CONTRACT FOR SERVICES
between
State of Wisconsin Department of Health Services (DHS)
and
Milwaukee County
for
Wraparound Milwaukee Prepaid Inpatient Health Plan

This Contract is between the State of Wisconsin Department of Health Services (DHS), at 1 West Wilson Street, Madison, Wisconsin 53703, and Milwaukee County at 9455 Watertown Plank Rd, Milwaukee, WI 53226. With the exception of the terms being modified by this Contract modification, all other terms and conditions of the existing contract, including funding, remain in full force and effect. This Modification, including any and all attachments herein and the existing contract, collectively, are the complete contract of the parties and supersede any prior contracts or representations. DHS and the Contractor acknowledge that they have read the Modification and understand and agree to be bound by the terms and conditions of the existing contract as modified by this action. This Modification becomes null and void if the time between the earlier dated signature and the later dated signature exceeds sixty (60) days, unless waived by DHS.

Contract ID Number: DHS - Wraparound Milwaukee 2020 - 435400-O21-MedHMO-00 M1
Contract Amount: See rate exhibits included in this amendment.
Contract Term: July 1, 2020 - June 30, 2022
Optional Renewal Terms: N/A

DHS Division: Division of Medicaid Services
DHS Contract Administrator: Isabelle Leventhal
DHS Contract Manager: Becky Granger

Contractor Contract Administrator: Brian McBride
Contractor Telephone: (414) 275-7158
Contractor Email: Brian.McBride@milwaukeecountywi.gov

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

Effective July 01, 2020

Article IV: Functions and Duties of the County

Amend Article IV(C) to read:

a. Coverage of Payment of Emergency Services

The PIHP must promptly provide or pay for needed contract services for mental health emergency 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 mental health emergency services based on the provider, hospital, or fiscal agent not notifying the member's primary care provider, or PIHP of the member's screening and treatment within ten (10) days of presentation for emergency mental health services. The PIHP in coordination with the

attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the PIHP as identified in 42 CFR § 438.114(b) and 42 CFR § 438.114(d) as responsible for coverage and payment. Nothing in this requirement mandates the PIHP to reimburse for non-authorized post-stabilization services.

1) The PIHP shall provide emergency mental health 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 screening examination to determine whether or not a mental health emergency exists.

2) The PIHP may not limit what constitutes an emergency mental health 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 mental health condition (even if the absence of immediate attention would not have had the outcomes specified in paragraphs 3 and 4 of the definition of Emergency Medical Condition) or for a member who had PIHP approval to seek emergency services.

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

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

b. 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 of 42 CFR § 438.114(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:

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

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

3) The PIHP must limit charges to members for post-stabilization care services to an amount no

greater than what the organization would charge the member if he/she had obtained the services through the PIHP. A member who has an emergency mental health condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

c. 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 signs and symptoms of the condition upon initial presentation. The retrospective findings of a work-up may legitimately be the basis for determining how much additional care may be authorized, but not for payment for dealing with the initial emergency. Liability for emergency services continues until the patient is stabilized and can be safely discharged or transferred.

2) When emergency services are provided by non-affiliated providers, the PIHP is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, FFS providers for services to BadgerCare Plus and/or Medicaid SSI populations. For more information on payment to non-affiliated providers see Article IV, Section A, part 2. 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:

a) Cases where prior payment arrangements were established; and

b) Specific subcontract agreements.

Shift current sections Article IV(CC)(4-19) down a number and add new Article IV(CC)(4) to read:

The PIHP must ensure that the care of new members is not disrupted or interrupted. Per 42 CFR §438.62(a), the PIHP must ensure continuity of care for members receiving health care under FFS prior to their enrollment in the PIHP, and for newly enrolled members switching PIHP enrollment. The PIHP must:

a. Ensure members receive continued access to previous services when the absence of continued services would pose serious health or hospitalization risks per 42 CFR § 438.62 (b).

b. Provide continued access to services consistent with previous access levels.

1) Authorize coverage of state plan approved services with the member's current providers for the first 90 days of enrollment.

2) Authorize approved prior authorizations at the utilization level previously authorized for 90 days. Exceptions to the 90-day requirement will be allowed in situations where the member agrees to change providers, the member agrees to a level of care, or if the PIHP can document that continuing the care would result in abuse, safety or quality concerns. This does not extend authorizations beyond the time or visits previously approved.

3) The 90-day continued access requirement only applies to services and authorizations covered under the state plan. In-lieu of services and authorizations are exempt.

c. The PIHP must have a detailed automated system for collecting all information on member contacts by care coordinators, case managers and any other staff that has a direct impact on the member's access to services.

d. The PIHP shall assist members who wish to receive care through an HMO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.

Amend Article IV(KK)(D)(5), 4th paragraph to read:

The County must pay all IHCPs, 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 Indian members. The County must make payments to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 438.14(c)(1).

Add new section Article IV(KK)(D)(6) to read:

The PIHP must ensure FQHC services are available to members to the same extent as such services are available under fee-for-service.

Article VI: Payments to County

Add new section, Article VI(I) to read:

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the PIHP must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the PIHP works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the PIHP will not be paid for that work. If the state paid the PIHP in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the PIHP worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the PIHP, the PIHP may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

Article VII: Reports and Data

Add new section Article VII(I) to read:

1. MLR Requirement

The PIHP is required to calculate and report a Medical Loss Ratio (MLR) each year consistent with MLR standards as specified by the Department and described in 42 C.F.R. § 438.8. The MLR is the ratio of the numerator (as defined in accordance with 42 C.F.R. § 438.8(e)) to the denominator (as defined in accordance with 42 C.F.R. § 438.8(f)). The PIHP must submit the MLR on April 1 of the following year with the annual financial reporting submission in the designated worksheet within the PIHP Financial Reporting Template. The PIHP must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting MLR reports in the required Financial Statement Certification submitted with the required audit submissions. If the Department makes a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the PIHP must recalculate the MLR for all affected by the change. It must then submit a new MLR report meeting the applicable requirements in the designated worksheet within the PIHP Financial Reporting Template in the next scheduled financial reporting submission based on the DHS reporting due dates.

2. MLR Reporting Requirements

a. Each PIHP expense must be included under only one type of expense category defined for MLR reporting, unless a proration between expense categories is required to reflect accuracy and a description of the allocation is provided.
b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.
c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.

d. Shared expenses, including the expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
f. The PIHP may add a credibility adjustment, which are published annually by CMS, to a calculated MLR if the MLR reporting year experience is partially credible.
g. The PIHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. Any PIHP with enrollment greater than the minimum number of member months set by CMS will be determined to be fully credible.
h. If a PIHP's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.
i. The PIHP will aggregate data for all Medicaid eligibility groups covered under the contract with the Department.
j. The PIHP's MLR report must include the following:
    1. Total incurred claims
    2. Expenditures on quality improving activities
    3. Expenditures related to activities compliant with program integrity requirements
    4. Non-claims costs
    5. Premium/capitation revenue
    6. Taxes
    7. Licensing fees
    8. Regulatory fees
    9. Methodology(ies) for allocation of expenditures
    10. Any credibility adjustment applied
    11. The calculated MLR
    12. Any remittance owed to the state, if applicable
    13. A reconciliation of the information reported in the annual financial report
    14. A description of the aggregation method used to calculate total incurred claims
    15. The number of member months
    16. Additional description and guidelines for the MLR report are located in the MLR worksheet within the DHS PIHP Financial Reporting Template.

The PIHP must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the PIHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the PIHP, whichever comes sooner, regardless of current contractual limitations, in order to calculate and validate the accuracy of MLR reporting to meet the DHS MLR reporting due date.

Article XIV: County Specific Contract Terms

Amend Article XIV to read:

1. COUNTY IN WHICH ENROLLMENT IS ACCEPTED: Milwaukee.

2. CAPITATION RATE: The monthly capitation rate for each member is [$1,627.14] (daily rate is [$53.49]) for the period from July 1, 2020 – June 30, 2021.

3. THE CONTRACT SHALL BECOME EFFECTIVE ON JULY 1, 2020 AND SHALL TERMINATE ON JUNE 30, 2022.

Addendum VII: BadgerCare Plus-Covered Services Provided by County

Amend Addendum VII to read:

BADGERCARE PLUS-COVERED SERVICES PROVIDED BY COUNTY

The County is required to provide all medically-necessary, Medicaid-covered services as detailed in the *County PIHP Guide to Covered Services, Coding, and Reporting* for this contract period, which is fully incorporated herein by reference.

ForwardHealth covered services in scope for the Wraparound Milwaukee contract include the following benefits, as further described in ForwardHealth Online Handbooks, WI Medicaid State Plan, DHS 107.13 Wis. Adm. Code, the County PIHP Guide, and/or max fee schedules:

- Adult Mental Health Day Treatment
- Certified peer specialist services
- Child/Adolescent Day Treatment
- Inpatient services
    - Mental Health Services
- Intensive In-Home Mental Health and Substance Abuse for Children
- Outpatient Mental Health
- Psycho-educational services
- Substance Abuse Day Treatment
- Targeted Case Management

State of Wisconsin

Department of Health Services

Authorized Representative

Name: James D. Jones

Title: State Medicaid Director

Signature: DocuSigned by: James D. Jones 7BD4E56017A7425...

Date: 9/16/2021

Contractor

Contractor Name: Wraparound Milwaukee

Authorized Representative

Name: Brian McBride

Title: Administrator, CCMH and Wrapaaorund

Signature: DocuSigned by: Brian McBride 01BA309BF43344B...

Date: 9/16/2021

SUPPLIER DIVERSITY AMENDMENT

The Wisconsin Department of Health Services (DHS) and Contractor agree to the below change to the Agreement. The below Agreement amendment is hereby incorporated by reference into the Agreement and is enforceable as if restated therein in its entirety.

The Agreement is hereby amended by incorporating and adding the following Section:

SUPPLIER DIVERSITY AND REPORTING REQUIREMENTS

Minority-Owned Business Enterprises (MBE) and Disabled Veteran-Owned Businesses (DVB) are certified by the Wisconsin Department of Administration (DOA). This program can be found at: https://doa.wi.gov/Pages/DoingBusiness/SupplierDiversity.aspx

The State of Wisconsin is committed to the promotion of MBEs and DVBs in the State's purchasing program. The Contractor is strongly urged to use due diligence to further this policy by awarding Subcontracts to MBEs and DVBs or by using such enterprises to provide goods and services incidental to this Agreement.

The Contractor shall furnish appropriate monthly information about its efforts to subcontract with MBEs and DVBs, including the identities of such businesses certified by the Wisconsin Supplier Diversity Program, their contract amount, and spend for each period to DHS. A listing of certified MBEs and DVBs, as well as the services and goods they provide, is available at: https://wisdp.wi.gov/Search.aspx

In accordance with WI Stats. Ch. 16.75 (3m), after completion of this contract, the Contractor shall report to DHS any amount of this contract that was subcontracted to DOA certified MBEs and DVBs.

DHS shall have the right to request any information regarding the use of subcontractors including, but not limited to, MBEs and DVBs. The Contractor shall provide any such information as requested by DHS and within a time period that is specified by DHS.

The Contractor shall submit monthly reports of efforts to subcontract with MBEs, DVBs, and other diverse entities/suppliers to DHS. A link to the Supplier Diversity PowerForm for submitting these reports can be found on the DHS Compliance Documentation page found here: https://www.dhs.wisconsin.gov/business/compliance.htm

For the duration of this Agreement, the Contractor shall provide monthly reporting of efforts to subcontract with MBEs and DVBs no later than the 15th of the following month.

For questions about reporting, please contact DHS Contract Compliance at DHSContractCompliance@dhs.wisconsin.gov