provided in Braille, larger fonts or be orally translated for its visually limited members.

e. The PIHP may create member handbook language that is simpler than the standard language, but this language must be approved by the Department. The PIHP must also independently arrange for the translation of any non-standard language.

f. The PIHP must submit their member handbook for review and approval within 60 days of signing the contract for 2014-2015.

The PIHP shall submit their member handbook for review and approval during the readiness review. The PIHP must ensure that the member handbook is available for distribution to out-of-home care provider during implementation of the FCMH Program.

g. Standard language on several subjects, including HealthCheck, family planning, grievance and appeal rights, conversion rights, and emergency and urgent care, must appear in all handbooks. Any exceptions to the standard language must be approved in advance by the Department, and will be approved only for exceptional reasons. If the standard language changes during the course of the contract period, due to changes in federal or state laws, rules or regulations, the PIHP must insert the new language

into the member handbooks as of the effective date of any such change.

h. In addition to the above requirements for the member handbook, the PIHP must perform other education and outreach activities for newly enrolled members. The PIHP must submit to the Department for prior written approval an education and outreach plan targeted towards newly enrolled members. The outreach plan will be examined by the Department during pre-contract review. Newly enrolled members are listed as "ADD-New" on the enrollment reports. The plan must identify at least two educational/outreach activities the PIHP will undertake to tell new members and the caregivers how to access services within the PIHP network. The plan must include the frequency (i.e., weekly, monthly, etc.) of the activities, the person within the PIHP responsible for the activities, and how the activities will be documented and evaluated for effectiveness.

9. 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 program must include:

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

b. Information on how to obtain these services (locations, hours, telephones, etc.).

c. Health-related educational 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.

d. Information on recommended check ups 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.

e. 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 Medicaid.)

f. 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.

g. 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.

h. 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 a list of the local WIC agencies can be found on the WIC website at http://www.dhs.wi.gov/wic/.

10. HealthCheck Services

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.

a. 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:

- Every month for the first six months of age;
- Every 3 months from 6 months to 2 years of age;
- 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.

b. 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.

d. 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.

11. Interpreter Services

The PIHP must provide interpreter and sign language services free of charge for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education and/or any other component of this contract. The PIHP must:

a. Offer an interpreter, including a sign language interpreter, in all crucial situations requiring language assistance as soon as it is determined that the member is of limited English proficiency.

b. Provide 24-hour a day, seven day a week access to interpreter and sign language services in languages spoken by those individuals eligible to receive the services provided by the PIHP or its providers.

c. Provide an interpreter in time to assist adequately with all necessary care, including urgent and emergency care, when a

member or provider requests interpreter services in a specific situation where care is needed. The PIHP must clearly document all such actions and results. This documentation must be available to the Department upon request.

d. Use professional interpreters, as needed, where technical, medical or treatment information or other matters, where impartiality is critical, are to be discussed or where use of a family member or friend, as interpreter is otherwise inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical.

e. Maintain a current list of "On Call" interpreters who can provide interpreter services. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.

f. Designate a staff person responsible for the administration of interpreter/translation services.

g. Receive Department approval of written policies and procedures for the provision of interpreter services.

As part of the certification application, the PIHP must submit the policies and procedures for interpreters, a list of interpreters the PIHP uses, and the language spoken by each interpreter. The PIHP must also submit, as part of certification, its policy on provision of auxiliary aids to hearing-impaired members. The policy must include a description of the PIHP's process for assessing the preferred method of communication of each hearing-impaired member. The PIHP must offer each hearing-impaired member the type of auxiliary aid(s) **s**/he prefers in order to access program services and benefits. Once the hearing-impaired member identifies the type of auxiliary aid(s) s/he prefers, a less effective form of communication may not be used. For example, a person who can most effectively communicate in sign language may not be required to communicate using hand written notes.

K. 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(3m). 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.

The PIHP and its providers and subcontractors must not bill a FCMH member for medically necessary covered services or for co-payments during the member's period of PIHP enrollment in the FCMH Program.

L. Marketing Plans and Informing Materials

1. Approval of Member Communication and Outreach Plans

   The PIHP is required to submit a member communication plan and an outreach plan to the Department. The member communication plan and outreach plan must describe the PIHP's timeline and process for distributing outreach and member communication materials, including materials posted to the PIHP's website or distributed electronically. The PIHP must also specify the format of its member communication and outreach materials (mailings, radio, TV, billboards, etc.) and its target population or intended audience. All member communications and outreach plans must be submitted to the Department for prior approval. The PIHP shall submit an initial description of its member communication plan and outreach plan it or its subcontractors plan to distribute to the Department for review on the second Friday of January of each calendar year. The Department will review/approve the plans within 30 days. The PIHP may make changes to its member communication and outreach plan throughout the year. Any significant changes to previously approved member communication or outreach plans must be submitted to the Department for review.

2. Review of Member Communication and Outreach Materials

   The Department will review all member communication and outreach materials that are part of the PIHP's plan as follows:

   a. The Department will review and either approve, approve with modifications, or disapprove all member communication materials and outreach materials within ten business days, except Member Handbooks, which will be reviewed within 30 days. If the PIHP does not receive a response from the Department within the prescribed time frame, the PIHP should contact the Managed Care

Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within two business days of this contact.

b. Time-sensitive member communication materials and outreach materials must be clearly marked time-sensitive by the PIHP and will be approved, approved with modifications, or disapproved by the Department within three business days. The Department reserves the right to determine whether the materials are indeed time-sensitive. If the PIHP does not receive a response from the Department within three business days, the PIHP must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within one business day of the contact.

c. The Department will not approve any materials it deems confusing, fraudulent, or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the FCMH program.

d. The PIHP must correct any problems and errors the Department identifies. The PIHP agrees to comply with Ins. 6.07 and 3.27, Wis. Adm. Code, and practices consistent with the Balanced Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C. 1396v(d)(2)].

Educational materials prepared by the PIHP or by their contracted providers and sent to the PIHP's entire membership (i.e., BadgerCare Plus and commercial members) do not require the Department's approval, unless there is specific mention of BadgerCare Plus, Medicaid SSI and/or the FCMH program. Educational material prepared by outside entities (i.e., the American Cancer Society, the Diabetic Association, etc.) does not require the Department's approval.

3. Allowable Member Communication and Outreach Practices

The PIHP is required to distribute member communication materials to FCMH members. Member communication requirements are detailed in Article III, Section J, "Responsibilities to Members."

Member communication materials should be designed to provide the members with clear and concise information about the PIHP's program, the PIHP's network, and FCMH program. All member communication materials must be written at a sixth-grade comprehension level. Member communication materials must be made available in at least Spanish, Russian, and Hmong if the PIHP has members that are conversant only in

those languages. The PIHP must also arrange for translation into any other dialects appropriate for its members.

The PIHP shall also be allowed to perform the following outreach and member communication activities and distribute the following materials:

a. Make available brochures and display posters at provider offices and clinics that inform patients that the clinic or provider is part of the plan's provider network, provided that all plans in which the provider participates have an equal opportunity to be represented. Examples include posters or brochures that read "BadgerCare Plus and/or Foster Care Medical Home Participating Health Plan."

b. Inform the public with a general health message which may utilize the FCMH program's logo or the PIHP's logo.

c. Attend activities that benefit the entire community, such as health fairs or other health education and promotion activities.

d. Offer nominal gifts (less than $5 value) for potential members at health fairs.

e. Offer gifts (valued $5 - $25) to current members as incentives for a quality improvement strategy. Gifts given in a raffle may be valued up to $100 (only a few members in the PIHP may receive gifts of this value). The Department will review any other incentives the PIHP may want to implement on an individual basis.

f. Make telephone calls, mailings, and home visits only to members currenly enrolled in the PIHP, for the sole purpose of educating them about services offered by or available through the PIHP.

g. Other activities that are approved by the Department.

Should the PIHP distribute outreach materials, it shall distribute the materials to its entire service area.

4. Prohibited Activities

PIHPs are prohibited from marketing to potential FCMH members who are not the PIHP's members. The Department defines "marketing" as any unsolicited contact by the PIHP, its employees, affiliated providers, subcontractors, or agents with a potential member, other than as permitted in 3., above, for the purpose of persuading such persons to enroll with the health plan or to disenroll from another health plan. PIHPs are prohibited from:

a. Direct and indirect cold calls, either door-to-door or via telephone with potential members.

b. Practices that seek to influence enrollment in conjunction with the sale of any other insurance product.

c. Offer of material or financial gain to potential members as an inducement to enroll.

d. Distributing materials which contain the assertion that the client must enroll in the PIHP in order to obtain benefits or avoid losing benefits.

e. Practices that are discriminatory.

f. Activities that could mislead, confuse, or defraud members or potential members or otherwise misrepresent the PIHP, its marketing representatives, the Department or CMS.

g. Distributing materials that contain false information.

h. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

5. PIHP Agreement to Abide by Marketing/Informing Criteria

The PIHP agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. If the PIHP fails to abide by these requirements, it may be subject to sanctions. In determining any sanctions, the Department will take into consideration any past unfair member communication or marketing practices, the nature of the current problem and the specific implications on the health and wellbeing of the members. In the event that the PIHP's affiliated provider fails to abide by these requirements, the Department will evaluate if it was reasonable for the PIHP to have had knowledge of the member communication or marketing issue and the PIHP's ability to adequately monitor future member communication or marketing activities of the subcontractor(s).

Any PIHP that engages in marketing or that distributes materials without prior approval by the DHS may be subject to:

a. Immediate retraction of materials;
b. Sanctions detailed in Article X.

M. Reproduction/Distribution of Materials

Reproduce and distribute at the PIHP's expense, according to a reasonable Department timetable, information or documents sent to the PIHP from the Department that contain information the PIHP-affiliated providers must have in order to fully implement this Contract.

N. PIHP ID Cards

The PIHP may issue its own PIHP ID cards. The PIHP may not deny services to a member solely for failure to present a PIHP issued ID card. The ForwardHealth ID card will always identify PIHP enrollment, even where a PIHP issues its own ID cards.

O. 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 or health status 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.

P. Selective Reporting Requirements

1. Communicable Disease Reporting

   As required by Wis. Stats. 252.05, 252.15(5)(a)6 and 252.17(7)(9b), physicians, physician assistants, podiatrists, nurses, nurse midwives, physical therapists, and dietitians affiliated with the 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.

2. Fraud and Abuse Investigations

The PIHP agrees to cooperate with the Affordable Care Act (ACA) suspension of payment requirements, and with the Department on fraud and abuse investigations. In addition, the PIHP agrees to report allegations of fraud and abuse (both provider and member) to the Department within 15 days of the suspected fraud or abuse coming to the attention of the PIHP. Failure on the part of the PIHP to cooperate or report fraud and/or abuse may result in any applicable sanctions under Article X.

The PIHP must have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse. The PIHP arrangements or procedures must include the following:

- Written policies, procedures, and standards of conduct that articulates the organization's commitment to comply with all applicable Federal and State standards.

- The designation of a compliance officer and a compliance committee that is accountable to senior management.

- Effective lines of communication between the compliance officer and the organization's employees.

- Enforcement of standards through well-publicized disciplinary guidelines.

- Provision for internal monitoring and auditing.

- Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the PIHP's contract.

- Provision for use of 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:

    - A – ACA suspension of payment is currently active. The HMO must suspend payment based on the effective date for the start of the investigation.
    - C – The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.

- 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.

The PIHP must report the following to the State:

- Number of complaints of fraud and abuse made to the State that warrant preliminary investigation;

- For each which warrants investigation, supply the

  - Name
  - ID number
  - Source of complaint
  - Type of provider
  - Nature of complaint
  - Approximate dollars involved
  - Legal and administrative disposition of the case

3. 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. The PIHP contract must provide for compliance with the requirements set forth in 42 CFR s.422.208 and 42 CFR s.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 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 member 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 is required if the physician incentive plan 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.

Q. Abortions, Hysterectomies and Sterilization Requirements

The PIHP shall comply with the following state and federal compliance requirements for the services listed below, aggregating all service areas if the PIHP has more than one service area:

1. Abortions must comply with the requirements of Wis. Stats., Ch. 20.927, 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 abide by Wis. Stats., s. 609.30

R. Participation in Department Health IT Workgroup

The PIHP must participate in a Health IT Workgroup established by the Department to coordinate activities and develop cohesive systems strategies

among the Department and the PIHP. The Health IT Workgroup will meet on a designated schedule as agreed to by the Department and the PIHP.

ARTICLE IV

IV. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT (QAPI)

The FCMH QAPI program must conform to the requirements of 42 CFR, Part 438, Medicaid Managed Care Requirements, Subpart D, QAPI. The program must also comply with 42 CFR 434.34 which states that the PIHP must have a QAPI system that:

- Is consistent with the utilization control requirement of 42 CFR 456.
- Provides for review by appropriate health professionals of the process followed in providing health services.
- Provides for systematic data collection of performance and patient results.
- Provides for interpretation of this data to the practitioners.
- Provides for making needed changes.

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/complexcare 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 under utilization.

1. The PIHP must evaluate the overall effectiveness of its FCMH 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 have documentation of all aspects of the QAPI program available for Department review upon request. The Department may perform off-site and on-site QAPI reviews to ensure that the PIHP is in compliance with contract requirements. The review may include: on-site visits; staff and member interviews; medical record reviews; review of all QAPI procedures, reports, committee activities, including credentialing and recredentialing activities, corrective actions and follow-up plans; peer review process; review of the results of the member satisfaction surveys, and 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 of the Department's member satisfaction surveys and HEDIS and other performance measures.

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: approval of the overall QAPI program and an annual QAPI plan; designating an accountable entity or entities within the organization to provide oversight of QAPI; review of written reports from the designated entity on a periodic basis which include a description of QAPI activities, progress on objectives, and improvements made; formal review on an annual basis of a written report on the QAPI program; and 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 persons with expertise in the care of children with chronic conditions who are knowledgeable and familiar with the needs of children in out-of-home placement. Representation must include medical disciplines, such as pediatricians or nurse practitioners, as well as mental health professionals, out-of-home care and birth parents, child welfare social workers, administrative staff of the PIHP, and other persons who work with children in out-of-home placement in counties in the PIHP's service area.

The committee must include persons not employed by the PIHP as well as the PIHP's staff.

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; 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, DCFS, BMCW, county child welfare agencies in the PIHP's service area, and their designees, shall develop performance indicators that meet the following objectives:

    a. Integrated and Comprehensive Health Service Delivery. 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 a out-of-home care health screen within 2 business daysof entering out-of-home care (i.e. a child removed from the home at 4:00pm on Wednesday will receive a 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 carerecommended 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 to 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 health system must demonstrate the capacity for tracking and reporting on:

i. Uniform and complete encounter data for all covered services as specified by the state, including case planning and care coordination information
ii. Health care data and outcomes at both the individual child and aggregate systems levels.
iii. Specific performance measurement data using standard metrics/performance indicators required by the state.
iv. Priority and non-clinical areas relevant to children in out-of-home care as specified by the state for quality improvement
v. 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.

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 improvement 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 Improvement Measures must be mutually agreed upon by the parties. The Department will give 90 days 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. The Department will inform the PIHP of its performance on each measure, whether the PIHP's performance satisfied the goal requirements set by the Department, and whether a performance improvement initiative by the PIHP is required. The PIHP will have 60 business days to review and respond to the Department's performance report. When a performance improvement initiative is required due to sub-goal performance on the measure, the PIHP may request recalculation of the performance level based on new or additional data the PIHP may supply, or if the PIHP can demonstrate material error in the calculation of the performance level. The Department will provide a tentative schedule of measure calculation dates to the PIHP within 90 days of the beginning of each calendar year in the contract period.

6. 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.

7. 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.

8. 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.

9. The PIHP must have the capacity and informatics to support and implement multi-directional communication and quality reporting at the provider, plan, and member level.

10. The PIHP must incorporate a health care management system at the medical home practice level designed to facilitate effective care coordination and transitional care across multiple disciplines and settings. The care management system must demonstrate the capacity and flexibility to support the integration of physical, behavioral/mental health, dental, and developmental services (e.g., Birth to Three, CLTS Waivers, CCR, etc.) for each child into an individualized coordinated health record and care plan that is integrated into the child welfare service plan for the child and family.

11. The PIHP must make documentation available to the Department upon request regarding quality improvement and assessment studies on plan performance, which relates to the FCMH population.

12. The PIHP must develop or adopt practice guidelines and disseminate them to providers and/or to members upon request. The guidelines must be based on valid and reliable medical evidence or consensus of health professionals; consider the needs of its FCMH members; developed or adopted in consultation with the contracting health professionals, and reviewed and updated periodically (42 CFR s. 438.236).

13. Decisions with respect to utilization management, member education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the guidelines. Application of the guidelines must be based on the individual clinical situation.

C. Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing)

1. The PIHP must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the FCMH members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under Medicaid and Medicaid certification. The PIHP written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

The PIHP may not employ or contract with providers 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 FCMH program's specific professional requirements.

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 the PIHP's contracted providers must actively participate 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 provide 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 be an appeals process available to the provider that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC s. 11101 et. Seq.).

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. Institutional Provider Selection: 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 provider holds any accreditation s/he claims, or that the provider meets standards established by the PIHP.
    c. The PIHP may not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Act.

10. Exceptions to credentialing and recredentialing requirements.

    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. Medical Records

1. The PIHP must have policies and procedures for participating provider medical 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. These policies must address patient confidentiality, 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 record 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 are 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, HFS 104.01(3), the Department requires Medicaid-certified providers to release relevant records to the PIHP to assist in compliance with this section. A 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. Medical records must be readily available for PIHP-wide QAPI and UM activities and provide adequate medical and other clinical data required for QAPI, UM and Department use.

   For medical 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 members are treated by more than one provider. This may include transfer to BMCW or county child

welfare agencies in the service area, subject to the receipt of a signed authorization form as specified above.

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.

E. Utilization Management (UM)

1. The PIHP must have documented policies and procedures for all UM activities that involve determining medical necessity, and the approval or denial of medical 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 result in the under-utilization of services. Criteria used to determine medical necessity and appropriateness must be communicated to providers. The criteria for determining medical necessity may not be more stringent thanWis. Adm. Code DHS 101.03 (96m). Documentation of denial of services must be available to the Department upon request.

2. If the PIHP delegates any part of the UM program to a third party, the delegation must meet the requirements of this contract.

3. The PIHP must document review and approval of qualification criteria of staff and clinical protocols or guidelines used in their telephone triage/ nurse line system. The PIHP must also evaluate this system's performance annually in terms of clinical appropriateness.

4. The PIHP's policies must specify timeframes for responding to requests for initial and continued service determinations, 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 timeframes 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; and
2) The member's right to file a grievance or request a state fair hearing.

b. Authorization decisions must be made within the following timeframes and in all cases as expeditiously as the member's condition requires:

1) Within 14 calendar days of the receipt of the request; or
2) Within three business days if the physician indicates or the PIHP determines that following the ordinary timeframe could jeopardize the member's health or ability to regain maximum function.

One extension of up to 14 calendar days may be allowed if the member requests it or if the PIHP justifies the need for more information.

On the date that the timeframes expire, the PIHP gives notice that service authorization decisions are not reached. Untimely service authorizations constitute a denial and are thus adverse actions.

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.

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.

F. External Quality Review Contractor

1. The PIHP must assist the Department and the external quality review organization (EQRO) under contract with the Department in completing all PIHP reviews in accordance with protocols found as part of the Balanced Budget Act of 1997 (BBA). These protocols guide the external, independent review of the quality outcomes and timeliness of, and access to, services provided by the PIHP.

2. The PIHP must assist the Department and the EQRO under contract with the Department in identification of provider and member information required to carry out annual, external independent reviews of the quality outcomes, and timeliness of on-site or off-site medical chart reviews. Work with the EQRO to provide the necessary parts of the member's medical records in a mutually agreeable format in order to evaluate access, timliness and quality of care according to federal and state standards criteria. This includes arranging orientation meetings for physician office staff concerning medical chart review, and encouraging attendance at these meetings by PIHP and physician office staff as necessary. The provider of service may elect to have charts reviewed on-site or off-site. The PIHP is responsible for the cost associated with providing the EQRO with the member records.

3. The purposes of the EQRO review are:

    a. To validate data and information including performance measures submitted by the PIHP to the Department for the purpose of quality assessment. Validation may include 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.

    b. To validate the PIHP's Performance Improvement Projects (PIPs) to ensure that PIPs are designed, conducted and reported in a methodologically sound manner.

    c. To review compliance with structural and operational standards established by the state and applicable federal managed care regulations found in 42 CFR 438.

    d. To provide Department and the PIHP with information about their performance that is not available from other sources of data.

    e. To provide information that will aid the Department and the PIHP in interpreting other sources of data, such as encounter data.

    f. To provide insight and information about factors that influenced differences in program performance among similar populations.

g. To provide information that is useful to programs for their ongoing quality improvement processes.

h. To provide information that will be useful to Department in fulfilling its oversight role for developing the PIHP's contract requirements.

4. When the EQRO identifies an adverse quality finding that needs to be followed up on, the PIHP must:

a. Assign a staff person(s) to conduct follow-up with the provider(s) concerning each adverse quality finding identified by the EQRO, including informing the provider(s) of the finding and monitoring the provider's resolution of the finding.

b. Inform the PIHP's QAPI committee of the final finding and involve the QAPI committee in the development, implementation and monitoring of the corrective action plan.

c. Submit a corrective action plan or an opinion in writing to the Department within 60 days that addresses the measures that the PIHP and the provider intend to take to resolve the finding. The PIHP's final resolution of all potential Quality Improvement cases must be completed within six (6) months of PIHP notification. The Department will not consider the case resolved until it has approved the response provided by the PIHP and provider.

5. The PIHP will facilitate training provided by the Department to its providers.

6. The results of the review will be made available to the Department, and PIHP providers in a manner that does not disclose the identity of any individual member, unless such identification is required to resolve an issue.

G. Dental Services Quality Improvement

The PIHP's QAPI Committee and QAPI coordinator will review subcontracted dental programs quarterly to ensure that quality dental care is provided and that the PIHP and the contractor comply with the following:

1. There must be a network or contracted dentist within a 25-mile radius of each zip code in the covered service area. The PIHP or PIHP affiliated dental provider must advise the member of the name of the dental provider and the address of the dental provider's site. The PIHP or PIHP affiliated

dental provider must also inform the member in writing how to contact his/her dentist (or dental office), what dental services are covered, when the coverage is effective, and how to appeal denied services.

2. The PIHP or PIHP affiliated dental provider who assigns all or some FCMH members to specific participating dentists must give members at least 30 days after assignment to choose another dentist. Thereafter, the PIHP and/or affiliated provider must permit members to change dentists at least twice in any calendar year and more often than that for just cause.

3. There must be a sufficient number of PIHP-affiliated dentists to ensure that each child receives a dental assessment within 3 months of enrollment, or a follow-up visit if an assessment was conducted within 6 months prior to enrollment in the FCMH. Member requests for emergency treatment must be addressed within 24 hours after the request is received.

4. Dental providers must maintain adequate records of services provided. Records must fully disclose the nature and extent of each procedure performed and should be maintained in a manner consistent with standard dental practice.

5. The PIHP affirms by execution of this contract that the PIHP's peer review systems are consistently applied to all dental subcontractors and providers.

6. The PIHP must document, evaluate, resolve, and follow up on all verbal and written complaints they receive from FCMH members related to dental services.

The PIHP must submit annual progress reports due July 1 documenting the outcomes or current status of activities intended to increase utilization among members and recruit and retain providers (including pediatric dental providers, orthodontists, and oral surgeons), specifically commenting on the requirements listed above.

H. Performance Improvement Priority Areas and Projects

The PIHP must develop and ensure implementation of program initiatives to address the specific clinical or non-clinical needs in the FCMH population served under this Contract. These priority areas must include clinical and non-clinical Performance Improvement Projects. The Department strongly advocates the development of collaborative relationships among PIHPs, BMCW, county child welfare agencies, mental health departments, community based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. Complete

encounter data for all services provided must be reported. Linkages between the PIHP and public health agencies is an essential element for the achievement of the public health objectives, potentially reducing the quantity and intensity of services the PIHP needs to provide. The Department and the PIHP are jointly committed to on-going collaboration in the area of service and clinical care improvements by the development and sharing of "best practices" and use of encounter data-driven performance measures.

The PIHP must annually evaluate the quality of care and services through a performance improvement project for at least one of the priority areas specified by the Department. Additionally, CMS, in consultation with the Department 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.

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:

- Incorporation of trauma-informed competence and services into FCMH practice and service delivery;
- Utilization of evidence-based, trauma-informed behavioral health/substance abuse services;
- Quality of outpatient behavioral and mental health services;
- Behavioral health joint care planning and accountability;
- Evaluation of the need for specialty services;
- Children with special health care needs identification and services;
- High volume/high-risk services identified by the PIHP (e.g., psychotropic medication management, asthma);
- Prevention and care of acute and chronic conditions;
- Comprehensive/complex care coordination;
- Care coordination and health/mental health promotion;
- Transitional care across settings;
- Appropriate monitoring and management of medication by a qualified provider.

Non-clinical priority areas include, but are not limited to:

- Wait times for an appointment to see a primary care provider or medical specialist or to receive a specialized service or piece of equipment;
- Access to specialized transportation services;
- Adequacy of the behavioral and mental health network with regard to geographic accessibility to its members;
- Monitoring of complaints, grievances and appeals (e.g., are the PIHP's complaint mechanisms easy to use?);
- Mechanisms to collect information from pediatric providers on how well the FCMH's system works for their patients;
- Mechanisms to involve consumer/family participation in the PIHP's policy development;
- Using a member satisfaction survey targeted to specific pediatric populations (e.g., with chronic conditions);
- Use of health information technology.

1. Health plans should submit PIPs which target policy interventions for performance improvement. Plans should not submit baseline studies which are designed to evaluate if a problem exists.

2. In the event that a health plan demonstrates a need to continue an intervention for PIP submission for a second year, the health plan should incorporate the EQRO's mutually agreed upon recommendations in the subsequent year.

3. The PIHP must submit a preliminary PIP proposal summary stating the proposed topic, the study question, and a brief description of the intervention and the study design for the next calendar year's PIP. The preliminary summary must address Steps 1 through 6 (per list of PIP steps, included as point 12) and must be submitted to DHS in template format via email to the health plan's Contract Monitor. This preliminary summary must be submitted by December 1st of each calendar year.

   DHS and the EQRO will review and approve or disapprove the preliminary PIP proposal, and meet with the PIHP during the month of December. DHS will determine if the topic selected by the plan is aligned with the Department's goals. The EQRO will review the methodology and the study design proposed by the plan. 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 DHS, health plans must re-submit a new or revised PIP proposal that will be subject to DHS and the EQRO's review protocol.

4. After receiving the State's approval, the plan must communicate with the EQRO throughout the implementation of the project if questions arise. This includes communication (conference call) on the preliminary summary submission with the EQRO and DHS Contract Monitor. The health plan should contact the EQRO throughout the year to discuss any concerns with the health plan's study. The PIHP should perform ongoing monitoring of the project throughout the year to ensure its interventions are successful.

5. After implementing the PIP over one calendar year, health plans must submit their completed PIP reports by the first business day of July of the following year. Health plans have the option of submitting their PIP in a report format as long as the report addresses CMS mandated protocol ("Validating Performance Improvement Projects", CMS-R-305). Alternately, health plans may submit their PIP report in a template format provided by DHS.

6. The EQRO has the liberty to contact the plans in circumstances where they need further clarification on certain issues. The plan can also contact the EQRO throughout the PIP process in order to ensure that they understand and incorporate appropriately the EQRO recommendations.

7. The EQRO may recommend a health plan's PIP for inclusion as part of Wisconsin's Best Practices Seminars. All health plans must participate in DHS Best Practices Seminars.

8. The Department will consider that the plan failed to comply with PIP requirements if:

9. The plan submits a final PIP on a topic that was not approved by DHS and the EQRO through the preliminary summary process, unless subsequent approval was granted by DHS.

10. The EQRO finds that the PIP does not meet federal regulations.

11. The plan 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 XI.

12. Ten Steps to a Successful PIP

Step 1: Describe the project/study topic.

Step 2: Describe the study questions/project aims.

Step 3: Describe the selected study indicators/project measures.

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 and interpretation of results of data collection.

Step 9: Describe the likelihood that the reported improvement is real improvement.

Step 10: Describe whether the organization has sustained its documented improvement.

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.

ARTICLE V

V. FUNCTIONS AND DUTIES OF THE DEPARTMENT

In consideration of the functions and duties of the PIHP contained in this contract, the Department must:

A. Eligibility Determination

Identify and provide informing materials to PIHP members who meet the initial FCMH enrollment criteria with one of the following medical status codes:

Foster Care Medical Home 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

B. Enrollment

Promptly notify the PIHP of all members enrolled in the PIHP under this Contract. Enrollment notification will be effected through three separate rosters:

1. The daily report (SM13A100, Care4Kids-Monitoring-Childrens) identifying members who are newly enrolled, ongoing members, and members that have been disenrolled. The PIHP will have access to the eReport through eWiSACWIS.

2. The monthly X12 834 Initial and Final Enrollment Rosters identifying members who are newly enrolled or an ongoing member. The rosters will be generated in the sequence specified under PIHP enrollment rosters.

3. 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.

C. Disenrollment

Promptly notify the PIHP of all members no longer eligible to receive services through the PIHP under this Contract. Disenrollment notification will be effected throughthree separate rosters:

1. The daily report (SM13A100, Care4Kids-Monitoring-Childrens) identifying members who are newly enrolled, ongoing members, and members that have been disenrolled. The PIHP will have access to the eReport through eWiSACWIS.

2. The monthly X12 834 Initial and Final Enrollment Rosters identifying any member who was enrolled in the PIHP in the previous enrollment month and is now disenrolled. The rosters will be generated in the sequence under PIHP enrollment rosters.

3. 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.

D. 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.

E. PIHP Enrollment Rosters

For each month of coverage throughout the term of the contract, the Department will provide "PIHP Enrollment Rosters".

1. The daily report (SM13A100, Care4Kids-Monitoring-Childrens) identifying members who are newly enrolled, ongoing members, and members that have been disenrolled. The PIHP will have access to the eReport through eWiSACWIS.

2. 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. The PIHP Enrollment Rosters will be generated in the following sequence:

    a. 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.

    b. 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.

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

d. The X12 820 Capitation 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.

e. 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.

f. Member Health History Report

3. The monthly initial and final reports that are currently pushed out on the MCO portal, sorted by MCO assigned ID.

F. Utilization Review and Control

Waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services provided by the PIHP to its members.

G. PIHP Review

Submit to PIHP for preview, materials that describe the specific PIHP and that will be distributed by the Department, BMCW or child welfare agencies, parent/legal guardian and out-of-home care provider.

H. 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.

I. PIHP Review of Study or Audit Results

Submit to the PIHP for a 30-business day review/comment period, any studies or audits that are going to be released to the public that are about the PIHP and FCMH Program.

J. Vaccines

Provide certain vaccines to PIHP providers for administration to its members according to the policies and procedures in the ForwardHealth Handbook. The Department will reimburse the PIHP for the cost of vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The cost of the vaccine shall be the same as the cost to the Department

of buying the new vaccine through the Vaccine for Children program. The PIHP retains liability for the cost of administering the vaccines.

K. Wisconsin Medicaid Provider Reports

Provide a weekly electronic listing of all Wisconsin Medicaid certified providers to include, at a minimum, the name, address, Wisconsin Medicaid provider ID number, and dates of certification in Wisconsin Medicaid.

L. Fraud and Abuse Training

The Department will provide fraud 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.

M. Provision of Data to the PIHP

Provide to the PIHP the following data related to its members:

1. Lead testing performed and sent to the State Lab of Hygiene for analysis.

2. Immunization information from the Wisconsin Immunization Registry to the extent available. The Department will make every effort to get the Wisconsin Immunization Registry information to the PIHP.

N. Conflict of Interest Safeguards

The Department will maintain State employee conflict of interest safguards at least equal to federal safeguards (41 USC 423, sec. 27) and in compliance with Ch. 16.705, Wis. Stats.

ARTICLE VI

VI. FINANCIAL REQUIREMENTS AND REIMBURSEMENT

Reimbursement for Care4Kids will be done under the authority of 42 CFR 438.2, a PIHP. 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 with adjustments 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 actual cost of services provided and the cost of those services 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. The PIHP will have 30 calendar days from the date of the written notification to accept the new rates in writing or to initiate termination or non-renewal of the Contract. The monthly non-risk prepayment rates are not subject to renegotiation once they have been accepted, unless such renegotiation is required by changes in federal or state laws, rules, or regulations. However, the monthly rates may be retrospectively adjusted according to the terms set forth in this contract.

Reconciliation & Quarterly Financial Review

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.

Final Reconciliation

Final reconciliation for each calendar year period will be initiated six months after the end of the calendar year period and completed no later than six months thereafter. This process will not be initiated earlier than six months after the end of the calendar year period in order to allow a sufficient claims run out time.

1. 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. The resulting total reported 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 correction amount calculated will be provided, or recouped, within 12 months after the end of the calendar year period in question. If third party liability (TPL) paid amounts cannot be identified in the encounter system the PIHP will be required to submit the TPL information in a format agreed to by the PIHP and the Department before final reconciliation.

2. Administrative Cost – Administrative Costs will not be reconciled.

Interim Payments for High Cost Enrollees

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 enrollees, benefit costs could vary if there are unanticipated high cost enrollees. 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 enrollee expenses will be subject to department approval.

B. Payment Schedule

Payment to the PIHP is based on the PIHP Enrollment Rosters that the Department transmits to the PIHP. Payment for each person listed as an ADD or CONTINUE on the PIHP Enrollment Rosters shall be made by the Department within 60 days of the date the report is generated. Notification of all paid and denied monthly payments will be given through the weekly Remittance Status Report.

C. Coordination of Benefits (COB)

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.

D. 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.

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. If a contract is terminated, recoupments will be handled through a payment by the PIHP within 30 business days of contract termination.

5. 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.

E. PPACA Primary Care Rate Increase

Federal law requires that physicians who attest to the Department as primary care providers be eligible to receive a rate increase for evaluation and management services and vaccine administration provided to Medicaid members. Eligible providers include any physician who attests to practicing in the community as a primary care provider and is either certified by a board identified in the rule or provides 60% or more of services from the targeted code set. Advanced practice providers who are supervised by an eligible provider may also attest to receive the increase. This increase is based on Medicare rates, and these rates will be updated annually, effective for each calendar year of the increase. The increase will apply to services rendered from January 1, 2013 through December 31, 2014.
Additionally, PIHP(s) are required to continue making provider payments on services which appear on the monthly PPACA Primary Care Report until December 31, 2016 or until the Department informs them in writing that the payments and reports will be discontinued as of a specific date.

The Department will maintain attestation records for all eligible physicians and advanced practice providers. Attested providers will be flagged on the Provider File Extract. The PIHP shall ensure that eligible providers receive the primary care rate increase in the manner described below.

1. Encounter Data

   a. The PIHP will be responsible for submitting the encounter records which appear on the PPACA Primary Care Report.

   b. The PIHP must submit to the Department all encounters with codes which appear on the ACA Primary Care Rate Increase Fee Schedule within 60 days of the date of payment to the provider.

   c. Only PPACA Primary Care Rate Increase qualifying encounters and members from attested providers will appear on the PPACA Primary Care Report.

2. Method of payment to providers

   a. The PIHP shall recalculate its payments to providers which appear on the monthly PPACA Primary Care Report to ensure that each provider has received at least the amount identified as the PPACA Paid Amount on the

report for each qualifying date of service. The PIHP shall take into account all cost sharing by the member and liable third parties in determining if it must pay an additional amount to the provider. Payments must be sent within 30 calendar days after the PIHP receives payment from the Department.

b. Examples of the payment methodology follow:

Example 1:

Encounter Paid Amount (A)	PPACA Paid Amount (B)	Net PPACA Supplement (B - A)	HMO Paid Amount (C)	Amount Distributed to Provider (B - C)
$100.00	$150.00	$50.00	$110.00	$40.00

The PIHP must ensure that the provider received $150.00 for the qualifying service. Because the PIHP had already paid $110.00 to the provider, the PIHP shall reimburse the provider with an additional $40.00 and may retain the remaining $10.00 or may elect to pass along to the provider the full $50.00 Net PPACA Supplement from the Department.

Example 2:

Encounter Paid Amount (A)	PPACA Paid Amount (B)	Net PPACA Supplement (B - A)	HMO Paid Amount (C)	Amount Distributed to Provider (B - C)
$100.00	$150.00	$50.00	$90.00	$60.00

The PIHP must ensure that the provider receives $150.00 for the qualifying service. Because the PIHP had already paid only $90.00 to the provider, the PIHP shall reimburse the provider with an additional $60.00 to account for the $50.00 Net PPACA Supplement from the Department plus the $10.00 by which the PIHP Paid Amount had fallen short of the Encounter Paid Amount.

Example 3:

Encounter Paid Amount (A)	PPACA Paid Amount (B)	Net PPACA Supplement (B - A)	HMO Paid Amount (C)	Amount Distributed to Provider (B - C)
$100.00	$150.00	$50.00	$100.00	$50.00

The PIHP must ensure that the provider receives the full $50.00 Net PPACA Supplement from the Department because the PIHP Paid Amount is equal to the Encounter Paid Amount.

c. If the PIHP has a sub-capitated payment arrangement with the providers for the qualifying service or it is unable to determine the PIHP Paid Amount, the PIHP shall pay to the provider the full Net PPACA Supplement from the Department.

d. The PIHP must apply all applicable cost sharing to the PIHP Paid Amount which was included with the original encounter submission. If the PIHP applies different cost sharing than what appeared on the encounter, the PIHP must resubmit the encounter with the correct information within 60 days. The PIHP must attest that the provider received the PPACA Primary Care Rate Increase Fee Schedule Amount after all other provider payments have been deducted. The attestation is found in Addendum V, E – Attestation Form.

e. At a minimum the PIHP will be required to forward all of the provider and encounter information contained within the PPACA Primary Care Report specific to the provider that is receiving payment.

3. Monthly reporting requirements

a. The PIHP shall return the entire monthly PPACA Primary Care Report to the Department with the following fields completed by the PIHP:

1) Distributed to Provider by PIHP (Y/N);
2) Amount Distributed to Provider;

b. The PIHP should mark the Distributed to Provider by PIHP field with a "Y" if the ACA Primary Care Rate Increase Fee Schedule amount of the increase was paid out to the listed provider.

c. The PIHP should mark the Distributed to Provider by PIHP field with an "N" if the amount was not paid out to the listed provider. The PIHP shall return all payments to the Department within 30 days of receipt of the payments from the Department. Prior to returning the funds, the PIHP is required to notify the Department via DHSDHCAABFM@dhs.wisconsin.gov email address. The PIHP should not return funds without the Department's consent.

Possible reasons why the funds would not be distributed is that the provider is no longer in business, the PIHP denied the original claim or the provider has a creditable allegation of fraud against him/her per Article III, Section P.2 - Fraud and Abuse Investigations. In cases of fraud the PIHP will be responsible for tracking the returned payments, by provider, and separately reporting that information to the Department. If the creditable allegation of fraud is lifted, it is the responsibility of the PIHP to contact the Department to receive reimbursement for the returned funds per the separate report.

d. The PIHP must report in the Amount Distributed to Provider field the amount actually paid to the provider.

e. Within 45 calendar days of receipt of payment from the Department, the PIHP must submit the report in Addendum V, H to the Department.

f. The report should be submitted via the PIHP's SFTP site with the original title of the file.

4. Noncompliance

The Department shall have the right to audit any records of the PIHP and to request any information, including PIHP Paid Amounts, 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 comply to the PIHP. 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 pursue action against the PIHP as provided under Article XI.

If the PIHP fails to send payment to the provider within 30 calendar days of receiving the primary care payment from the Department, the PIHP will be subject to an assessment by the Department equal to three percent of the delayed payment.

5. Payment Disputes

If the primary care provider disputes the monthly amount that the PIHP is required to pay, the provider and PIHP should follow the appeal process outlined in Article III, Section G – Provider Appeals of the contract. The PIHP or provider may request a contested case hearing under Ch. 227 on the Department's determination.

6. Resolution of Reporting Errors

If the PIHP discovers any error in the payment, the Bureau of Fiscal Management must be contacted in writing within 15 days of the discovery. It is the responsibility of the PIHP to recoup any overpayments or pay out any underpayments as a result of the error. Errors shall be corrected on the PPACA Primary Care Report for the impacted months and the entire report should be resubmitted detailing the corrected amounts by provider.

F. 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 prepayment 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 discharges and visits 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 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 claims" are inpatient discharges and outpatient claims for which the PIHP made payments 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 Childless Adult (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.

i. Monthly reporting requirements

1. The PIHP shall send a report along with its monthly payment to each eligible hospital that contains the following information:

    a. The number of qualifying inpatient discharges for the PIHP's members;
    b. The number of qualifying outpatient claims for the PIHP's members;

c. Access payment amount per qualifying inpatient discharge as specified by the Department;
d. Access payment amount per qualifying outpatient visit as specified by the Department;
e. The amount of the total access payments.

2. Within 20 calendar days of the payment of Access Payments, the PIHP must submit the report in Addendum V, F to the Department.

ii. 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 XII.

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.

iii. 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.

iv. 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. If an error is discovered, the Bureau of Fiscal Management must be contacted in writing within 15 days of the discovery.

G. Ambulatory Surgical Center (ASC) Assessment

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 prepayment 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 ASCs based on the qualifying 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.

An "eligible ASC" is a Medicare certified ASC in the state of Wisconsin. A list of qualifying ASCs is available from the Department upon request.

"Qualifying claim" is any claim on which the PIHP made payments, in the preceding month for services to the PIHP's members.. The PIHPs shall include all members who are dually-eligible and all dual-eligible visits. The PIHP shall exclude all Childless Adult (CLA) Plan members.

- Non-Crossover Claims
  For non-crossover claims, 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 ASC 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 the ASC access payment.

- Crossover Claims
  For crossover claims, if the PIHP adjudicates a claim to be valid, the claim shall count as a qualifying claim for the ASC access payment even if the adjudication results in a payment of zero. 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 the ASC access payment.

  1. Monthly reporting requirements

     a. The PIHP shall send a report along with its monthly payment to each eligible ASC that contains the following information:

        1) The number of qualifying claims for the PIHP's members;
        2) Access payment amount per qualifying claim;

3) The amount of the total access payments.

b. The PIHP must submit the report in Addendum V, G to the Department within 20 calendar days after the payment of the Access Payments.

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 XII.

Upon request, the PIHP must submit a list of qualifying claims to the Department and any other records the Department deems necessary to determine compliance.

If the PIHP fails to send access payment to an ASC within the service payment time frame, the PIHP will pay a fine to the Department equal to three percent of the delayed payment.

3. Payment disputes

If the PIHP or an ASC dispute the amount that the PIHP is required to pay the ASC, 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 ASC may request a contested case hearing under Ch. 227 on the Department's determination.

4. Resolution of Reporting Errors

The PIHP shall adjust prior ASC payments that were based on an inaccurate counting of qualifying claims. If an error is discovered, the Bureau of Fiscal Management must be contacted in writing within 15 days of the discovery.

H. 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 VII

VII. COMPUTER/DATA REPORTING SYSTEM, DATA, RECORDS AND REPORTS

A. Required Use of the secure ForwardHealth Trading Partner Portal

The PIHP must use a secure ForwardHealth Portal account to access data and reports, maintain information, and conduct financial transactions and other business with DHS.

The PIHP must assign users roles/permissions within the secure ForwardHealth Trading Partner 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 requirements.

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 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 five 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 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 provided in this Contract.

D. Computer Data Reporting System

The PIHP must maintain a computer/data reporting system that meets the following Department requirements. The PIHP is responsible for complying with all the Department's reporting requirements and with ensuring the accuracy and completeness of the data as well as the timely submission of the data. The data submitted must be supported by records available to the Department or its

designee. The Department reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract. The PIHP must have a contact person responsible for the computer/data reporting system who can answer questions from the Department and resolve problems identified by the Department regarding the requirements listed below:

1. The PIHP must have a claims processing system that is adequate to meet all claims processing and retrieval requirements specified in this Contract.

2. The PIHP must have a computer/data collection, processing, and reporting system sufficient to monitor PIHP enrollment/disenrollment (in order to determine on any specific day which recipients are enrolled or disenrolled from the PIHP) and to monitor service utilization for the Utilization Management requirements of Quality Assessment/Performance Improvement (QAPI) that are specified in this Contract.

3. The PIHP must have a computer/data collection, processing, and reporting system sufficient to support the QAPI requirements. The system must be able to support the variety of QAPI monitoring and evaluation activities, including the monitoring/evaluation of quality of clinical care and service ; periodic evaluation of PIHP providers; member feedback on QAPI; maintenance of and use of medical records in QAPI; and monitoring and evaluation of priority areas.

4. The PIHP must have a computer and data processing system sufficient to accurately produce the data, reports, and encounter data set, in the formats and time lines prescribed by the Department in this contract, that are included in this Contract. A newly certified PIHP or a PIHP that substantially changes its system during the contract period is required to submit electronic test encounter data files as required by the Department, in the format specified in the encounter data user manual and according to the timelines of this contract and as may be further specified by the Department. The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production claims or other documented encounter data must be used for the test data files.

5. The PIHP must capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, and HIPAA transaction code sets, or other claim formats that are adequate to meet all reporting requirements of this Contact. The computerized database must be a complete and accurate representation of all services the PIHP covers for the contract period. The PIHP is 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.

6. The PIHP must have a computer processing and reporting system that is capable of following or tracing an encounter within its system using a unique encounter record identification number for each encounter.

7. The PIHP reporting system must have the ability to identify all denied or partially paid claims/encounters using national HIPAA Claim Adjustment Reason Codes.

8. The PIHP system must be capable of reporting original and reversed claim detail records and encounter records.

9. The PIHP system must be capable of correcting an error to the encounter record within 90 days of notification by the Department.

10. The PIHP must maintain and populate a tobacco registry (electronic database of information about members with identified tobacco or nicotine addiction or current smoker status).
11. All encounter submissions must be in the HIPAA compliant ASC X12 transaction format.

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 software and vendors and significant changes in personnel.

E. Coordination of Benefits (COB), Encounter Record, Formal Grievances and Birth Cost Reporting Requirements

The PIHP agrees to furnish to the Department and to its authorized agents, within the Department's timeframe and format, information that the Department requires to administer this Contract, including but not limited to the following:

1. Coordination of Benefits (COB)

   Summaries of amounts recovered from third parties for services rendered to members under this Contract in the format specified.

2. 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. The encounter data set must be submitted no less frequently than monthly via electronic media.

3. Formal Grievances

Copies of all formal grievances and documentation of actions taken on each grievance, as specified in Article IX and Addendum V.

4. Birth Cost

As Specified in Addendum V.

F. Encounter Data Reporting Requirements

A PIHP that contracts with the Department to provide Medicaid services must submit encounter data files. The PIHP may submit as often as desired throughout the month and multiple files may be submitted on the same day according to the specifications and submission protocols published in the Wisconsin Medicaid HMO Encounter Data User Manual. PIHPs are encouraged to submit files periodically throughout the month. All PIHP encounter data, including encounters submitted on paper, are required to be submitted to ForwardHealth in the 837 format.

1. Reporting Requirement

The rules governing the level of detail when reporting encounters should be those rules established by the following classification schemes: current ICD diagnosis codes and CPT and HCPCS procedure codes, National Drug Codes (NDC), CDT codes, hospital revenue codes for inpatient and outpatient hospital services, and hospital inpatient Diagnostic Related Group (DRG) codes, if DRG codes are used.

Multiple encounters can occur between a single provider and a single member on a day. For example, if a physician provides a limited office visit, administers an immunization, and takes a chest x-ray, and the provider submits a claim or report specifically identifying all three services, then there are three encounters, and the PIHP will report three encounters to the Wisconsin Medicaid Program.

2. Testing Encounter Data

The 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.

3. Primary PIHP Contact Person

The PIHP must specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting PIHP encounter and utilization data, and a secondary contact person in the event the primary contact person is not available.

4. Encounter Data Technical Workgroup Requirement

The PIHP must assign staff to participate in the encounter data technical workgroup meetings periodically scheduled by the Department. This workgroup's purpose is to enhance the PIHP and Medicaid data submission protocols and improve the accuracy and completeness of the data.

5. Encounter Data Completeness and Accuracy

The Department will conduct data validity and completeness audits during the contract period. At least one of these audits will include a review of the PIHP's encounter data system and system logic.

6. Analysis of Encounter Data

The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. However, the Department will make every effort to ensure that the analysis does not violate the integrity of the reported data submitted by the PIHP.

The PIHP that subcontracts with providers must have the provisions for assuring that the data required on the PIHP Utilization Report is reported to the PIHP by the subcontractor. For example, subcontracts with providers of mental health or dental services must have a provision ensuring that survey and encounter data is reported to the PIHP in an accurate and timely fashion.

The Department agrees to involve the PHIP in the planning process prior to implementing any changes in questions or measures, format and definitions, and will request the PHIP to review and comment on those changes before they go into effect

G. 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 five years from the date of termination of this contract. Records involving matters that are the subject of litigation shall be retained for a period of not less than five years following the termination of litigation. Microfilm 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.

Upon expiration of the five-year retention period and upon request, the subject records must be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

H. Reporting of Corporate and Other Changes

The PIHP must report to the Department any change in corporate structure or any other change in information previously reported. The PIHP must report the change as soon as possible, but not later than 30 days after the effective date of the change. Changes in information covered under this section include all of the following:

1. Any change in information relevant to this contract, relating to ineligible organizations.

2. Any change in information relevant to this contract, relating to ownership and business transactions of the PIHP.

1. Any change to the information the PIHP previously provided in response to the Department's questions in the current PIHP certification application.

I. 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 report, in the format designated by DHS, to the State's FTP when the PIHP experiences significant change with respect to network adequacy. (Facility report includes any physical address in which PIHP providers serve members, i.e. clinics and hospitals.)

2. The provider network and facility file shall include only Medicaid-certified providers who are contracted with the PIHP to provide contract services FCMH members. The provider network and facility data submission must be completed by the first business day of July. Reporting dates are included in Article VII, J.

3. PIHP must submit full and complete, accurate, provider network and facility data. The Department will provide the PIHP with the required and critical 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 XI.

J. Contract Specified Reports and Due Dates

2014 – 2015 REPORTS AND DUE DATES

Type of Report	**Frequency**	**Report Period**	**Reporting Unit**	**Report Format**	**Location in Contract**
Affirmative Action Plan	Every 3 years		AA/CRC Office	As specified on VendorNet	Art. III, C, 4
Civil Rights Compliance Letter of Assurance and Plan	As specified by website listed in (Art. III, C.4.b)	Contract period	AA/CRC Office or filed until request	As specified on DHS website	Art. III, C, 4
Encounter Data File	As often as needed	Monthly	Fiscal Agent	FTP Server	Art. VII, E
PIHP Provider and Facility Network	Whenever there are significant changes	Next month	DHS	Electronic Media	Art. III, H Art. VII, I
Formal/Informal Grievance Experience Summary Report	Quarterly (within 30 days of end of quarter)	Previous Quarter	BBM	Hardcopy or Password protected e-mail	Art. VII, E. 3 Art. IX Add. IV, G
Attestation Form	Quarterly	Previous Quarter	BBM	Electronic Media	Art. III, C. Add. V, D
Dental Utilization Report	Annually on July 1	Annual	BBM	Electronic media	Art. IV, G
Member Communication and Outreach Plan	Second Friday of January	Annual	BBM	Electronic Media	Art. III, L
Performance Improvement Project Final Report	First business day of July	Annual	BBM & EQRO	Electronic Media	Art. IV, A, 12 Art. IV, I
Individual Hospital Access Payment Data	Monthly, at the time of access payment (Within 15 calendar days of receiving payment from	Previous month	Any hospital the PIHP made payments to	As determined by hospital contract	Add. V, E Art. VI, F

	DHS)				
Summary Hospital Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Add. V, E Art. VI, F
Individual Ambulatory Surgical Center Access Payment Data	Monthly, at the time of access payment (Within 15 calendar days of receiving payment from DHS)	Previous month	Any ASC the PIHP made payments to	As determined by ASC contract	Add. V, F Art. VI, G
Summary Ambulatory Surgical Center Access Payment Report	Monthly, within 20 calendar days of receiving payment from DHS	Previous month	BFM	Electronically	Add. V, F Art. VI, G
Newborn Report	Monthly	Previous Month	Fiscal Agent	Password-protected E-mail or Fax	Add. V, B
Court Ordered Birth Costs Report	Within 14 days of receipt of request by DHS	Upon request	BFM	Mail or Fax	Add. V, A

Any reports that are due on a weekend or holiday are due the following business day.
BBM = Bureau of Benefits Management, Division of Health Care Access and Accountability
BFM = Bureau of Fiscal Management, Division of Health Care Access and Accountability

K. 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).

4. 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.

ARTICLE VIII

VIII. ENROLLMENT AND DISENROLLMENT

A. Covered Population

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 initial 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.

B. Member Information

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

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.

1. 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)).

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

C. Enrollment

The PIHP must accept as enrolled all persons eligible for coverage under this contract without regard to health status of the eligible persons or any other factor(s). Enrollment in the FCMH program is voluntary.

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.

The PIHP shall designate, in this contract, its maximum enrollment levels. The PIHP shall accept as enrolled all children who appear as enrollees on the PIHP Enrollment Reports up to the PIHP specified enrollment level for a particular service area. The Department does not guarantee any minimum enrollment level.

1. Section 1115(A) Waiver and State Plan Amendment

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

2. Enrollment Levels

   The PIHP must designate its maximum enrollment level for its entire service area. The Department may take up to 60 days from the date of written notification to implement maximum enrollment level changes.
   The PIHP must accept as enrolled all persons who appear as enrollees on the PIHP Enrollment Reports up to the PIHP specified enrollment level for its service area. The number of enrollees may exceed the maximum enrollment level by 5% on a temporary basis.
   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.

D. Enrollment/Disenrollment Practices

The PIHP must permit the Department to monitor its enrollment and disenrollment practices under this Contract. The PIHP will not discriminate in enrollment/disenrollment activities between individuals on the basis of health status or requirement for health care services, including those who have AIDS or are HIV-Positive. This includes a member with a diminished mental capacity, who is uncooperative and displays disruptive behavior due to the member's special needs.

The Department must ensure that members with medical status codes that are not eligible for FCMH enrollment are appropriately disenrolled according to Department policy

E. Hospitalization at the Time of Enrollment or Disenrollment

1. The PIHP will not assume financial responsibility for members who are hospitalized at the time of enrollment (effective date of coverage) until an appropriate hospital discharge.

2. The Department will be responsible for paying on a FFS basis all Medicaid-covered services for such hospitalized members during hospitalization.

3. Enrollees 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 and shall continue for the duration of the hospitalization, except:

   a. Where loss of Medicaid eligibility or death occurs.
   b. Where disenrollment is due to voluntary disenrollment.
   c. Where disenrollment is due to just cause

   In these three exceptions, the PIHP's liability shall not exceed the period for which it has received its monthly payment.

4. Hospitalization in this section is an inpatient stay at a certified hospital as defined DHS 101.03(76), Wis. Adm. Code. Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

F. Disenrollment

Disenrollment requests should be directed to the enrollment specialist.

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..

2. Involuntary Disenrollment

The PIHP may request and the Department may approve an involuntary disenrollment with an effective date that must be no later than the first day of the next month, when there is a situation where enrollment would be harmful to the interests of the member or when the PIHP cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. For any request for involuntary disenrollment, the PIHP must submit a disenrollment request to the Department that includes evidence attesting to cause which might include, but is not limited to:

a. Just Cause

The PIHP may request and the Department will approve disenrollment requests for specific cases or persons where there is just cause. Just cause is defined as 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 may not request just cause disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the PIHP seriously impairs the entity's ability to furnish services to either this particular member or other members) (42 CFR 438.56).

1) Criteria for Just Cause

a) The member's parent/legal guardian refuses critical services and/or is unwilling to meet significant conditions of participation, despite repeated good faith efforts by the PIHP to communicate the seriousness of the problem and attempt alternate methods of providing care in a manner more consistent with parent/legal guardian's preferences.

b) The member has demonstrated a history of physical aggression which places others and/or self at risk, as demonstrated by clinical/medical records, family and/or provider information; AND documented previous attempts at treatment or plan intervention have been unsuccessful, resulting in physical risk to the individual or others.

c) The member parent/legal guardian has a history of willful noncompliance with an essential treatment plan, which has resulted in significant physical risk to the individual, as demonstrated by clinical/medical records, AND that risk continues.

d) The member or member's parent/legal guardian refuses an essential component of the treatment plan.

3. Ineligibility Disenrollment

a. Out of Service Area

The member was placed in out-of-home care outside of the PIHP's certified service area.

The member moves outside of the PIHP's certified service area during their 12 month extension.

b. Loss of Program Eligibility

If a member is no longer eligible for enrollment due to loss of full benefit Medicaid eligibility during their 12 month extension for more than one month, s/he shall be disenrolled.

c. Ineligible Out-of-Home Care Placement Setting

The member was placed in a Residential Care Center.

4. Native American Disenrollment

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

G. Effective Dates of Disenrollment

Effective dates of disenrollment are determined as follows:

1. Voluntary Disenrollment

If a parent/legal guardian wishes to disenroll their child from the program, the date of the disenrollment shall be the last day of the month in which the disenrollment was requested. Payment(s) made for the member disenrolled the last day of the month will be recouped based on a daily rate.

2. Involuntary Disenrollment

If the PIHP requests an involuntary disenrollment, the disenrollment shall be the first of the next month after the Department approved the request. The PIHP may request an involuntary disenrollment for:

a. Just Cause Disenrollment

If PIHP involuntarily disenrolls a member (as allowed under Section D.2.a) and the Department approves the disenrollment.

If the entity or State agency fails to make a disenrollment determination within the timeframes specified, the disenrollment is considered approved.

3. Ineligibility Determination

a. Out of Service Area Move

If a member is placed in, or moves to a location that is outside of the PIHP's approved service area, 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 out-of-county placement/move.

b. Loss of Medicaid Eligibility

If a member is disenrolled due to death or the loss of full benefit Medicaid eligibility for more than one month, then the date of disenrollment shall be effective on the first date of Medicaid ineligibility. Any payment(s) made for month(s) subsequent to the loss of eligibility will be recouped.

c. Ineligible Setting Move

If a 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 setting placement/move.

H. 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.

I. 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 IX

IX. COMPLAINT, GRIEVANCE AND APPEAL PROCESS

The grievance process refers to the overall system that includes complaints, grievances and appeals or expedited appeals as defined in Article I. FCMH members may grieve any aspect of service delivery provided or arranged by the PIHP, to the PIHP and to the Department. The member may appeal an action to the PIHP, the Department and/or to the Division of Hearings and Appeals.

A. Procedures

The PIHP must:

1. Have written policies and procedures that detail what the grievance system is and how it operates.

2. Identify a contact person in the PIHP to receive grievances and be responsible for routing/processing.

3. Operate a complaint process that members can use to get problems resolved without going through the formal, written grievance process. However, the PIHP must treat any verbal requests seeking to appeal an action as an appeal and confirm those in writing, unless the member or authorized representative requests expedited resolution.

4. Operate a grievance process that allows members or authorized representatives to grieve in writing or orally.

5. Inform members or authorized representatives about the existence of the complaint and grievance process and how to use it.

6. Attempt to resolve complaints, grievances and appeals informally.

7. Respond to grievances and appeals in writing within 10 business days of receipt, except in emergency or urgent (expedited grievance) situations. This represents the first response. The PIHP must resolve the grievance or appeal within two business days of receipt of a verbal or written expedited grievance, or sooner if possible.

8. Operate a grievance process within the PIHP that a member or authorized representative can use to grieve or appeal any negative response to the Board of Directors of the PIHP. The PIHP Board of Directors may delegate the authority to review grievances to a PIHP grievance appeal committee, but the delegation must be in writing. If a grievance

committee is established, the FCMH's Member Advocate must be a member of the committee. The decision makers responsible for reviewing a member's grievance or appeal must not have participated in prior decision making.

9. Provide the member or authorized representative an opportunity, before and during the appeals process, to examine member's case file, including medical records and any other documents and records considered during the appeals process.

10. Grant the member or authorized representative, the right to appear in person before the grievance committee to present written and oral information. The member or authorized representative may bring an advocate to the meeting. The PIHP must inform the member, or their authorized representative, in writing of the time and place of the meeting at least seven calendar days before the meeting or in expedited grievances or appeals, the PIHP must also notify the member orally of the limited time to present additional information.

11. Maintain a record keeping "log" of complaints and grievances that includes a short, dated summary of each problem, the response, and the resolution. The log must distinguish FCMH members from other Medicaid members, if the PIHP serves other Medicaid populations. If the PIHP does not have a separate log for FCMH members and commercial members, the PIHP must have a method for distinguishing each population. The PIHP must submit quarterly reports to the Department of all complaints, grievances and appeals (Addendum V). The analysis of the log will include the number of complaints, grievances and appeals divided into two categories: program administration and benefit denials. The PIHP should report (in Addendum V) those members that grieved or appealed to the PIHP's grievance appeal committee.

12. Maintain a record keeping system for grievances and appeals that includes a copy of the original grievance or appeal, the response, and the resolution. The system must distinguish FCMH members from other Medicaid members and from commercial members.

13. At the time of the PIHP's initial grievance denial of an action decision the PIHP must notify the member that the grievance denial decision may be appealed to the Department and/or to the Division of Hearings and Appeals (DHA). The member and his/her authorized representative may appeal orally, but must follow up with a signed written appeal.

14. Ensure that individuals with the authority to require corrective action are involved in the grievance process.

15. Distribute to its gatekeepers* and IPAs the informational flyer on member grievance and appeal rights (the Ombuds brochure). When a new brochure is available, the PIHP must distribute copies to its gatekeepers and IPAs within three weeks of receipt of the new brochure.

16. Ensure that the PIHP's gatekeepers* and IPAs have written procedures for describing how members are informed of denied services. The PIHP will make copies of the gatekeepers' and IPAs' grievance procedures available for review upon request by the Department.

17. Inform members about the availability of interpreter services and provide interpreter services for non-English speaking and hearing impaired members throughout the PIHP's grievance process.

B. Grievance and Appeal Process

The member or authorized representative may choose to use the PIHP's grievance and appeal process or may appeal to the Department instead of using the PIHP's grievance and appeal process. If the member or their authorized representative chooses to use the PIHP's process, the PIHP must provide an initial response within 10 business days and a final response within 30 days of receiving the grievance or appeal. If the PIHP is unable to resolve the grievance or appeal within 30 days, the time period may be extended another 14 days from receipt if the PIHP notifies the member in writing that the PIHP has not resolved the grievance or appeal, when the resolution may be expected, and why the additional time is needed. The total timeline for PIHP to finalize a formal grievance or appeal may not exceed 45 calendar days from the date of the receipt. The PIHP must include the resolution and date of the appeal resolution in the written notification of the member or their authorized representative. The PIHP must give notice on the date of action when the action is a denial of payment.

Any grievance or appeal decision by the PIHP may be appealed to the Department by the member or authorized representative. The Department shall review such appeals and may affirm, modify, or reject any formal decision of the PIHP at any time after the member files the formal appeal. The Department will request the name and credentials of the person making the denial decision as part of the grievance process. The Department will give a final response within 30 days from the date the Department has all information needed for a decision. Also, a member can submit a grievance or appeal directly to the Department at any time during the grievance process. Any decision made by the Department under this

* The word "gatekeeper" in this context refers to any entity that performs a management services contract, a behavioral health science IPA, or a dental IPA, and not to individual physicians acting as a gatekeeper to primary care services.

section is subject to member appeal rights to the extent provided by state and federal laws and rules. The Department will receive input from the member and the PIHP in considering grievances and appeals.

For an expedited grievance or appeal, the PIHP must resolve all issues within two business days of receiving the verbal or written request for an expedited grievance. In addition to written notice, the PIHP must make reasonable effort to provide oral notice of the resolution.

The PIHP must ensure that punitive action is not taken against anyone who either requests an expedited resolution or supports a member's grievance.

In the event that services are not furnished while the appeal is pending and the decision to deny, limit or delay services is reversed, the PIHP must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires.

A member may request a State Fair Hearing. The parties to the State Fair Hearing will include the PIHP as well as the member and his or her representative or the representative of a deceased member's estate. Decisions will be reached within the specified timeframes:

- Standard resolution: within 90 days of the date the member filed the appeal with the PIHP if the member filed initially with the PIHP (excluding the days the member took to subsequently file for a State Fair Hearing) or the date the member filed for direct access to a State Fair Hearing.

- Expedited resolution (if the appeal was heard first through the PIHP appeal process): within three (3) working days from Department receipt of a hearing request for a denial of a service that:

    - Meets the criteria for an expedited appeal process but was not resolved using the PIHPs appeal timeframes; or

    - Was resolved wholly or partially adversely to the member using the PIHP's expedited appeal timeframes.

- Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the PIHP appeal process): within three (3) working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

C. Notifications to Members

When the PIHP, its gatekeeper,* or its IPA discontinues, terminates, suspends, limits, or reduces a service (including services authorized by a PIHP or an HMO in which the member was previously enrolled or services the member received on a Medicaid FFS basis), the PIHP must notify the affected member(s), at least 10 days before the date of action, in writing. When the PIHP, its gatekeeper, or its IPA denies coverage of a new service, the PIHP must notify the member of the denial in writing.

The Department must review and approve all notice language prior to its use by the PIHP. Department review and approval will occur during the FCMH certification process of the PIHP and prior to any change of the notice language by the PIHP.

Notices for both ongoing services and new benefits must include all of the following:

1. The nature of the intended action.

2. The reason for the intended action. The reason must be clearly stated in sufficient detail to ensure that the member understands the action being taken by the PIHP.

3. The fact that the member or authorized representative has the right to appeal within 45 days of the date of the notice.

4. The fact that the member or representative has the right to examine the documentation used when the PIHP made its determination prior to the PIHP grievance committee hearing or the DHA.

5. The fact that interpreter services are available free of charge during the grievance process and how the member or authorized representative can access those services.

6. A sentence in various languages that explains who to call for interpreter services or a copy of the letter in the appropriate language.

7. The right of the member to have a representative assist him/her at any point in the appeal process including reviews or hearings.

* The word "gatekeeper" in this context refers to any entity that performs a management services contract, a behavioral health science IPA, or a dental IPA, and not to individual physicians acting as a gatekeeper to primary care services.

8. The right of the member or representative to present "new" information before or during the grievance and appeal process including reviews or hearings.

9. The fact that punitive action will not be taken against a member who appeals the PIHP's decision.

10. That the process for requesting an oral or written expedited grievance or appeal requires a medical provider to verify that delay can be a health risk. If the PIHP determines the grievance or appeal does not meet expedited requirements, the PIHP will review the grievance within the standard timeframes and will make reasonable effort to provide prompt oral notice to the member followed by written notice within two calendar days.

11. An explanation of the member's right to appeal the PIHP's decision to the Department at any point in the process.

12. The fact that the member or representative, if appealing the PIHP action, may file a request for a hearing with the Division of Hearings and Appeals (DHA) at any point in the process.

13. The fact that the member or representative can receive help in filing a grievance or appeal by calling either the FCMH Member Advocate or the Ombuds.

14. The address and telephone number of both the FCMH Member Advocate and the Ombuds.

Notifications to members of termination, suspension, or reduction of an ongoing benefit (including services authorized by a PIHP the member was previously enrolled in or services received by the member on a FFS basis), must in addition to items 1 through 14 above, also include the following:

a. The fact that a benefit will continue during the appeal or DHA fair hearing process if the member requests that it continue within 10 days of notification or before the effective date of the action, whichever is later.

b. The circumstances under which a benefit will continue during the grievance and appeal process.

c. The fact that if the member continues to receive the disputed service, the member may be liable for the cost of care if the decision is adverse to the member.

This notice requirement does not apply when the PIHP, its gatekeeper or its IPA triages a member to a proper health care provider or when an individual health care provider determines that a service is medically unnecessary.

The Department must review and approve all notice language prior to its use by the PIHP. Department review and approval will occur during the FCMH certification process of the PIHP and prior to any change of the notice language by the PIHP.

15. The PIHP must notify the member of the member's ability to obtain services outside the network.

    - From any other provider (in terms of training, experience, and specialization) not available within the network.

    - From a provider not part of the network who is the main source of a service to the member – provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within 60 days.

    The member may also receive services outside of the network for the following reasons:

    - Because the only plan or provider available does not provide the service because of moral or religious objections.

    - Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network.

    - The State determines the other circumstances warrant out-of-network treatment.

    The period of advanced notice is shortened to 5 days if probable member fraud has been verified or by the date of the action for the following:

    - In the death of a member (when the PIHP is made aware of the death);
    - A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where he/she understands that this must be the result of supplying that information);

- The member's admission to an institution where he/she is ineligible for further services;
- The member's address is unknown and mail directed to him/her has no forwarding address;
- The member has been accepted for Medicaid services by another local jurisdiction;
- The member's physician prescribes the change in the level of medical care;
- An adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or
- The safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

D. Continuation of Benefits Requirements

If the member files a request for a hearing with the DHA on or before the later of the effective date or within 10 days of the PIHP mailing the notice of action to reduce, limit, terminate or suspend benefits, upon notification by the DHA the PIHP will notify the member they are eligible to continue receiving care but may be liable for care if DHA upholds the PIHP's decision. If the member requests that the services in question be continued pending the outcome of the fair hearing, the following conditions apply:

1. If the DHA reverses the PIHP's decision, the PIHP is responsible to cover services provided to the member during the administrative hearing process.

1. If the DHA upholds the PIHP's decision, the PIHP may pursue reimbursement from the member for all services provided to the member, to the extent that the services were covered solely because of this requirement.

   Benefits must be continued until one of the following occurs:

   - The member withdraws the appeal.
   - A state fair hearing decision adverse to the member is made.
   - The authorization expires or the authorization service is met.

E. Reporting of Grievances to the Department

The PIHP must forward both the complaint and grievance reports to the Department within 30 days of the end of a quarter in the format specified. Failure on the part of the PIHP to submit the quarterly complaint and grievance reports in the required format within five days of the due date may result in any or all sanctions available under this Contract.

ARTICLE X

X. 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. The subcontractor agrees to abide by all applicable provisions of the PIHP's contract with the Department of Health Services. Subcontract compliance with the FCMH Contract specifically includes but is not limited to the requirements specified below.

A. Subcontract Standard Language

The PIHP must ensure that all subcontracts are in writing and include the following standard language when applicable.

1. Subcontractor uses only Medicaid-certified providers in accordance with the FCMH PIHP contract.

2. No terms of this subcontract are valid which terminate legal liability of the PIHP.

3. Subcontractor agrees to participate in and contribute required data to PIHP Quality Assessment/Performance Improvement programs as required in the FCMH PIHP contract.

4. Subcontractor agrees to abide by the terms of the FCMH PIHP 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 the FCMH PIHP contract.

5. 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 the FCMH PIHP 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.

6. Subcontractor agrees to comply with all non-discrimination requirements in the FCMH PIHP contract.

7. Subcontractor agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on abortions, sterilizations, hysterectomies, and HealthCheck requirements.

8. Subcontractor agrees 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 or penalties in Article XI 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.

9. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in the FCMH PIHP Contract.

10. Subcontractor agrees to ensure confidentiality of family planning services according to the terms of the FCMH PIHP Contract.

11. 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).

12. Subcontractor agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts.

13. Subcontractor agrees not to bill FCMH Members for medically necessary services covered under the FCMH PIHP 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-Medicaid-covered service, then the PIHP, PIHP provider, or PIHP subcontractor can 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 FCMH Member in the absence of a knowing assumption of liability for a non-Medicaid 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.

14. Within 15 business days of the PIHP's request subcontractors must forward medical records pursuant to grievances 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.

15 Subcontractor agrees to abide by the terms of the contract regarding appeals to the PIHP and to the Department regarding the PIHP's nonpayment for services provided to FCMH Members.

16. 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 Medicaid 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.

17. 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.

B. Subcontract Submission Requirements

1. Changes in Established Subcontracts

a. 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.

1) Technical changes do not have to be approved.

2) Changes in rates paid do not have to be approved, with the exception of changes in the amounts paid to PIHP management services subcontractors.

b. The Department will review the subcontract changes and respond to the HMO within 15 business days. If the Department does not respond to the request for review within 15 business days of submission, the PIHP must contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

2. New Subcontracts

The PIHP must submit new subcontracts to the Department for review and approval before they take effect. If the Department does not respond to the request for review within 15 business days of submission, the PIHP must

contact the Managed Care Compliance Section Chief in the Bureau of Benefits Management. A response will be prepared within five business days of this contact.

C. 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 and Medicaid Members, including but not limited to the proposed subcontractor's past performance. The Department will:

1. 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.

2. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the PIHP.

3. 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.

4. Ensure that the PIHP has included the standard subcontract language as specified in section A of this Article (except for specific provisions that are inapplicable in a specific PIHP management subcontract).

D. 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 either approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

E. Notification Requirements Regarding Subcontract Additions or Terminations

The PIHP must:

1. Notify the Department of Additions or Terminations

The PIHP must notify the Department within 10 days of subcontract additions or terminations involving:

(i) A clinic or group of physicians,
(ii) An individual physician,
(iii) An individual mental health provider and/or clinic,
(iv) An individual dental provider and/or clinic.

This Department notification must be through the submission of an updated provider network to the FTP server.

2. Notify the Department of a Termination or Modification that Involves Reducing Access to Care

The PIHP must notify the Department within seven 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 reduce a FCMH member's access to care. The Department notification must be to both the Bureau of Benefits Management and through the submission of an updated provider network to the FTP 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 to receive services through Medicaid FFS.

In addition to the monthly submission, the HMO 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 HMO's operations that would affect adequate capacity and services.

3. Notify Members of Provider Terminations

Not less than 30 days prior to the effective date of the termination, the PIHP must send written notification to members whose PCP, mental health provider, gatekeeper or dental clinic terminates a contract with the PIHP. The Department must approve all notifications before they are sent to Members.

F. Management Subcontracts

The Department will review PIHP management subcontracts to ensure that:

1. Rates are reasonable.

2. They clearly describe the services to be provided and the compensation to be paid.

3. 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.

4. The requirements addressed in 1 through 3 do not have to relate to non-Medicaid members if the PIHP wishes to have separate arrangements for non-Medicaid Members.

ARTICLE XI

XI. REMEDIES FOR VIOLATION, BREACH, OR NON-PERFORMANCE OF CONTRACT

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 for the member to enroll in another PIHP if one is available in their service area, or the member may receive benefits through FFS.

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 services required under this contract or that 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 member 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.

D. Withholding of Monthly Payments and Orders to Provide Services

Notwithstanding the provisions of the contract, the Department may withhold portions of monthly payments as liquidated damages or otherwise recover damages from the PIHP on the following grounds:

1. Whenever the Department determines that the PIHP has failed to provide one or more of the medically necessary Medicaid covered services required by this contract, the Department may either order the PIHP to provide such service, or withhold a portion of the PIHP's monthly 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 monthly payments an amount up to 150% of the FFS 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:

   a. If the Department withheld payments, it will restore the full monthly payment to the PIHP; or

   b. 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.

2. 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 PIIHP's monthly payments.

   Notwithstanding the preceding paragraph, the Department may be damaged by the PIHP's failure to submit complete encounter data prior to submission deadlines. If the Department is 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.

3. If the PIHP fails to comply with state and federal reporting and compliance requirements for abortions, hysterectomies and sterilizations, the Department may impose liquidated damages in the amount of $10,000.

4. The term "erred encounter record" means an encounter record that failed an edit when a correction is expected by the Department, unless the record remains listed as an "erred encounter record" but is priced for inclusion 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. The liquidated damage amount will be deducted from the PIHP's monthly 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.

   The following criteria will be used prior to assessing liquidated damages:

   - The Department will calculate a percentage rate by dividing the number of erred records not corrected within 90 days (numerator), by the total number of records in error (denominator) and multiply the result by 100.

   - Records failing non-critical edits, as defined in the Wisconsin Medicaid Encounter User Guide, will not be included in the numerator.

   - If this rate is 2% or less, liquidated damages will not be assessed.

   - The Department will calculate this rate each month.

   - 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 encounter data monthly for all claims adjudicated in the prior month.

- If it is found that the PIHP submitted inaccurate encounter data that was used in the development of the current rates, the Department may assess damages associated with the reporting error. The damages will be the priced amount of the inaccurate encounter records.

5. Whenever the Department determines that the PIHP has failed to perform administrative functions, the Department may withhold a portion of future monthly 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. For the purposes of this section, "administrative function" is defined as any contract obligation other than the actual provision of contract services.

6. In any case under this Contract where the Department has the authority to withhold monthly payments, the Department also has the authority to use all other legal processes for the recovery of damages.

7. Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of monthly payments under this Contract, the following procedures will be used:

   a. 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.

   b. 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.

   c. 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 Wisconsin Medicaid Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

d. If the PIHP submits any other required data or report but in the required format within five business days from the deadline, the Department will rescind liquidated damages and immediately process the data or report.

e. 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 an action plan to comply with the contract requirements that must meet Department approval.

f. 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 A, Suspension of New Enrollment, or from Section B, Department-Initiated Enrollment Reductions, or both, in addition to liquidated damages that may have been imposed for a current violation.

g. 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 monthly 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.

8. Withholding of Monthly Payments and Orders to Provide Services

Payments to the PIHP under this 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 of 42 CFR 438.730.

9. Failure to successfully report usable data using the ASC X12 837 HIPAA Compliant Transaction or the Medical Loss Ratio Report information may result in a 1% withhold to the PIHP's administration rate. The amount will be withheld from the capitation 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.

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 monthly 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 or 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. Sanctions

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 Medicaid 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 so 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.

G. Sanctions and Remedial Actions

The Department may pursue all sanctions and remedial actions with the PIHP that are taken with Medicaid FFS providers, including any civil penalties in the following specified amounts:

- 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.

- A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or to the State.

- 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).

- 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).

- Appointment of temporary management for a PIHP as provided in 42 CFR 438.706.

H. Temporary Management

The State will impose temporary management 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

- There is substantial risk to members' health; or
- 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.

ARTICLE XII

XII. TERMINATION AND MODIFICATION OF CONTRACT

A. Termination by Mutual Consent

This Contract may be terminated at any time by mutual written agreement of both the PIHP and the Department.

B. Unilateral Termination

This Contract between the parties may be terminated by either party as follows:

1. Either party may terminate this Contract at any time, due to modifications mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this Contract. At least 90 days prior to the proposed date of termination, the party initiating the termination must notify the other party of its intent to terminate this Contract. Termination by the Department under these circumstances shall impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.

2. 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 this 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. A "substantial failure to perform" for purposes of this paragraph 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.

3. Either party may terminate this Contract if federal or state funding of contractual services rendered by the Contractor become or will become permanently unavailable. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will be temporarily suspended or unavailable, the Department shall immediately notify the Contractor, in writing, identifying the basis

for the anticipated unavailability or suspension of funding. Upon such notice, the Department or the Contractor may suspend performance of any or all of the Contractor's obligations under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or Contractor shall attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the Contractor may remove suspension hereunder by written notice to the Department, to be made within 30 calendar days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor shall give the Department written notice of its reasons for such decision, to be made within 30 calendar days from the date the funds are reinstated. The Contractor shall make such decision in good faith and will provide to the Department documentation supporting its decision. In the event of termination under this Section, this Contract shall terminate without termination costs to either party.

C. Obligations of Contracting Parties Upon Termination

When termination of the Contract occurs, the following obligations must be met by the parties:

1. Where this Contract is terminated unilaterally by the Department due to non-performance by the PIHP or by mutual consent with termination initiated by the PIHP:

    a. The Department will be responsible for notifying all members of the date of termination and process by which the members will continue to receive contract services.

    b. The PIHP will be responsible for all expenses related to said notification.

    c. The Department will grant the PIHP a hearing before termination by the Department occurs. The Department will notify the members of the hearing and allow them to disenroll from the PIHP.

2. Where this Contract is terminated on any basis not given in 1 above including non-renewal of the contract for a given contract period:

    a. The Department will be responsible for notifying all members of the date of termination and process by which the members will continue to receive contract services.

b. The Department will be responsible for all expenses relating to said notification.

3. Where this contract is terminated for any reason the following payment criteria will apply:

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. The PIHP will supply all information necessary for the reimbursement of any outstanding Medicaid claims within the period of time specified by the Department.

c. If a contract is terminated, recoupments will be handled through a payment by the PIHP within 90 days of contract termination.

D. Modification

This Contract may be modified at any time by written mutual consent of the PIHP and the Department or when modifications are mandated by changes in federal or state laws, rules or regulations. If changes in state or federal laws, rules or regulations require the Department to modify its contract with the PIHP, the PIHP will receive written notice.

If the Department exercises its right to renew this Contract, the Department will recalculate the monthly rate for succeeding calendar years. The PIHP will have 30 days to accept the new monthly rate in writing or to initiate termination of the Contract. If the Department changes the reporting requirements during the contract period, the PIHP shall have 180 days to comply with such changes or to initiate termination of the Contract.

ARTICLE XIII

XIII. 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 Department's interpretation and/or application.

ARTICLE XIV

XIV. 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.

A. Duty of Non-Disclosure and Security Precautions

The 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 reporoduced 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.

B. Limitations on Obligations

The obligations of confidentiality assumed by Contractor pursuant to this Agreement shall not apply to the extent Contractor can demonstrate that suche information:

- Is part of the public domain without any breach of this Agreement by Contractor;
- Is or becomes generally known on a non-confidential basis, through no wrongful act of contractor;
- Was known by Contractor prior to disclosure hereunder without any obligation to keep it confidential;
- Was disclosed to it by a third party which, to the best of Contractor's knowledge, is not required to maintain its confidentiality;
- Was independently developed by Contractor; or
- 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.

C. 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.

D. Unauthorized Use, Disclosure, or Loss

If Contractor 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 (Contract Manager/Contact Liaison/Privacy Officer) within the same business day the Contractor 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 Contractor shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The Contractor 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:

1. 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.

2. Notify consumer reporting agencies of the unauthorized release.

3. 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.

4. 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.

5. Adequately staff customer service telephone lines to assure an actual wait time of less than five (5) minutes for callers.

If the unauthorized use, disclosure, or loss is of Individually Identifiable Health Information, Contractor shall, at its own cost, 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. In addition, the Contractor will take other measures as are directed by the State as part of a Corrective Action Plan.

E. Trading Partner requirements under HIPAA

For the purposes of this section, Trading Partner means the PIHP

1. Trading Partner Obligations

   a. 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)).

b. 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)).

c. 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)).

d. 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)).

e. 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.

2. 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)).

3. Trading Partners or Trading Partner's Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.

4. Trading Partner or their Business Associate agrees to cure transaction errors or deficiencies identified by the Department.

5. 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).

6. 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)).

7. 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 of 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.

8. Security

a. 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.

b. 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.

F. Indemnification and Equitable Relief

Indemnification: In the event of a breach of this Section by Contractor, Contractor 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 Contractor, 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 Contractor 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.

Equitable Relief: The Contractor 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.

G. Liquidated Damages

The Contractor 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 Contractor in writing of the assessment. The Contractor 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:

1. $100 for each individual whose Confidential Information was used or disclosed;

2. $100 per day for each day that the Contractor fails to substantially comply with the Corrective Action Plan under this Section.

3. Damages under this Section shall in no event exceed $50,000 per incident.

H. Compliance Reviews

The State may conduct a compliance review of the Contractor’s security procedures to protect Confidential Information.

I. Survival

This Section shall survive the termination of the Agreement.

ARTICLE XV

XV. DOCUMENTS CONSTITUTING CONTRACT

A. Current Documents

In addition to this base agreement, the Contract between the Department and the PIHP includes the Addenda following the Contract, the reporting documentation manual, existing Medicaid Provider publications addressed to the PIHP, the terms of the most recent FCMH certification application issued by this Department, any questions and answers released pursuant to FCMH certification application by the Department, and the PIHP's signed application. The terms of the FCMH application are part of this contract even if the PIHP has a contract to serve other Medicaid populations. In the event of any conflict in provisions among these documents, the terms of this contract shall prevail. The provisions in any question and answer document will prevail over the FCMH certification application. The FCMH certification application terms shall prevail over any conflict with the PIHP's actual signed application.

B. Future Documents

The PIHP is required by this Contract to comply with all future ForwardHealth 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.

ARTICLE XVI

XVI. DISCLOSURE STATEMENT(S) OF OWNERSHIP OR CONTROLLING INTEREST IN A PIHP AND BUSINESS TRANSACTIONS

A. Ownership or Controlling Interest Disclosure Statement(s)

The PIHP agrees to submit to the Department full and complete information as to the identity of each person or corporation with an ownership or controlling interest in the PIHP, or any subcontractor in which the PIHP has a 5% or more ownership interest.

1. A "person with an ownership or controlling interest" means a person or corporation that:

   a. Owns, directly or indirectly, 5% or more of the PIHP's capital or stock or receives 5% or more of its profits

   b. Has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the PIHP or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the PIHP; or

   c. Is an officer or director of the PIHP (if it is organized as a corporation or is a partner in the PIHP (if it is organized as a partnership).

2. Calculation of 5% Ownership or Control is as follows:

   The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

   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.

   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.

3. Information to be Disclosed

The following information must be disclosed:

a. The name and address of each person with an ownership or controlling interest of 5% or more in the PIHP or in any subcontractor in which the PIHP has direct or indirect ownership of 5% or more;

b. A statement as to whether any of the persons with ownership or controlling interest is related as spouse, parent, child, or sibling to any other of the persons with ownership or controlling interest; and

c. The name and address of any other organization in which the person also has ownership or controlling interest. This is required to the extent that the PIHP can obtain this information by requesting it in writing. The PIHP must keep copies of all of these requests and the responses to them, make them available upon request, and advise the Department when there is no response to a request. The address for corporate entities must include a primary business address, every business location, and P.O. Box address

d. The date of birth and Social Security number for individuals, or the tax ID number for corporations with an ownership or controlling interest of 5% or more in the PIHP, or if any subcontractor in which the PIHP has direct or indirect ownership of 5% or more.

e. Disclosures are due upon submission of the provider application, upon execution of the Medicaid contract, upon recertification of the PIHP, and within 35 days of any change in ownership.

4. Potential Sources of Disclosure Information

This information may already have been reported on Form HCFA-1513, "Disclosure of Ownership and Controlling Interest Statement." Form HCFA-1513 is likely to have been completed in two different cases. First, if the PIHP is federally qualified and has a Medicare contract, it is required to file Form HCFA-1513 with CMS within 120 days of the PIHP's fiscal year end. Secondly, if the PIHP is owned by or has subcontracts with Medicaid providers that are reviewed by the state survey agency, these providers may have completed Form HCFA-1513 as part of the survey process. If Form HCFA-1513 has not been completed, the PIHP may supply the ownership and controlling 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 the information that must be disclosed, 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.

B. Business Transaction Disclosures

The PIHP that is not federally qualified must disclose to the Department information on certain types of transactions they have with a "party in interest" as defined in the Public Health Service Act. (See Sections 1903(m)(2)(A)(viii) and 1903(m)(4) of the Act.)

1. Party In Interest as defined in Section 1318(b) of the Public Health Service Act, is:

   a. Any director, officer, partner, or employee responsible for management or administration of an PIHP and HIO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the PIHP; any person who is the beneficial owner of more than 5% of the PIHP; or, in the case of an PIHP organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;

   b. Any organization in which a person described in subsection a., 1) above is director, officer or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the PIHP; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the PIHP;

   c. Any person directly or indirectly controlling, controlled by, or under common control with an PIHP; or

   d. Any spouse, child, or parent of an individual described in subsections 1, 2, or 3 above.

2. Business Transactions That Must Be Disclosed Include:

   a. Any sale, exchange or lease of any property between the PIHP and a party in interest.

   b. Any lending of money or other extension of credit between the PIHP and a party in interest.

   c. Any furnishing for consideration of goods, services (including management services) or facilities between the PIHP and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment.

3. Information That Must Be Disclosed In The Transactions Between the PIHP and a Party In Interest Includes:

   a. The name of the party in interest for each transaction.

   b. A description of each transaction and the quantity or units involved.

   c. The accrued dollar value of each transaction during the fiscal year.

   d. Justification of the reasonableness of each transaction.

If the 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 preceding 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.

ARTICLE XVII

XVII. MISCELLANEOUS

A. 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:

1. Any failure, inability, or refusal of the PIHP or any of its subcontractors to provide contract services.

2. The negligent provision of contract services by the PIHP or any of its subcontractors.

3. Any failure, inability or refusal of the PIHP to pay any of its subcontractors for contract services.

B. 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.

C. 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.

D. Choice of Law

This Contract is be 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. Headings

The article and section headings used herein are for reference and convenience only and do not affect its interpretation.

J. 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.

K. Right to Publish

The PIHP must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

L. Media Contacts

The PIHP agrees to forward to the Department all media contacts regarding the FCMH Program or its members.

ARTICLE XVIII

XVIII. PIHP SPECIFIC CONTRACT TERMS

A. Initial Contract Period

The respective rights and obligations of the parties as set forth in this Contract shall commence on January 1, 2014, and, unless earlier terminated as specified in this contract, shall remain in full force and effect through December 31, 2015. The specific terms for enrollment and rates are as specified in the Contract.

B. Renewals

By mutual written agreement of the parties, there may be a one-year renewal of the terms of the Contract. An agreement to renew must be effected at least 90 calendar 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.

C. Specific Terms of the Contract

The specific terms agreed to as set forth in this Contract. The Contract rates to which the PIHP agrees are indicated by the Department.

1. The counties in the PIHP's designated service area are: Milwaukee, Waukesha, Racine, Kenosha, Washington and Ozaukee.

2. Maximum Enrollment Limit: (5,000). The number of enrollees may exceed the maximum by up to 5% on a temporary basis. The Department does not guarantee any minimum enrollment level.

3. The nonrisk prepaid rates in this contract will be paid for the covered population as follows:

    a. Initial rate for January 1, 2014 to (December 31, 2014) for the eligible enrollees.

    b. Initial rate will be reconciled as specified in Article VI, Section A.2.

4. The respective rights and obligation of the parties as set forth in this contract shall commence on January 1, 2014, and unless earlier terminated under this contract, shall remain in full force and effect through December 31, 2015.

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

Prepaid Inpatient Health Plan	State of Wisconsin
Official Signature	Official Signature
Title	Title
Date	Date

ADDENDUM I

STANDARD MEMBER HANDBOOK LANGUAGE

This handbook is available in English. For help understanding this information, please call the Customer Service Department at [1-800-xxx-xxxx].

Este manual esta disponible en espanol. Si Ud. quisiera ayuda para entender esta información, por favor llame al Departamento de Servicios para Consumidores, al número [1-800-xxx-xxxx.

Phau ntawv no muaj ua lus Care4Kids ob. Yog koj xav tau kev pab kom koj to taub zoo daim ntawv los yog cov xov ntawm no, koj hu tau rau Customer Service Department tus xov tooj [1-800-xxx-xxxx.

Если вам не всё понятно в этом документе, позвоните по телефону [1-800-xxx-xxx] (TTY).

Important Care4Kids Phone Numbers:

Customer Service	[1-800-xxx-xxxx]	[Hours/Days Available]
Emergency Number	[1-800-xxx-xxxx]	Call 24 hours a day, 7 days a week
TDD/TTY	[1-800-xxx-xxxx]	

WELCOME

Welcome to Care4Kids.The Care4Kids Member handbook is for the parent/legal guardian and the out-of-home care provider of children placed in out-of-home care. As a member ofCare4Kids, your child enrolled in Care4Kids will receive all their health care from Care4Kidsdoctors, hospitals, and pharmacies. See Care4Kids Provider Directory for a list of these providers. You may also call our Customer Service Department at [1-800-xxx-xxxx]. Providers not accepting new patients are marked in the Provider Directory.

Health Care Coordinator -- Care4Kids matches your child with a Health Care Coordinator to help your child with medical and social service needs. Call your Health Care Coordinator at [PIHP NAME]:

- To assist in choosing a primary care provider
- To help you get medical services.
- When you have questions about your child's health care.

Call your Health Care Coordinator directly during business hours or call our CUSTOMER SERVICE OFFICE at [phone number].

YOUR CHILD'S FORWARDHEALTH ID CARD

Always carry your child's ForwardHealth ID card with you, and show it every time your child gets care. You may have problems getting care or prescriptions if you do not have your child's card with you. Also bring any other health insurance cards you may have. It is important to inform providers of your child's enrollment in Care4Kids.

PRIMARY CARE PHYSICIAN (PCP)

It is important to call your child's primary care physician (PCP) first when the child needs care. This doctor will manage all your child's health care. If you think your child needs to see another doctor, or a specialist, ask your PCP. Your PCP will help you decide if your child needs to see another doctor, and give you a referral. Remember you must get approval from your child's PCP before seeing another doctor.

You can choose your primary care physician (PCP) from those available. NOTE: Young women may also see a women's health specialist (for example a OB/GYN doctor or a nurse midwife) without a referral, in addition to choosing a PCP.) There are Care4Kids doctors who are sensitive to the needs of many cultures. To choose a PCP, or to change your child's PCP, call our Customer Service Department at [1-800-xxx-xxxx].

URGENT CARE

Urgent Care is care needed sooner than a routine doctor's visit. Urgent care is not emergency care. Do not go to a hospital emergency room for urgent care unless your child's doctor tells you to go there. Some examples of urgent care are:

- Minor cuts
- Sprains
- Bruises
- Non-severe bleeding
- Most drug reactions
- Minor burns

If your child needs urgent care, call [insert instructions here—call clinic, doctor, 24-hour number, nurse line, etc.] We will tell you where you can get care for your child. You must get urgent care from Care4Kids doctors unless you get our approval to see a doctor that is not a Care4Kids doctor.

Remember, do not take your child to a hospital emergency room for urgent care unless you get approval from Care4Kids first.

EMERGENCY CARE

Emergency care is care needed right away. An injury or a sudden illness may cause this. Some examples are:

Choking	Severe or unusual bleeding
Trouble breathing	Suspected poisoning
Broken bones	Head injuries
Unconsciousness	High fever
Severe burns	Severe pain
Prolonged or repeated seizures	

If your child needs emergency care, go to a Care4Kids provider for help if you can. BUT, if the emergency is severe, go to the nearest provider (hospital, doctor or clinic). You may want to call 911 or your local police or fire department emergency services if the emergency is severe.

If you must go to a hospital or provider that is not a Care4Kids provider call the health care coordinator at [1-800-xxx-xxxx] as soon as you can and tell us what happened. This is important so we can help you get follow up care.

Remember, hospital emergency rooms are for true emergencies only. Call your child's doctor or our 24-hour emergency number at [1-800-xxx-xxxx] before you go to the emergency room, unless the emergency is severe.

HOW TO GET MEDICAL CARE WHEN YOU ARE AWAY FROM HOME

Follow these rules if your child needs medical care but is too far away from home to go to the assigned primary care physician (PCP) or clinic.

For severe emergencies, go to the nearest hospital, clinic, or doctor.

For urgent or routine care away from home, you must get approval from us to go to a different doctor, clinic or hospital. Call us at [1-800-xxx-xxxx] for approval to go to a different doctor, clinic, or hospital.

PREGNANT WOMEN AND DELIVERIES

Your child must go to a hospital that is in the Care4Kids network to have her baby. Talk to her Care4Kids doctor to make sure you understand which hospital she is to go to when it's time to have her baby.

Also, talk to her doctor if she plans to travel in her last month of pregnancy. Because we want her to have a healthy birth and a good birthing experience, it may not be a good time for her to be traveling. We want her to have a healthy birth and her Care4Kids doctor knows her history and is the best doctor to help her have a healthy birth.

WHEN YOU MAY BE BILLED FOR SERVICES

It is very important to follow the rules when your child gets medical care so the parent/legal guardian or out-of-home care provider is not billed for services. Your child must receive care from Care4Kids providers, hospitals, and pharmacies unless you have Care4Kids approval. The only exception is for severe emergencies.

IF YOU ARE BILLED

If you receive a bill for services, call our Customer Service Department at [1-800-xxx-xxxx]. You do not have to pay for services that Care4Kids is required to provide you.

OTHER INSURANCE

If the child has other insurance in addition to Care4Kids you must tell their doctor or other provider. The health care provider must bill the other insurance before billingCare4Kids. If the child's Care4Kids doctor does not accept their other insurance, call the Care4Kids Enrollment Specialist at 1-800-291-2002. The Enrollment Specialist can tell you how to match the child's Care4Kids enrollment with their other insurance so you can use both insurance plans.

SERVICES COVERED BY [PIHP NAME]

Care4Kids provides all medically necessary covered services. Some services may require a doctor's order or a prior authorization. Covered services include:

- Prescription drugs and certain over-the counter drugs when ordered by a doctor
- Services by doctors and nurses, including nurse practitioners and nurse midwives
- Inpatient and outpatient hospital services
- Laboratory and X-ray services
- HealthCheck for members under 21 years of age, including referral for other medically necessary services
- Certain podiatrists' (foot doctors) services
- Inpatient care at institutions for mental disease
- Optometrists' (eye doctors) or opticians' services, including eyeglasses
- Mental health treatment
- Substance abuse (drug and alcohol) services
- Family planning services and supplies
- The following services when a doctor gives a written order:
    - Prostheses and other corrective support devices

- Hearing aids and other hearing services
- Home health care
- Personal care
- Independent nursing services
- Medical supplies and equipment
- Occupational therapy
- Physical therapy
- Speech therapy
- Respiratory therapy
- Nursing home services
- Medical nutrition counseling
- Hospice care
- Appropriate transportation to obtain medical care by ambulance or specialized medical vehicles

- Certain dental services (not all dental services are covered).

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Care4Kids provides mental health and substance abuse (drug and alcohol) services to all children enrolled in Care4Kids. If your child needs these services, please contact the PCP, health care coordinator, or customer services as appropriate. If your child is in crisis contact the crisis intervention agency at [xxx-xxx-xxxx]

FAMILY PLANNING SERVICES

We provide confidential family planning services to all Members. This includes minors. If your child does not want to talk to their primary care doctor about family planning, call the health care coordinator at [1–800-xxx-xxx]. The health care coordinator will help them choose a Care4Kids doctor who is different from their primary care doctor.

Your child can also go to any family planning clinic that will accept your child's Forward ID card even if the clinic is not part of Care4Kids. But we encourage your child to receive family planning services from a Care4Kids doctor. That way we can better coordinate all health care.

DENTAL SERVICES

Care4Kids provides all covered dental services. But you must take your child to a Care4Kids dentist. See the Care4Kids Provider Directory or call the Health Care Coordinator for assistance in locating and scheduling an appointment.

HEALTHCHECK

HealthCheck is a preventive health checkup program for members under the age of 21. The HealthCheck program covers complete health checkups. These checkups are very important for children's health. Your child may look and feel well, yet may have a health problem. Your doctor wants to see your children for regular checkups, not just when they are sick.

The HealthCheck health program has three purposes:

(1) To find and treat children's health problems early,
(2) To let you know about the special child health services you can receive, and
(3) To make your children eligible for some health care not otherwise covered.

The HealthCheck program covers the care for any health problems found during the checkup including medical care, eye care and dental care.

The HealthCheck checkup includes:

(1) a health history
(2) physical exam
(3) developmental and/or mental health screening
(4) hearing and vision test
(5) blood and urine lab tests
(6) complete immunizations (shots)

Children age one and older will be referred to a dentist. You will receive help in choosing and getting to a dentist.

Ask your child's primary care doctor (PCP) when your child should have his/her next HealthCheck exam or call the Health Care Coordinator at [1-800-xxx-xxxx] for more information.

TRANSPORTATION

Non-emergency medical transportation to receive care are arranged by MTM. Call MTM at [1-800-xxx-xxxx] if you need a ride.

AMBULANCE

Care4Kids covers ambulance service for Emergency Care. We may also cover this service at other times, but you must have approval for all non-emergency ambulance trips. Call our Customer Service Department at [1-800-xxx-xxxx] for approval.

SECOND MEDICAL OPINION

A second medical opinion on recommended surgeries may be appropriate in some cases. Contact your child's doctor or the health care coordinator for information.

LIVING WILL OR POWER OF ATTORNEY FOR HEALTH CARE

The child's parent/legal guardian has a right to make decisions about the child's medical care. The parent/legal guardian has a right to accept or refuse medical or surgical treatment for the child. The parent/legal guardian also has the right to plan and direct the types of health care the child may receive in the future if they become unable to express their wishes. The parent/legal guardian can let their child's doctor know about their feelings by completing a living will or power of attorney for health care form. Contact the child's doctor for more information. The out-of-home care provider has no right to authorize any health care services or complete a living will for their child.

RIGHT TO MEDICAL RECORDS

You or your child has the right to ask for copies of their medical record from their provider(s). We can help you get copies of these records. Please call the health care coordinator at [1-800-xxx-xxxx] for help. Please note: There may be a charge for copying your child's medical record. Your child may correct wrong information in the medical records if their doctor agrees to the correction.

[PIHP NAME'S] MEMBER ADVOCATE

Care4Kids has a Member Advocate to help the parent/legal guardian get the needed care for their child. The Advocate can answer questions about getting health care from Care4Kids. The Advocate can also help solve any problems getting health care for your child from Care4Kids. The Advocate can be reached at [1-800-xxx-xxxx].

STATE OF WISCONSIN PIHP OMBUDS PROGRAM

The State has Ombuds who can help the parent/legal guardian with any questions or problems regarding the Care4Kids member. The Ombuds can tell the parent/legal guardian how to get the care their child needs from Care4Kids. The Ombuds can also help the parent/legal guardian solve problems or complaints they may have about the Care4Kids Program. The parent/legal guardian should call 1-800-760-0001 and ask to speak to an Ombuds.

COMPLAINTS

We would like to know if you have a complaint about your child's care atCare4Kids. Please call Care4Kid's Member Advocate at [1-800-xxx-xxxx] if you have a complaint. Or you can write to us at:

[Care4Kids name and mailing address]

If you want to talk to someone outside of Care4Kids about the problem, call the Care4Kids enrollment specialist at [1-800-xxx-xxx]. The enrollment specialist may be able to help you solve the problem, or can help you write a formal complaint to Care4Kids or to the State Department of Health Services. The address to complain to the Care4Kids Program is:

Medicaid
Care4Kids Ombuds
P.O. Box 6470
Madison, WI 53716

We cannot treat your child differently than other members because you file a complaint. Your child's health care benefits will not be affected.

WHEN BENEFITS ARE DENIED (FAIR HEARINGS)

The child's parent/legal guardian may appeal to the state if they believe the child's benefits are unfairly denied, limited, reduced, delayed or stopped by Care4Kids. An appeal must be made not later than 45 days after the date of the action being appealed. To appeal to the state, the child's parent/legal guardian should call the Care4Kids Ombuds at 1-800-760-0001. Or the child's parent/legal guardian can write to the Care4Kids Ombuds at:

Medicaid
Care4Kids Ombuds
P.O. Box 6470
Madison, WI 53716

The child's parent/legal guardian has the right to appeal to the State of Wisconsin Division of Hearings and Appeals for a Fair Hearing if they believe the child's benefits are unfairly denied, limited, reduced, delayed or stopped by Care4Kids. An appeal must be made no later than 45 days after the date of the action being appealed. If the child's parent/legal guardian appeals this action to DHA before the effective date, the child enrolled in Care4Kids may continue to get the service.

If the child's parent/legal guardian wants a Fair Hearing, they must send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

The hearing will be held in the county where the child's parent/legal guardian lives. Your child has the right to be represented at the hearing. If your child needs a special arrangement for a disability, or for English language translation, please call (608) 266-3096 (voice) or (608) 264-9853 (hearing impaired).

We cannot treat your child differently than other members because the parent/legal guardian requests a Fair Hearing. Your child's health care benefits will not be affected.

If the parent/legal guardian needs help writing a request for a Fair Hearing, please call:

Medicaid Ombuds	1-800-760-0001
or	
Enrollment Broker	1-800-291-2002

PHYSICIAN INCENTIVE PLAN

You are entitled to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services your child might need. To get this information, call our Customer Service Department at [1-800-xxx-xxxx] and request information about our physician payment arrangements.

PROVIDER CREDENTIALS

You and your child have the right to information about our providers that includes the provider's education, Board certification and recertification. To get this information, call our Customer Service Department at [1-800-xxx-xxxx].

CHILD'S BILL OF HEALTH CARE RIGHTS

You have the right to ask for an interpreter and have one provided to you during any Care4Kids-covered service.

You have the right to receive the information provided in this member handbook in another language or another format.

Your child has the right to receive health care services as provided for in federal and state law. All covered services must be available and accessible to your child. When medically appropriate, services must be available 24 hours a day, 7 days a week.

Your child has the right to receive age-appropriate information about treatment options.

The child's parent/legal guardian has the right to request a second opinion for their child.

The child's parent/legal guardian has the right to participate in decisions regarding the child's health care, including the right to refuse treatment.

Your child has the right to be treated with dignity and respect.

Your child has the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

YOUR CHILD'S CIVIL RIGHTS

[PIHP NAME] provides covered services to all eligible members regardless of:

- Age
- Race
- Religion
- Color
- Disability
- Sex
- Sexual Orientation
- National Origin
- Marital Status
- Arrest or Conviction Record
- Military Participation

All medically necessary covered services are available to all members.

All services are provided in the same manner to all members.

All persons or organizations connected with [PIHP Name] who refer or recommend members for services shall do so in the same manner for all members.

Translating or interpreting services are available for those members who need them. This service is free.

RIGHT TO VOLUNTARILY DISENROLL

The child's parent/legal guardian has the right to voluntarily disenroll their child from Care4Kids at any time for any reason. The date of disenrollment shall be the last day of the month in which the disenrollment was requested. If you, the parent/legal guardian, would like to disenroll your child from Care4Kids please contact the Care4Kids Enrollment Specialist at [1-800-xxx-xxx].

INVOLUNTARY DISENROLLMENT

Care4Kids may request and the Department may approve an involuntary disenrollment of your child when there is a situation where enrollment in Care4Kids would be harmful to the interests of the child or when Care4Kids cannot provide the child with appropriate medically necessary contract services for reasons beyond Care4Kids' control. Just cause for involuntary disenrollment may include, but is not limited to: the child's parent/legal guardian refusing critical services or is unwilling to meet significant conditions of participation; the child has demonstrated a history of physical aggression which places others and/or self at risk; the parent/legal guardian has a history of willful noncompliance with an essential treatment plan, which has resulted in significant physical risk to the child; or the child or child's parent/legal guardian refuses an essential component of the treatment plan.

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), Bureau of Milwaukee Child Welfare (BMCW) 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.

A. Proposed components of the Comprehensive Initial Health Assessment include:

1. 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.

2. A standard medical review of systems.

B 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.

C. 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.

D. 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.

E. 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.

F. Growth and nutritional assessment including measurement of height, weight, BMI (and head circumference for children <3 years old).

G. Immunization review.

H. Hearing/vision screen with referral as indicated.

I. Dental/oral inspection with referral as indicated.

J. 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.

K. 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).

L. 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.

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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 Bureau of Milwaukee Child Welfare (BMCW) 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 BMCW or the county child welfare agency, out-of-home care family, birth family, and other service providers.

Coordination Goals

A. 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.

B. 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.

C. 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.

D. 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.

E. To facilitate coordination and communication among developmental and mental health providers involved in an individual child's care.

F. To communicate and coordinate developmental and behavioral/mental health services with the BMCW or county child welfare agency.

G. 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.

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.

2. 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

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ADDENDUM IV

EXAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN CHILDRENS COMMUNITY HEALTH PLAN (CCHP) AND THE (INSERT BUREAU OF MILWAUKEE CHILD WELFARE OR COUNTY CHILD WELFARE AGENCY)

Purpose

This document represents an agreement between Children's Community Health Plan (CCHP) and the {insert child welfare agency name]. Specifically, this memorandum is written to identify roles and responsibilities between the CCHP 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 CCHP 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 CCHP 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 BMCW 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.

Children's Community Health Plan (CCHP) Rights and Responsibilities:

A. CCHP 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.
B. CCHP 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.
C. CCHP 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 CCHP will provide court ordered services in accordance with the contract.
D. CCHP'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.
E. CCHP's responsibilities related to the Out-of-Home Care Health Screening includes the following:
    a. If needed, CCHP 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.

F. CCHP'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. CCHP 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.

G. CCHP'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.

H. CCHP'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.

I. CCHP'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.

J. CCHP'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 CCHP 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 enrollees, stratified by age and number of medications prescribed.
    i. Other activities required by the contract.

K. CCHP's responsibilities related to the Discharge from Out-of-Home Care includes the following:
    a. Prior to discharge from out-of-home care, the CCHP 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.

L. CCHP'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.

M. CCHP's liaison, or other appropriate staff as designated by CCHP, 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.

N. The CCHP liaison and [insert the agency] will determine who will be responsible for ensuring that the Member receives the services authorized and provided through CCHP. CCHP 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.

O. CCHP agrees to participate in dispute resolution using the following process:

a. CCHP will provide the agency with contact information for the designated personnel who will respond to disputes.
b. The [Insert agency name] and CCHP 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 CCHP designees (known as the team) are unable to resolve the issues, the [insert agency name] and the CCHP 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.

P. CCHP 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.
Q. CCHP will share with the [insert agency name] the process and procedure for prior authorization and out-of-plan referrals.
R. Annually and when requested by the [insert agency name], CCHP 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, CCHP'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.
S. CCHP will participate in the [insert agency name] site managers' meetings when requested by [insert agency name].
T. The CCHP will share client specific information to assist [insert agency name] in any court-related proceedings.

[Insert agency name] Rights and Responsibilities:

A. [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.
B. [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.
C. It is the [insert agency name]s' responsibility to initiate contact with the CCHP 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 CCHP services.

D. [insert agency name] will involve CCHP 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.
E. [Insert agency name] will utilize CCHP's provider network for routine services and will attempt to utilize CCHP's provider network for emergency services. [Insert agency name] will obtain criteria from the CCHP concerning [insert agency name]'s ability to utilize non-participating providers and the mechanism for authorizing non-participating providers.
F. [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 CCHP.
G. [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 CCHP.
H. [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 CCHP.
I. [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 CCHP.
J. [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 CCHP.
K. [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 CCHP.

L. [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 CCHP.

M. [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.

N. [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 CCHP.

O. [Insert agency name] agrees to participate in dispute resolution using the following process:
   a. [Insert agency name] and CCHP 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 CCHP designees (known as the team) are unable to resolve the issues the [Insert agency name] and CCHP 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.

P. [Insert agency name] will assist CCHP 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.

Q. [Insert agency name] agrees to provide training to CCHP staff or CCHP's provider network on child welfare issues at the request of the CCHP.

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, [CCHP] 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 Benefits Management within 14 days from the date the request was received by the PIHP.

The birth cost report forms follows this page.

Care4Kids PIHP 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 Benefits Management 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 Benefits Management
ATTN: Birth Costs, Room 350
P.O. BOX 309
MADISON, WI 53701-0309

FAX To:
Bureau of Benefits Management
ATTN: Birth Costs
(608) 266-1096

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 Benefits Management
ATTN: Birth Costs, Room 350
P.O. Box 309
Madison, WI 53701-0309

FAX To:
Bureau of Benefits Management
ATTN: Birth Costs
(608) 266-1096

B. PIHP Newborn Report

This 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 requirements for the Newborn Report can be found at:
https://www.forwardhealth.wi.gov/kw/pdf/2011-26.pdf

C. Member Complaint and Grievance Reporting Forms

Grievance Experience Summary Report

Summarize each FCMH grievance reviewed in the past quarter. The log must distinguish FCMH members from other Medicaid and commercial members, if the PIHP serves both populations. If the PIHP does not have a separate log for FCMH members, the log must distinguish between the programs.

The PIHP should report in sections 1. through 3. below only those members that grieved or appealed to the PIHP's grievance appeal committee.

a. Grievances Related to Program Administration

Member Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

b. Grievance Related to Benefit Denial/Reduction

Member Identification Number	Date Grievance Filed	Nature of Grievance	Date Resolved	Summary of Grievance Resolution	Administrative Changes as a Result of Grievance Review

c. Summary

SUBTOTAL: Program Administration _____
SUBTOTAL: Benefit Denial/Reduction _____
TOTAL NUMBER OF GRIEVANCES _____

PIHP Reporting Form for Member Complaints

_____

PIHP Name

☐ First Quarter
☐ Second Quarter
☐ Third Quarter
☐ Fourth Quarter
☐ Calendar Year 2010
☐ Calendar Year 2011

TYPE OF COMPLAINT	TOTAL NUMBER OF COMPLAINTS
1. ACCESS PROBLEMS	
2. BILLING ISSUES	
3. QUALITY OF CARE	
4. DENIAL OF SERVICE	
5. OTHER SPECIFY	

General Definitions

1. Access problems include any problem identified by the PIHP that causes a member to have difficulty getting an appointment, receiving care, or on culturally appropriate care, including the provision of interpreter services in a timely manner.

2. Billing issues include the denial of a service or a member receiving a bill for a FCMH covered service that the PIHP is responsible for providing or arranging for the provision of that service.

3. Quality of care includes long waiting times in the reception area of providers' offices, rude providers or provider staff, or any other complaint related directly to patient care.

4. Denial of service includes any FCMH covered service that the PIHP denied.

5. Others as identified by the PIHP.

Return the completed form to:

Bureau of Benefits Management
Department of Health Services
1 W. Wilson Street, Room 350
Madison, WI 53701-0309

D. Attestation Form

ATTESTATION

I, _____, have reviewed the following data:
(Name and Title)

☐ Encounter Data for _____ quarter 20___.
☐ Abortion Sterilization and Hysterectomy Report for quarter _____ for 200___.
☐ AIDS Report
☐ PPACA Primary Care Rate Increase Payment for (quarter) _____(year) 20__.

☐ Other _____
(Specify Report)

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.

(PIHP Name)	Will maintain these claims for a period of five years from the date of contract termination.
(Signature)	(Date)
(Print Name)	(Print Date)

E. Summary Hospital Access Payment Report to Department of Health Services

This report will be provided to the PIHP electronically in the 2014-2015 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 20 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**	

* Total payments made to all hospitals should be equal to the total amount the PIHP received from the Department. The distribution of these funds by the PIHP to hospitals shall be based on eligible discharges and visits 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)

F. Summary Ambulatory Surgical Center (ASC) Access Payment Report to Department of Health Services

This report will be provided to the PIHP electronically in the 2014-2015 PIHP contract for completion. ASC Access Payments must be sent to the ambulatory surgical centers 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 ASC within 20 calendar days of payment from the Department:

PIHP Name	
Month, Year payment was received from the Department	
Month, Year from which claim is being reported (i.e. previous month)	
Date the last ASC access payment was sent	
*** Grand Total Payment**	

Ambulatory Surgical Center (ASC) Access Payment

* Total payments made to all ambulatory surgical centers (ASCs) should be equal to the total amount the PIHP received from the Department. The distribution of these funds by the PIHP to ASCs shall be based on eligible visits in the prior month paid by the PIHP to eligible ASCs. If the PIHP has no qualifying visits, the PIHP shall return the payment to the Department and indicate this on the form.

1	2	3	4	5	6	7	8
MA ID	**NPI**	**ASC Name**	**Funding Received from DHS**	**Number of Claims Paid to the Individual ASC**	**Number of Total Claims by PIHP to All Eligible ASCs**	**Percent of the ASC's Total Claims Paid by the PIHP (Column 5 / Column 6)**	**Payment to ASC for Claims (Column 4 x Column 7)**
		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. Summary of the PPACA Primary Care Report to the Department of Health Services

This report will be provided to the PIHP electronically for completion. Payments must be sent to the primary care providers within 30 calendar days after the PIHP receives the payment from the Department. The PIHP must submit back to the Department the information outlined in Article VI – Financial Requirements and Reimbursement, Section E, of the contract.

The actual PPACA Primary Care Report format can be found in the HMO Report Matrix on the Forward Health Portal. The link to the website is: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/hmomatrix.htm.spage

An example of the report is provided below. The PIHP must use the most updated version of the report found on the link above.

Field Name	Maximum Field Length	Field Description
TRADING PARTNER ID	15	ID Number of the Submitting Trading Partner
HMO ID	8	Submitting HMO ID for the encounter
PROVIDER NPI	10	Rendering Provider NPI
PROVIDER LAST NAME	30	Rendering Provider Last Name
PROVIDER FIRST NAME	15	Rendering Provider First Name
PROVIDER TAX ID	9	Tax ID associated with the rendering provider on the encounter
PROVIDER TAX ID NAME	40	Name associated with the Tax ID for the rendering provider on
PROVIDER 1ST ADDRESS LINE	30	Rendering Provider Address Line 1
PROVIDER 2ND ADDRESS LINE	30	Rendering Provider Address Line 2
CITY	30	Rendering Provider Address City
STATE	2	Rendering Provider Address State
ZIP CODE	9	Rendering Provider Address Zip Code
ICN NUMBER	13	ICN Number of the Encounter with PPACA Supplemental Payr
DETAIL LINE	4	Detail Line Number of the impacted Encounter record
PROVIDER CONTROL NUMBER	38	The header level claim identifier value submitted on the 837 for identifying the encounter
PROCEDURE CODE	6	Procedure code from the impacted Encounter record
FDOS	8	From Date of Service for the impacted Encounter record
Encounter Paid Amount	12	Medicaid Paid Amount for the impacted Encounter record
PPACA Paid Amount	12	PPACA Paid Amount for the impacted Encounter record
NET PPACA SUPPLEMENT	12	Difference between PPACA Paid amount and Medicaid Paid an
DISTRIBUTED TO PROVIDER BY HMO (Y/N)	17	Indicator from the HMO detailing whether the supplemental pa the provider
AMOUNT DISTRIBUTED TO PROVIDER BY HMO	15	The amount paid to the provider related to ACA enhancement

HMO PPACA PRIMARY CARE CASH REPORT TO HMOS - MONTH OF PROCESSING XXXXXXXX

REPORT DATA: MM/DD/YY

		RENDERING PROVIDER					RENDERING PROVIDER MAILING ADDRESS					CLAIM/DETAIL INFORMATION					
TRADING PARTNER ID XXXXXXXXX	HMO ID XXXXXXXX	PROVIDER NPI YYYYYYYYYY	PROVIDER LAST NAME	PROVIDER FIRST NAME	PROVIDER TAX ID	PROVIDER TAX ID NAME	PROVIDER 1ST ADDRESS LINE	PROVIDER 2ND ADDRESS LINE	CITY	STATE	ZIP CODE	ICN NUMBER	DETAIL LINE	PROVIDER CONTROL NUMBER (RIN)	PROCEDURE CODE	FDOS	Pai
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
XXXXXXXXXX	YYYYYYYY	ZZZZZZZZZZ	Adams	Frank	XXXXXXXXX	Frank Adams		123 JUMP STREET	GREEN BAY	WI	53423	7DXXXXXXX	XXXX	XXXX	XXXXX	MM/DD/YY	
	TOTAL AMOUNT PPACA SUPPLEMENT							123 JUMP STREET	GREEN BAY	WI	53423						

REPORT FORMAT

* Break at each change in HMO ID
* Break at each change in rendering provider ID

ADDENDUM VI

CARE4KIDS QUALITY MEASURES

Program Goals:

The PIHP agrees to calculate and submit all quality measures defined below in accordance with the Foster Care Medical Home (Care4Kids) Quality Measures Operational Guide published by the Department.

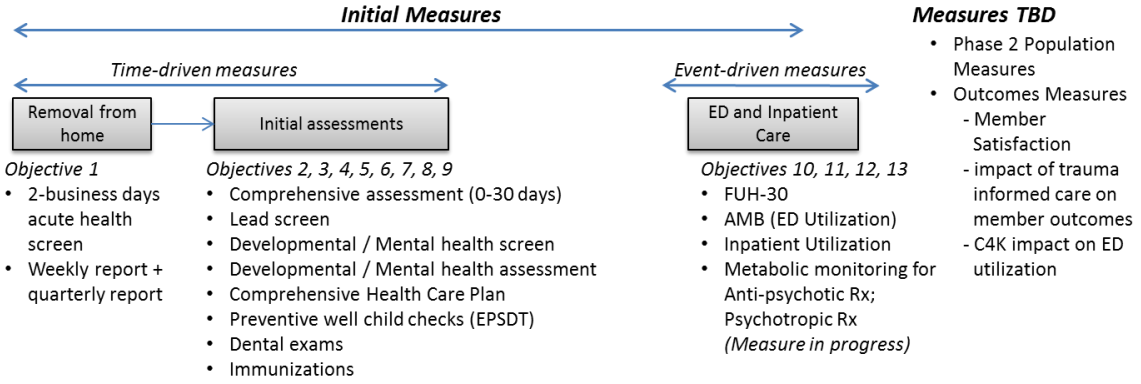
Care4Kids provides comprehensive, coordinated physical, dental, developmental and behavioral health services for children in out of home care delivered through a medical home model
The program has been designed to ensure that children in out of home care receive high quality, trauma-informed health care that includes early screening and comprehensive health assessment at the time of entry into out of home care, an enhanced schedule of well child checks, and access to dental and evidence-informed behavioral health services.

The Care4Kids medical home will provide comprehensive and coordinated health care services based on a child-centric, individualized treatment plan. Care is integrated across multiple elements of the broader health care system including primary and specialty care, dental, developmental, behavioral health, inpatient hospital, and community services and supports. Expected outcomes include improved quality, timeliness and access to necessary health services, as well as coordinated health service delivery including transitional planning, to assure continuity of health care throughout the child's stay in out of home care and up to an additional twelve months after discharge from out of home care.

Phases:
The evaluation plan will have several phases:

1. Initial Measures focus primarily on process objectives that track timely access to care and service utilization including the out of home care health screen and comprehensive initial health assessment, care plan development, measures of clinical prevention services (developmental and behavioral health screenings, immunizations, dental, etc.)and access to needed mental health services including oversight of psychotropic medications. These measures will be used to begin to establish baselines.
2. Measures TBD may include impact of Care4Kids on emergency department visits and hospitalizations, population health, trauma-informed practice and service delivery, and methods to measure child and/or caregiver satisfaction with Care4Kids health care coordination, provider network, and service delivery. .

Overview of measures:



Objectives and Measures:

Objective 1: Out of Home Care Health Screen is completed within 2 business days of the child's removal date.

Measure: 1: Number and % of children who had a timely health screen

Numerator: Children newly entering out of home care in the report period with health screen completed before the end of the day on the second business day from the removal date (example: youth removed on 1/1/14, screen completed before the end of 1/3/14).

Denominator: All children newly entering out of home care in the report period.

Comment:

1. Newborns being detained from the birth hospital are an exemption, per Article III, E (2).
2. Children detained from an inpatient hospital setting are an exemption, per Article III, E (2).
3. Children taken into protective custody at the time of or subsequent to the completion of a forensic evaluation may be granted an exemption under specific circumstances, per Article III, E (2)
4. Children with an out-of-home care placement date prior to January 1, 2014 are an exemption, per Article III, E (2).
5. Report will break down screens at CAC/CPC and other locations.

Note: a weekly operational report documenting % of children who had a timely screen, using data from CHW database, will be provided to DHS for monitoring timely access. This weekly operational report will not need to be reconciled with the quarterly report for this measure, since the data for the two reports will come at different times and from different sources.

Tracking Purposes Only: Number and % of children who had a health screen.

Numerator: Children newly entering out of home care in the report period that had a completed health screen before the end of the day up to 7 business days from the removal date.

Denominator: All children newly entering out of home care in the report period.

Comment:

1. Newborns being detained from the birth hospital are an exemption, per Article III, E (2).
2. Children detained from an inpatient hospital setting are an exemption, per Article III, E (2).
3. Children who receive a physical abuse or sexual abuse exam at a CPC/CAC within 72 hours prior to removal are an exemption, per Article III, E (2).
4. Children with an out-of-home care placement date prior to January 1, 2014 are an exemption, per Article III, E (2).
5. Report will break down screens at CAC/CPC and other locations.
6. Report will be stratified by day of completion (business day #3-7) and include how many "missed" (aka did not receive out of home care health screen within 7 business days)

Objective 2: Within 30 days of enrollment in Care4Kids, children will have a comprehensive initial assessment of their health that includes either a developmental screen or a mental health screen, depending on their age on the date of the exam.

Measure: 2(a): Number and % of children newly enrolled in Care4Kidsduring the report period who have a Comprehensive Initial Health Assessment completed within 30 days of their enrollment date.

Numerator: Children newly enrolled in Care4Kids during the report period with a completed Comprehensive Initial Health Assessment within 30 days of their enrollment date.

Denominator: All children newly enrolled in Care4Kids in the report period.

Comment:

1. Track separately children receiving expected Comprehensive Initial Health Assessment between 30 and 45 days.
2. Report will break out Comprehensive Initial Health Assessments that take place at COEs
3. Children with out of home care placement dates prior to January 1, 2014 will be reflected as "compliant" in the calculation if they are up to date with HealthCheck periodicity and have documentation of the most recent HealthCheck that occurred during their out of home care placement

Measure: **2(b): Number and % of children newly enrolled in Care4Kids that had a completed Comprehensive Initial Health Assessment, who receive an expected screen (developmental or mental health) as part of the Comprehensive Initial Health Assessment.**

Numerator: Children age 60+ days newly enrolled in Care4Kids during the report period who receive a completed developmental or a mental health screen documented as part of their Comprehensive Initial Health Assessment.

Denominator: All children age 60+ days newly enrolled in Care4Kids during the report period with a completed Comprehensive Initial Health Assessment.

Objective 3: **All children enrolled in Care4Kids 2 years of age will be screened for lead poisoning.**

Measure: **3: Number and % of children enrolled in Care4Kids 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday (HEDIS 2014, LSC specifications).**

Numerator: All children enrolled in Care4Kids who turned 2 years of age during the report period, with a completed lead screen (at least one lead capillary or venous blood test on or before the child's second birthday).

Denominator: All children enrolled in Care4Kids who turned 2 years of age during the report period.

Objective 4: **Children newly enrolled in Care4Kids screened as needing a developmental assessment receive a developmental assessment.**

Measure: **4: Of children newly enrolled in Care4Kids whose Comprehensive Initial Health Assessment indicated a need for a developmental assessment, number and % who had a completed and documented developmental assessment.**

Numerator: Children (2-60 months in age) newly enrolled in Care4Kids during the report period with a completed developmental screen as a part of the Comprehensive Initial Health Assessment that indicated the need for a developmental assessment and who have a documented developmental assessment.

Denominator: All children (2-60 months in age) newly enrolled in Care4Kids during the report period who were screened as needing a developmental assessment as part of their completed Comprehensive Initial Health Assessment.

Comment:

1. Report will be stratified by distribution: % of developmental assessments completed within 30 days; within 60 days; after 60 days of the Comprehensive Initial Health Assessment date; and not completed.

Objective 5: Children newly enrolled in Care4Kids screened as needing a mental health assessment receive a mental health assessment.

Measure: 5: Of children newly enrolled in Care4Kids whose Comprehensive Initial Health Assessment indicated a need for a mental health assessment, number and % who had a completed and documented mental health assessment.

Numerator: All children newly enrolled in Care4Kids during the report period who were identified as needing a mental health assessment during their Comprehensive Initial Health Assessment, and have a documented completed mental health assessment.

Denominator: All children newly enrolled in Care4Kids during the report period who were identified as needing a mental health assessment as part of their completed Comprehensive Initial Health Assessment.

Comment:

1. Report will be stratified by distribution: % of mental health assessments completed within 30 days; within 60 days; after 60 days of the Comprehensive Initial Health Assessment date; and not completed.

Objective 6: All children enrolled in Care4Kids will have an up-to-date Comprehensive Health Care Plan.

Measure: 6(a): Number and % of Comprehensive Health Care Plans developed within 60 days of enrollment in Care4Kids.

Numerator: All children newly enrolled in Care4Kids within the report period with a Comprehensive Health Care Plan developed within 60 days of enrollment in Care4Kids.

Denominator: All children newly enrolled in Care4Kids during the report period.

Comment:

1. If a member is re-enrolled less than six months after the member's last disenrollment, the member's previously developed Comprehensive Health Care Plan may be used. The Comprehensive Health Care Plan must be reviewed and updated if indicated.
   Per Article VIII, G (2).

Measure: 6(b): Number and % of Comprehensive Health Care Plans that have been updated once in the last six-months.

Numerator: All children enrolled in Care4Kids during the report period who have a Comprehensive Health Care Plan that has been updated within six months from the date of the previous Comprehensive Health Care Plan.

Denominator: All children enrolled in Care4Kids during the report period who have a Comprehensive Health Care Plan.

Objective 7: All children enrolled in Care4Kids will be up to date with expected HealthCheck periodicity.

Measure: 7(a): Number and % of children who are up to date with expected HealthCheck exams as defined by the enhanced periodicity schedule.

Numerator: All children enrolled in Care4Kids who are up to date with their last expected HealthCheck exam during the reporting period as defined by the enhanced periodicity schedule.

Denominator: All children enrolled in Care4Kids.

Comment:

1. Enhanced periodicity schedule for well child exams:
    - Every month for the first 6 months of age;
    - Every three months between ages 6 months and 2 years of age;
    - Twice a year after 2 years of age
2. Where applicable, the Comprehensive Initial Health Assessment will count as the last expected HealthCheck exam following which the recommended enhanced periodicity schedule will apply.
3. Compliance is defined to allow the following age-related variance regarding the date of completion of the last expected HealthCheck exam:
    - For children ages 6 months and under during the report period: the allowable variance includes the 20 days subsequent to the expected date of completion
    - For children ages 7 months to 24 months during the report period: the allowable variance includes the 30 days subsequent to the expected date of completion
    - For children ages 25 months and older during the report period: the allowable variance includes the 60 days subsequent to the expected date of completion

Objective 8: Children enrolled in Care4Kids age 12 months and older will be seen twice yearly for comprehensive dental exams. Children age 12 months and older with no previous comprehensive dental exam history will receive a comprehensive dental exam within 3 months of enrollment.

Measure 8a: Number and % of children newly enrolled in Care4Kids who received a comprehensive dental exam within 3 months of enrollment.

Numerator: Number of children age 12 months and older newly enrolled in Care4Kids during the report period who received an initial comprehensive dental exam within 3 months of their enrollment date.

Denominator: All children ages 12 months and older newly enrolled in Care4Kids during the report period that did not have a comprehensive dental exam documented in the 3 months prior to their enrollment.

Comments:

1. If there is no record of a comprehensive dental exam in the 6 months prior to enrollment, the initial comprehensive dental exam must be completed within 3 months from the date of enrollment
2. If a comprehensive dental exam occurred before 3 months prior to the date of enrollment, the initial comprehensive dental exam must be completed within 3 months from the date of enrollment
3. If a comprehensive dental exam occurred within 3 months prior to the date of enrollment, the initial comprehensive dental exam must be completed within 6 months from the date of the documented comprehensive dental exam – these children are not included in the above measure.

Measure: **8b: Number and % of children enrolled in Care4Kids expected to receive a comprehensive dental exam during the report period that received a comprehensive dental exam.**

Numerator: All children enrolled in Care4Kids with an expected date of next dental exam during the report period that received a comprehensive dental exam during the report period.

Denominator: All children enrolled in Care4Kids with an expected date of next dental exam during the report period.

Objective 9: **Children enrolled in Care4Kids will be fully immunized within 6 months of enrollment (HEDIS 2014, Childhood Immunization Status (CIS) Combo 2 and Immunization for Adolescents (IMA)).**

Measure: **9a: Number and % of children enrolled in Care4Kids that receive Immunization HEDIS 2014, CIS Combo 2.**

Numerator: All children enrolled in Care4Kids who turned 2 years of age during the report period that are up to date on all CIS Combo 2 immunizations.

Denominator: All children enrolled in Care4Kids who turned 2 years of age during the report period.

Measure **9b: Number and % of children enrolled in Care4Kids that receive Immunization HEDIS 2014, Immunization for Adolescents (IMA)**

Numerator: All children enrolled in Care4Kids who turned 13 years of age during the report period that have had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) (HEDIS 2014, IMA).

Denominator: All children enrolled in Care4Kids who turned 13 years of age during the report period.

Objective 10: **HEDIS Measure for Outpatient MH Follow Up within 30 days following Inpatient MH Hospitalization**

Measure: **10: –Number and % of children 6 years of age and older enrolled in Care4Kids who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge for treatment of selected mental health disorders (HEDIS 2014, FUH-30 specifications).**

Numerator: Children 6 years of age or more enrolled in Care4Kids during the report period with an outpatient visit, intensive outpatient encounter or partial hospitalization (Table FUH-C) with a mental health practitioner within 30 days after discharge for treatment of selected mental health disorders. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

Denominator: All children 6 years of age or more enrolled in Care4Kids during the report period who were hospitalized and discharged for treatment of selected mental health disorders.

Objective 11: Emergency Department Utilization

Measure: **11: % of children enrolled in Care4Kids who utilize the emergency department for care (HEDIS 2014, AMB measure without revenue code 0456).**

Numerator: All children enrolled in Care4Kids during the report period that have emergency department (ED) visits.

Denominator: All children enrolled in Care4Kids during the report period.

Comment:

1. This is a utilization measure (# of ED visits per 1000 member months). The HEDIS AMB measure has two components – ED and Outpatient visits. This measure focuses only on ED visits and excludes revenue code 0456 which pertains to Urgent Care.
2. Measure excludes ED visits that resulted in an inpatient admission

Objective 12: Inpatient Hospital Utilization

Measure: **12: Number and % of children enrolled in Care4Kids who have 1 or more inpatient hospital stay(s) during the reporting period.**

Numerator: All children enrolled in Care4Kids during the report period that have one or more inpatient hospital stays (excluding inpatient mental health hospitalizations)

Denominator: All children enrolled in Care4Kids during the report period

Objective 13: Anti-Psychotic medication measures

Measure: **13a: Number and % of children starting on anti-psychotic medication after entering Care4Kids 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.**

Measure: **13b: Number and % of children already on anti-psychotic medication before entering Care4Kids program, 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.**

Measure: **13c: 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.**

Objective 14: Psychotropic medication measure:

Measure: **14: Number and % of children who met the polypharmacy criteria, and for whom an interdisciplinary team case review was performed.**
(The precise criteria for polypharmacy are yet to be finalized).

Comments:

1. The interdisciplinary case review must be performed within 60 days of the provider being alerted of the child's polypharmacy status.
2. There should be documentation of the outcome of the meeting results in the child's updated care plan, including any recommended action steps and follow up.

ADDENDUM VII

RATES

	Reconciled Cost		Non-Reconciled Cost			
	Total Benefit PMPM		Administrative PMPM		Final Rate	
Age Group	Title IV-E	Non Title IV-E	Title IV-E	Non Title IV-E	Title IV-E	Non Title IV-E
Age 0	$919.66	$894.54	$150.18	$145.74	$1,069.84	$1,040.28
Ages 1-5	$559.41	$523.65	$86.60	$80.29	$646.01	$603.94
Ages 6-14	$613.30	$588.63	$96.11	$91.76	$709.41	$680.38
Ages 15-20 F	$742.39	$674.95	$118.89	$106.99	$861.28	$781.94
Ages 15-20 M	$618.10	$628.58	$96.96	$98.81	$715.06	$727.39
All Ages	$631.12	$610.24	$99.26	$95.57	$730.38	$705.81

EXHIBIT 1

Wisconsin Department of Health Services							Exhibit 1

Rate Setting for Care4Kids Member Months and PMPM Summary

Selection Criteria Updated, November 2013

Member Months Summary		Title IV-E			Non Title IV-E			Total		
Eligibility	**Age Group**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**
CCF/WAM	Age 0									
	Ages 1-5									
	Ages 6-14	454	572	892	648	705	305	1,102	1,277	1,197
	Ages 15-20 F	281	440	656	429	378	203	710	818	859
	Ages 15-20 M	328	621	1,386	1,443	1,323	565	1,771	1,944	1,951
CCF/WAM Total		1,063	1,633	2,934	2,520	2,406	1,073	3,583	4,039	4,007
All Other	Age 0	2,581	3,137	3,285	2,022	1,993	1,784	4,603	5,130	5,069
	Ages 1-5	12,248	14,503	17,249	7,261	8,528	9,864	19,509	23,031	27,113
	Ages 6-14	11,505	13,332	16,016	9,003	9,285	10,673	20,508	22,617	26,689
	Ages 15-20 F	3,718	4,185	5,180	4,577	4,683	4,157	8,295	8,868	9,337
	Ages 15-20 M	3,566	4,219	5,255	5,953	6,211	5,858	9,519	10,430	11,113
All Other Total		33,618	39,376	46,985	28,816	30,700	32,336	62,434	70,076	79,321
All Eligibility Categories	Age 0	2,581	3,137	3,285	2,022	1,993	1,784	4,603	5,130	5,069
	Ages 1-5	12,248	14,503	17,249	7,261	8,528	9,864	19,509	23,031	27,113
	Ages 6-14	11,959	13,904	16,908	9,651	9,990	10,978	21,610	23,894	27,886
	Ages 15-20 F	3,999	4,625	5,836	5,006	5,061	4,360	9,005	9,686	10,196
	Ages 15-20 M	3,894	4,840	6,641	7,396	7,534	6,423	11,290	12,374	13,064
All Eligibility Categories Total		34,681	41,009	49,919	31,336	33,106	33,409	66,017	74,115	83,328

PMPM Summary		Title IV-E			Non Title IV-E			Total		
Eligibility	**Age Group**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**
CCF/WAM	Age 0									
	Ages 1-5									
	Ages 6-14	$105.81	$131.16	$94.55	$143.85	$138.67	$76.42	$128.18	$135.30	$89.93
	Ages 15-20 F	$202.59	$224.79	$173.74	$213.54	$189.52	$200.50	$209.21	$208.49	$180.07
	Ages 15-20 M	$119.64	$171.28	$112.91	$257.95	$221.14	$68.48	$232.33	$205.21	$100.05
CCF/WAM Total		$135.66	$171.65	$120.93	$221.05	$192.01	$95.72	$195.72	$183.77	$114.18
All Other	Age 0	$395.88	$518.01	$706.72	$707.72	$424.18	$424.42	$532.86	$481.56	$607.37
	Ages 1-5	$189.28	$181.23	$150.92	$134.20	$125.16	$133.29	$168.78	$160.47	$144.51
	Ages 6-14	$292.73	$248.76	$202.41	$283.47	$205.23	$165.00	$288.66	$230.89	$187.45
	Ages 15-20 F	$411.55	$363.52	$386.11	$347.55	$301.89	$276.53	$376.24	$330.97	$337.32
	Ages 15-20 M	$305.60	$265.37	$196.06	$282.28	$215.94	$285.15	$291.02	$235.93	$243.02
All Other Total		$277.47	$259.31	$238.31	$285.56	$214.11	$205.74	$281.20	$239.51	$225.03

EXHIBIT 2A

Wisconsin Department of Health Services			Exhibit 2a			

Rate Setting for Care4Kids
Rate Cell PMPM by Broad Category of Service and Calendar Year
CCF/WAM Eligibles

		CCF/WAM								
		Title IV-E			Non Title IV-E			Total		
Service Category	**Age Group**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**
Hospital Inpatient	Age 0									
	Ages 1-5									
	Ages 6-14	$13.39	$20.48	$11.88	$5.89	$5.51	$0.00	$8.98	$12.21	$8.85
	Ages 15-20 F	$28.03	$39.23	$23.67	$27.35	$23.08	$45.97	$27.62	$31.77	$28.94
	Ages 15-20 M	$0.00	$6.15	$28.33	$5.50	$9.16	$0.00	$4.48	$8.20	$20.12
Hospital Inpatient Total		$13.13	$20.08	$22.29	$9.32	$10.28	$8.70	$10.45	$14.24	$18.65
Hospital Outpatient	Age 0									
	Ages 1-5									
	Ages 6-14	$28.77	$25.94	$27.29	$24.88	$20.97	$24.86	$26.49	$23.20	$26.67
	Ages 15-20 F	$56.28	$47.96	$42.97	$51.42	$32.64	$42.93	$53.34	$40.88	$42.96
	Ages 15-20 M	$32.44	$13.60	$15.38	$16.62	$16.10	$14.25	$19.55	$15.30	$15.06
Hospital Outpatient Total		$37.18	$27.18	$25.17	$24.67	$20.13	$22.69	$28.38	$22.98	$24.51
NH, HHC, PC, PDN	Age 0									
	Ages 1-5									
	Ages 6-14	$0.57	$2.99	$0.00	$0.00	$0.00	$0.00	$0.23	$1.34	$0.00
	Ages 15-20 F	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Ages 15-20 M	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
NH, HHC, PC, PDN Total		$0.24	$1.05	$0.00	$0.00	$0.00	$0.00	$0.07	$0.42	$0.00
Physician	Age 0									

	Ages 1-5									
	Ages 6-14	$23.79	$30.66	$22.85	$21.78	$28.27	$16.43	$22.61	$29.34	$21.21
	Ages 15-20 F	$64.93	$68.57	$46.62	$50.92	$61.13	$46.30	$56.46	$65.13	$46.54
	Ages 15-20 M	$21.91	$22.53	$24.98	$21.65	$23.70	$14.56	$21.70	$23.32	$21.96
Physician Total		$34.09	$37.79	$29.17	$26.67	$30.92	$21.09	$28.87	$33.69	$27.01
Other	Age 0									
	Ages 1-5									
	Ages 6-14	$24.16	$36.75	$15.20	$74.97	$65.24	$18.94	$54.04	$52.48	$16.16
	Ages 15-20 F	$34.28	$49.82	$39.05	$68.70	$52.17	$50.65	$55.07	$50.91	$41.79
	Ages 15-20 M	$47.84	$104.48	$24.67	$193.66	$154.92	$26.81	$166.65	$138.81	$25.29
Other Total		$34.14	$66.03	$25.01	$141.87	$112.50	$29.08	$109.91	$93.71	$26.10
Dental	Age 0									
	Ages 1-5									
	Ages 6-14	$15.14	$14.33	$17.33	$16.32	$18.68	$16.19	$15.83	$16.73	$17.04
	Ages 15-20 F	$19.08	$19.20	$21.44	$15.16	$20.50	$14.65	$16.71	$19.80	$19.84
	Ages 15-20 M	$17.45	$24.51	$19.54	$20.52	$17.26	$12.87	$19.95	$19.58	$17.61
Dental Total		$16.89	$19.51	$19.29	$18.53	$18.19	$14.15	$18.04	$18.72	$17.92

All Services and Ages	$135.66	$171.65	$120.93	$221.05	$192.01	$95.72	$195.72	$183.77	$114.18

Wisconsin Department of Health Services

Exhibit 2a

Rate Setting for Care4Kids
Rate Cell PMPM by Broad Category of Service and Calendar Year
All Other FFS Eligibles

		All Other Title IV-E			Non Title IV-E			Total		
Service Category	**Age Group**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**	**2009**	**2010**	**2011**
Hospital Inpatient	Age 0	$183.03	$326.67	$482.25	$467.11	$220.57	$269.39	$307.82	$285.45	$407.33
	Ages 1-5	$14.41	$38.90	$22.63	$19.86	$19.58	$21.06	$16.44	$31.75	$22.06
	Ages 6-14	$50.78	$35.17	$36.14	$82.57	$39.73	$24.73	$64.73	$37.04	$31.58
	Ages 15-20 F	$155.42	$139.45	$156.93	$141.94	$85.05	$81.19	$147.98	$110.72	$123.21
	Ages 15-20 M	$114.71	$80.07	$56.40	$98.07	$50.53	$148.88	$104.30	$62.48	$105.15
Hospital Inpatient Total		$66.03	$75.66	$77.95	$106.38	$54.97	$66.86	$84.66	$66.60	$73.43
Hospital Outpatient	Age 0	$44.51	$31.39	$45.07	$48.19	$33.50	$30.18	$46.13	$32.21	$39.83
	Ages 1-5	$32.02	$23.84	$23.75	$33.81	$22.48	$21.81	$32.69	$23.33	$23.04
	Ages 6-14	$23.22	$21.80	$20.77	$27.98	$18.51	$17.26	$25.31	$20.45	$19.37
	Ages 15-20 F	$46.50	$41.66	$45.61	$41.19	$37.43	$47.72	$43.57	$39.42	$46.55
	Ages 15-20 M	$23.47	$26.62	$27.45	$25.33	$24.11	$22.38	$24.64	$25.13	$24.78
Hospital Outpatient Total		$30.66	$25.94	$27.05	$32.42	$24.60	$24.20	$31.47	$25.36	$25.89
NH, HHC, PC, PDN	Age 0	$2.84	$19.08	$27.63	$8.04	$32.71	$14.14	$5.12	$24.38	$22.88
	Ages 1-5	$35.75	$12.95	$22.50	$4.15	$5.64	$8.53	$23.99	$10.24	$17.42
	Ages 6-14	$1.03	$11.98	$11.19	$14.78	$1.98	$3.39	$7.06	$7.87	$8.07
	Ages 15-20 F	$0.00	$0.00	$0.00	$1.09	$4.18	$0.25	$0.60	$2.21	$0.11
	Ages 15-20 M	$1.83	$1.09	$0.00	$0.06	$6.58	$15.19	$0.72	$4.36	$8.01

NH, HHC, PC, PDN Total		$13.79	$10.46	$14.00	$6.41	$6.26	$7.29	$10.38	$8.62	$11.27
Physician	Age 0	$108.28	$95.81	$103.87	$136.70	$94.03	$81.79	$120.76	$95.12	$96.10
	Ages 1-5	$32.43	$35.54	$29.01	$31.65	$29.93	$29.43	$32.14	$33.46	$29.16
	Ages 6-14	$17.76	$18.45	$19.31	$22.78	$19.36	$17.64	$19.97	$18.82	$18.64
	Ages 15-20 F	$42.06	$39.74	$48.23	$42.85	$41.76	$38.38	$42.50	$40.81	$43.85
	Ages 15-20 M	$15.90	$18.36	$16.69	$20.26	$18.50	$19.50	$18.63	$18.44	$18.17
Physician Total		$32.54	$33.16	$31.68	$35.68	$30.38	$27.78	$33.99	$31.95	$30.09
Other	Age 0	$57.17	$44.98	$47.75	$47.62	$43.29	$28.83	$52.97	$44.32	$41.09
	Ages 1-5	$67.16	$61.31	$46.23	$36.53	$39.24	$43.01	$55.76	$53.13	$45.06
	Ages 6-14	$185.03	$147.08	$101.08	$122.16	$112.25	$88.11	$157.43	$132.78	$95.89
	Ages 15-20 F	$149.06	$125.18	$117.46	$102.56	$118.01	$94.60	$123.40	$121.39	$107.28
	Ages 15-20 M	$137.66	$125.44	$83.17	$125.03	$104.72	$68.79	$129.76	$113.10	$75.59
Other Total		$123.27	$102.71	$77.02	$92.83	$86.85	$68.41	$109.22	$95.76	$73.51
Dental	Age 0	$0.05	$0.09	$0.17	$0.05	$0.07	$0.09	$0.05	$0.08	$0.14
	Ages 1-5	$7.52	$8.69	$6.81	$8.20	$8.30	$9.45	$7.77	$8.55	$7.77
	Ages 6-14	$14.91	$14.27	$13.92	$13.20	$13.41	$13.88	$14.16	$13.92	$13.90
	Ages 15-20 F	$18.51	$17.49	$17.88	$17.91	$15.48	$14.38	$18.18	$16.43	$16.32
	Ages 15-20 M	$12.03	$13.78	$12.37	$13.54	$11.49	$10.41	$12.97	$12.42	$11.33
Dental Total		$11.17	$11.38	$10.61	$11.84	$11.05	$11.20	$11.48	$11.23	$10.85

All Services and Ages	$277.47	$259.31	$238.31	$285.56	$214.11	$205.74	$281.20	$239.51	$225.03

EXHIBIT 2B

Wisconsin Department of Health Services

Exhibit 2b

Rate Setting for Care4Kids
Rate Cell PMPM by Broad Category of Service - CY2009-11 Blended Average
CCF/WAM and All Other FFS Eligibles

		CY2009-11 Average								
		CCF/WAM			All Other			CCF/WAM and All Other		
Service Category	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
Hospital Inpatient	Age 0				$342.26	$321.55	$334.15	$342.26	$321.55	$334.15
	Ages 1-5				$25.70	$20.23	$23.69	$25.70	$20.23	$23.69
	Ages 6-14	$14.80	$4.65	$10.09	$39.94	$47.52	$43.09	$38.82	$45.20	$41.48
	Ages 15-20 F	$29.53	$29.50	$29.52	$150.91	$103.26	$126.78	$139.35	$98.10	$118.75
	Ages 15-20 M	$18.45	$6.02	$11.14	$80.00	$98.20	$90.56	$70.65	$83.82	$78.31
Hospital Inpatient Total		$19.92	$9.59	$14.59	$73.86	$75.29	$74.48	$71.44	$71.26	$71.36
Hospital Outpatient	Age 0				$40.14	$37.60	$39.15	$40.14	$37.60	$39.15
	Ages 1-5				$26.08	$25.43	$25.84	$26.08	$25.43	$25.84
	Ages 6-14	$27.24	$23.21	$25.37	$21.80	$20.99	$21.46	$22.04	$21.11	$21.65
	Ages 15-20 F	$47.28	$42.68	$45.34	$44.60	$41.90	$43.23	$44.86	$41.96	$43.41
	Ages 15-20 M	$17.31	$16.01	$16.54	$26.09	$23.95	$24.85	$24.76	$22.71	$23.57
Hospital Outpatient Total		$28.02	$22.49	$25.17	$27.70	$26.91	$27.36	$27.71	$26.64	$27.24
NH, HHC, PC, PDN	Age 0				$17.54	$18.39	$17.88	$17.54	$18.39	$17.88
	Ages 1-5				$23.04	$6.33	$16.89	$23.04	$6.33	$16.89

	Ages 6-14	$1.03	$0.00	$0.55	$8.58	$6.48	$7.71	$8.25	$6.13	$7.36
	Ages 15-20 F	$0.00	$0.00	$0.00	$0.00	$1.91	$0.97	$0.00	$1.77	$0.89
	Ages 15-20 M	$0.00	$0.00	$0.00	$0.85	$7.22	$4.55	$0.72	$6.10	$3.85
NH, HHC, PC, PDN Total		$0.35	$0.00	$0.17	$12.78	$6.67	$10.13	$12.22	$6.26	$9.61
Physician	Age 0				$102.32	$105.14	$103.43	$102.32	$105.14	$103.43
	Ages 1-5				$32.11	$30.22	$31.42	$32.11	$30.22	$31.42
	Ages 6-14	$25.40	$23.56	$24.55	$18.59	$19.79	$19.09	$18.90	$19.99	$19.36
	Ages 15-20 F	$57.37	$53.81	$55.86	$43.76	$41.08	$42.41	$45.06	$41.98	$43.52
	Ages 15-20 M	$23.90	$21.26	$22.35	$17.01	$19.41	$18.40	$18.06	$19.69	$19.01
Physician Total		$32.60	$27.37	$29.90	$32.41	$31.13	$31.85	$32.42	$30.90	$31.75
Other	Age 0				$49.48	$40.35	$45.91	$49.48	$40.35	$45.91
	Ages 1-5				$57.03	$39.92	$50.73	$57.03	$39.92	$50.73
	Ages 6-14	$23.75	$60.53	$40.80	$139.73	$106.43	$125.92	$134.53	$103.95	$121.77
	Ages 15-20 F	$41.52	$58.88	$48.87	$128.91	$105.49	$117.05	$120.59	$102.22	$111.42
	Ages 15-20 M	$49.15	$149.97	$108.42	$111.75	$99.75	$104.79	$102.24	$107.58	$105.35
Other Total		$38.63	$109.91	$75.40	$98.41	$82.24	$91.40	$95.73	$83.93	$90.56
Dental	Age 0				$0.11	$0.07	$0.09	$0.11	$0.07	$0.09
	Ages 1-5				$7.63	$8.71	$8.03	$7.63	$8.71	$8.03
	Ages 6-14	$15.92	$17.30	$16.56	$14.31	$13.52	$13.98	$14.38	$13.72	$14.11
	Ages 15-20 F	$20.24	$17.05	$18.89	$17.93	$15.97	$16.94	$18.15	$16.04	$17.10
	Ages 15-20 M	$20.57	$17.93	$19.02	$12.73	$11.82	$12.20	$13.92	$12.77	$13.25
Dental Total		$18.90	$17.61	$18.24	$11.02	$11.35	$11.16	$11.37	$11.73	$11.53

All Services and Ages	$138.42	$186.98	$163.47	$256.17	$233.58	$246.38	$250.90	$230.72	$242.06

Wisconsin Department of Health Services

Exhibit 3

Rate Setting for Care4Kids

Utilization Adjustments

CCF/WAM and All Other FFS Eligibles

Note: Base data is summarized across CY2009-11 and uniformly applied to all rate cells unless otherwise noted

Care Coordination applicable to All Ages

Twenty instances of T1016 per member month at $10.81 per instance; PMPM value	**$216.20**	A

Mental Health Services applicable to All Ages

1 Increase in utilization for 96110 and 96111		
Claims associated with procedure codes	$30,022	
2009-11 Member Months	223,460	
Value of 10% increased utilization; PMPM value	**$0.01**	B
2 Add procedure code 96101 (rate $65.65) once per year per child		
Unique member count	28,530	
Cost per Unit	$65.65	
2009-11 Member Months	223,460	
Adjustment PMPM Value = Total Unique Members x Cost per Unit / 2009-11 MM	**$8.38**	C
3 Add four instances of procedure code H0004 (rate is per four instances); PMPM value	**$65.72**	D

Physical, Occupational, and Speech Therapies applicable to All Ages

Increase in utilization for select procedure codes in Evaluations, Therapeutic Procedures, Modalities, Speech and Language Pathology, and Other Procedures: 93797, 93798, 94667, 94668

Claims associated with procedure codes	$2,048,326	
2009-11 Member Months	223,460	
Value of 10% increased utilization; PMPM value	**$0.92**	E

HealthCheck (EPSDT) applicable to All Ages

1 Add procedure code 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395

Cost per Unit $57.53	CCF/WAM Title IV-E	CCF/WAM Non Title IV-E	All Other Title IV-E	All Other Non Title IV-E	
1 per Member Month for members 0-5 months old = MM x Cost per Unit					
Ages 0 Member Months (0-5 months)			4,276	2,737	
1 per 3 Member Months for members 6 months - 23 months old = MM / 3 x Cost per Unit					
Ages 0 Member Months (6-11 months)			4,727	3,062	
Ages 1-5 Member Months (12-23 months)			33,788	19,815	
1 per 6 Member Months for members 2 years old and older = MM / 6 x Cost per Unit					
Ages 1-5 Member Months (> 23 months)			10,212	5,838	
Ages 6-20 Member Months	5,630	5,999	66,976	60,400	
Aggregate Adjustment					
Ages 0 PMPM add-on	**$0.00**	**$0.00**	**$37.39**	**$37.28**	F
Ages 1-5 PMPM add-on	**$0.00**	**$0.00**	**$16.95**	**$16.99**	G
Ages 6-20 PMPM add-on	**$9.59**	**$9.59**	**$9.59**	**$9.59**	H

2 Add procedure code 99212 (rate $21.96) once per year per child

Unique member count	28,530	
Cost per Unit	$21.96	
2009-11 Member Months	223,460	
Adjustment PMPM Value = Total Unique Members x Cost per Unit / 2009-11 MM	$2.80	
Average Base Physician PMPM	$31.75	
Adjustment Value = Adjustment PMPM Value / Average Base PMPM	**8.8%**	I

New Enrollee Assessments applicable to All Ages

Add procedure code 99381 (rate $57.53) once per child

Add procedure codes D2150 (rate $45) and D0150 (rate $41.95) once per child

Projected 2014 New Enrollees	2,739

Cost per Unit	$144.48	
Projected 2014 Member Months	14,358	
Adjustment PMPM Value = Projected New Enrollees x Cost per Unit / Projected Member Months	**$27.56**	J

Wisconsin Department of Health Services

Exhibit 3

Rate Setting for Care4Kids

All Adjustments - Summary

CCF/WAM and All Other FFS Eligibles

Trend	Data Period	Contract Period	Contract Period	Trend Factors: Data Period	Trend Factors: Contract Period	Trend Factors: Contract Period	IBNR	Total Trend+IBNR
Hospital Inpatient	0.0%	0.0%	2.1%	1.0000	1.0000	1.0214	1.0048	**1.0263**
Hospital Outpatient	0.0%	0.0%	8.7%	1.0000	1.0000	1.0869	1.0029	**1.0901**
NH, HHC, PC, PDN	0.0%	0.0%	2.1%	1.0000	1.0000	1.0214	1.0045	**1.0260**
Physician	0.0%	0.0%	3.2%	1.0000	1.0000	1.0321	1.0028	**1.0350**
Other	0.0%	0.0%	2.1%	1.0000	1.0000	1.0214	1.0045	**1.0260**
Chiropractic	0.0%	0.0%	3.2%	1.0000	1.0000	1.0321	1.0000	**1.0321**
Dental	0.0%	0.0%	8.7%	1.0000	1.0000	1.0869	1.0000	**1.0869**
			Months of Trend:	**18**	**30**	**12**		

Regional Variation

Statewide PMPM	$242.06
Region 5-6 PMPM	$206.37
Factor to apply to All Rate Cells	**0.8526**

Final Utilization Adjustments Summary - Projected 2014 PMPM

Physician		CCF/WAM		All Other		
Age Group		**Title IV-E**	**Non Title IV-E**	**Title IV-E**	**Non Title IV-E**	**NOTES**
Age 0				$47.34	$47.48	E+F+(I x Respective Base PMPM from Ex 2b)
Ages 1-5				$20.70	$20.58	E+G+(I x Respective Base PMPM from Ex 2b)
Ages 6-14		$12.75	$12.58	$12.15	$12.25	
Ages 15-20 F		$15.57	$15.26	$14.37	$14.13	E+H+(I x Respective Base PMPM from Ex 2b)
Ages 15-20 M		$12.62	$12.38	$12.01	$12.22	

New Service Categories

		CCF/WAM		All Other		
Service Category		**Title IV-E**	**Non Title IV-E**	**Title IV-E**	**Non Title IV-E**	**NOTES**
Care Coordination		$216.20	$216.20	$216.20	$216.20	A
Mental Health		$74.12	$74.12	$74.12	$74.12	B+C+D
New Enrollee Assessments		$27.56	$27.56	$27.56	$27.56	J

EXHIBIT 4A

Wisconsin Department of Health Services

Exhibit 4a

Rate Setting for Care4Kids
CY2015 Blended PMPM with Adjustments
CCF/WAM and All Other FFS Eligibles

Note: All weighted averages calculated based on underlying CY2009-11 member months

CY2009-11 Member Months	CCF/WAM			All Other			CCF/WAM and All Other		
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**
Age 0	0	0	0	9,003	5,799	14,802	9,003	5,799	14,802
Ages 1-5	0	0	0	44,000	25,653	69,653	44,000	25,653	69,653
Ages 6-14	1,918	1,658	3,576	40,853	28,961	69,814	42,771	30,619	73,390
Ages 15-20 F	1,377	1,010	2,387	13,083	13,417	26,500	14,460	14,427	28,887
Ages 15-20 M	2,335	3,331	5,666	13,040	18,022	31,062	15,375	21,353	36,728
All Ages	5,630	5,999	11,629	119,979	91,852	211,831	125,609	97,851	223,460

		CCF/WAM			All Other			CCF/WAM and All Other		
Service Category	**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**
Hospital Inpatient	Age 0	$0.00	$0.00	$0.00	$299.46	$281.34	$292.36	$299.46	$281.34	$292.36
	Ages 1-5	$0.00	$0.00	$0.00	$22.49	$17.70	$20.73	$22.49	$17.70	$20.73
	Ages 6-14	$12.95	$4.06	$8.83	$34.95	$41.58	$37.70	$33.96	$39.54	$36.29
	Ages 15-20 F	$25.84	$25.81	$25.83	$132.04	$90.35	$110.93	$121.92	$85.83	$103.90
	Ages 15-20 M	$16.14	$5.27	$9.75	$70.00	$85.92	$79.24	$61.82	$73.34	$68.52

Hospital Inpatient Total		$17.43	$8.39	$12.77	$64.62	$65.87	$65.16	$62.51	$62.35	$62.44
Hospital Outpatient	Age 0	$0.00	$0.00	$0.00	$37.31	$34.95	$36.38	$37.31	$34.95	$36.38
	Ages 1-5	$0.00	$0.00	$0.00	$24.24	$23.63	$24.02	$24.24	$23.63	$24.02
	Ages 6-14	$25.31	$21.57	$23.58	$20.26	$19.51	$19.95	$20.49	$19.62	$20.12
	Ages 15-20 F	$43.94	$39.67	$42.13	$41.45	$38.94	$40.18	$41.69	$38.99	$40.34
	Ages 15-20 M	$16.08	$14.88	$15.38	$24.25	$22.26	$23.10	$23.01	$21.11	$21.90
Hospital Outpatient Total		$26.04	$20.90	$23.39	$25.74	$25.01	$25.43	$25.76	$24.76	$25.32
NH, HHC, PC, PDN	Age 0	$0.00	$0.00	$0.00	$15.35	$16.09	$15.64	$15.35	$16.09	$15.64
	Ages 1-5	$0.00	$0.00	$0.00	$20.15	$5.54	$14.77	$20.15	$5.54	$14.77
	Ages 6-14	$0.90	$0.00	$0.48	$7.51	$5.66	$6.74	$7.21	$5.36	$6.44
	Ages 15-20 F	$0.00	$0.00	$0.00	$0.00	$1.67	$0.84	$0.00	$1.55	$0.78
	Ages 15-20 M	$0.00	$0.00	$0.00	$0.75	$6.32	$3.98	$0.63	$5.33	$3.37
NH, HHC, PC, PDN Total		$0.31	$0.00	$0.15	$11.18	$5.83	$8.86	$10.69	$5.47	$8.41
Physician	Age 0	$0.00	$0.00	$0.00	$137.64	$140.26	$138.66	$137.64	$140.26	$138.66
	Ages 1-5	$0.00	$0.00	$0.00	$49.04	$47.25	$48.38	$49.04	$47.25	$48.38
	Ages 6-14	$35.16	$33.37	$34.33	$28.55	$29.71	$29.04	$28.85	$29.91	$29.29
	Ages 15-20 F	$66.20	$62.74	$64.73	$52.98	$50.39	$51.67	$54.24	$51.25	$52.75
	Ages 15-20 M	$33.70	$31.14	$32.20	$27.02	$29.34	$28.37	$28.04	$29.62	$28.96
Physician Total		$42.15	$37.08	$39.53	$46.75	$44.54	$45.79	$46.54	$44.08	$45.46
Other	Age 0	$0.00	$0.00	$0.00	$43.28	$35.30	$40.15	$43.28	$35.30	$40.15
	Ages 1-5	$0.00	$0.00	$0.00	$49.88	$34.92	$44.37	$49.88	$34.92	$44.37
	Ages 6-14	$20.77	$52.94	$35.69	$122.23	$93.10	$110.15	$117.68	$90.93	$106.52
	Ages 15-20 F	$36.32	$51.51	$42.74	$112.76	$92.27	$102.39	$105.48	$89.42	$97.46
	Ages 15-20 M	$43.00	$131.18	$94.84	$97.75	$87.25	$91.66	$89.43	$94.11	$92.15
Other Total		$33.79	$96.15	$65.96	$86.08	$71.93	$79.95	$83.74	$73.42	$79.22
Dental	Age 0	$0.00	$0.00	$0.00	$0.10	$0.07	$0.09	$0.10	$0.07	$0.09
	Ages 1-5	$0.00	$0.00	$0.00	$7.07	$8.07	$7.44	$7.07	$8.07	$7.44

	Ages 6-14	$14.75	$16.03	$15.34	$13.26	$12.53	$12.96	$13.33	$12.72	$13.07
	Ages 15-20 F	$18.76	$15.80	$17.51	$16.62	$14.80	$15.70	$16.82	$14.87	$15.85
	Ages 15-20 M	$19.06	$16.61	$17.62	$11.80	$10.95	$11.30	$12.90	$11.83	$12.28
Dental Total		$17.52	$16.32	$16.90	$10.21	$10.52	$10.34	$10.54	$10.87	$10.68
Care Coordination	All Ages	$216.20	$216.20	$216.20	$216.20	$216.20	$216.20	$216.20	$216.20	$216.20
Mental Health	All Ages	$74.12	$74.12	$74.12	$74.12	$74.12	$74.12	$74.12	$74.12	$74.12
New Enrollee Assessments	All Ages	$27.56	$27.56	$27.56	$27.56	$27.56	$27.56	$27.56	$27.56	$27.56
All Services and Ages		$455.11	$496.71	$476.57	$562.46	$541.58	$553.41	$557.65	$538.83	$549.41

EXHIBIT 4B

Wisconsin Department of Health Services

Exhibit 4b

Rate Setting for Care4Kids
CY2015 Final PMPM
CCF/WAM and All Other FFS Eligibles

Note: All weighted averages calculated based on underlying CY2009-11 member months

	CY2015 Blended PMPM with Adjustments								
	CCF/WAM			All Other			CCF/WAM and All Other		
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
Age 0				$851.00	$825.88	$841.16	$851.00	$825.88	$841.16
Ages 1-5				$490.75	$454.99	$477.58	$490.75	$454.99	$477.58
Ages 6-14	$427.73	$445.86	$436.13	$544.64	$519.97	$534.40	$539.40	$515.95	$529.62
Ages 15-20 F	$508.92	$513.40	$510.82	$673.73	$606.29	$639.58	$658.03	$599.79	$628.94
Ages 15-20 M	$445.87	$516.96	$487.66	$549.44	$559.92	$555.52	$533.71	$553.22	$545.05
All Ages	$455.11	$496.71	$476.57	$562.46	$541.58	$553.41	$557.65	$538.83	$549.41

	CY2015 Final PMPM with Admin at 15.0%								
	CCF/WAM			All Other			CCF/WAM and All Other		

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
Age 0				$1,001.18	$971.62	$989.60	$1,001.18	$971.62	$989.60
Ages 1-5				$577.35	$535.28	$561.86	$577.35	$535.28	$561.86
Ages 6-14	$503.21	$524.54	$513.10	$640.75	$611.72	$628.71	$634.59	$607.00	$623.08
Ages 15-20 F	$598.74	$604.00	$600.96	$792.62	$713.28	$752.45	$774.16	$705.63	$739.93
Ages 15-20 M	$524.55	$608.19	$573.72	$646.40	$658.73	$653.55	$627.89	$650.85	$641.24
All Ages	$535.42	$584.37	$560.67	$661.72	$637.15	$651.07	$656.06	$633.92	$646.36

Access Payment Based on 2015 BCP Standard CCHP Access Payment PMPM

Acute Hospital Inpatient	$34.68
Acute Hospital Outpatient	$33.92
Critical Access Hospital Inpatient	$0.00
Critical Access Hospital Outpatient	$0.00
Ambulatory Service Center	$0.06
Access Payment Total PMPM	**$68.66**

	CY2015 Final PMPM with Admin at 15.0% and Access Payment								
	CCF/WAM			**All Other**			**CCF/WAM and All Other**		
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**
Age 0				$1,069.84	$1,040.28	$1,058.26	$1,069.84	$1,040.28	$1,058.26
Ages 1-5				$646.01	$603.94	$630.52	$646.01	$603.94	$630.52
Ages 6-14	$571.87	$593.20	$581.76	$709.41	$680.38	$697.37	$703.25	$675.66	$691.74
Ages 15-20 F	$667.40	$672.66	$669.62	$861.28	$781.94	$821.11	$842.82	$774.29	$808.59
Ages 15-20 M	$593.21	$676.85	$642.38	$715.06	$727.39	$722.21	$696.55	$719.51	$709.90

All Ages	$604.08	$653.03	$629.33	$730.38	$705.81	$719.73	$724.72	$702.58	$715.02

	Reconciled Cost		Non-Reconciled Cost			
	Total Benefit PMPM		Administrative PMPM		Final Rate	
Age Group	**Title IV-E**	**Non Title IV-E**	**Title IV-E**	**Non Title IV-E**	**Title IV-E**	**Non Title IV-E**
CCF/WAM						
Age 0						
Ages 1-5						
Ages 6-14	$496.39	$514.52	$75.48	$78.68	$571.87	$593.20
Ages 15-20 F	$577.58	$582.06	$89.81	$90.60	$667.40	$672.66
Ages 15-20 M	$514.53	$585.62	$78.68	$91.23	$593.21	$676.85
All Ages	$523.77	$565.37	$80.31	$87.66	$604.08	$653.03
All Other						
Age 0	$919.66	$894.54	$150.18	$145.74	$1,069.84	$1,040.28
Ages 1-5	$559.41	$523.65	$86.60	$80.29	$646.01	$603.94
Ages 6-14	$613.30	$588.63	$96.11	$91.76	$709.41	$680.38
Ages 15-20 F	$742.39	$674.95	$118.89	$106.99	$861.28	$781.94
Ages 15-20 M	$618.10	$628.58	$96.96	$98.81	$715.06	$727.39
All Ages	$631.12	$610.24	$99.26	$95.57	$730.38	$705.81