Contract Amendment for BadgerCare Plus and SSI Medicaid Services

This agreement entered into for the period of January 1, 2018 through December 31, 2019 between the State of Wisconsin acting by or through the Department of Health Services, hereinafter referred to as the "Department" and _____ an insurer with a certificate of authority to do business in Wisconsin for the BadgerCare Plus and/or Medicaid SSI Managed Care Program hereinafter referred to as the "HMO", is hereby amended effective, January 1, 2019, as follows:

1. **Article I**
   Rename Article I to read:

   DEFINITIONS AND ACRONYMS

2. **Article I – DEFINITIONS AND ACRONYMS**
   Amend the first paragraph to read:

   This contract is between the Wisconsin Department of Health Services (the Department) and the Health Maintenance Organization (HMO) participating in the State of Wisconsin BadgerCare Plus and/or Medicaid SSI programs. These programs are approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act. An HMO is an insurer offering comprehensive health care services delivered by providers. These providers may be both employees and partners of the HMO, or they may have entered into a referral or contractual agreement with the HMO for the purpose of providing contract-related services for enrolled members. HMOs should work with providers for the further specific purpose of promoting coordination and continuity of preventive health services and other medical care related to behavioral health, emergency care, and social determinants of health. In exchange for making contract-covered services available to enrolled members, the HMO will receive periodic fixed payments from the Department. The HMO is required to hold a certificate of authority to do business in Wisconsin; a separate certificate of authority must be submitted for each contract the HMO intends to enter into with the Medicaid program. This requirement applies to HMOs offering multiple product lines and doing business under another name. The HMO is not required to contract for both programs, and if they are not contracted for both, only the provisions applicable to their program apply. The HMO does herewith agree:

3. **Article I, Section A – Definitions**
   Add "Administrative Service Organization (ASO)" as a new definition after the definition of "Actuary":

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

4. **Article I, Section A – Definitions**
   Remove extra space between the definition of "Affirmative Action Plan" and "Alternative Payment Models (APMs)"

5. **Article I, Section A – Definitions**
   Amend the definition of "BadgerCare Plus" to read:

   BadgerCare Plus: BadgerCare Plus is Wisconsin's health care program for low income individuals that merged BadgerCare, the family portion of the current Wisconsin Medicaid population, with Healthy Start to form a single program that expands coverage to Wisconsin residents. Effective April 1, 2014, the following populations are eligible for BadgerCare Plus:
   - Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Level (FPL).
   - Pregnant women with incomes at or below 300 percent of FPL.
   - Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.

- Childless adults with incomes at or below 100 percent of the FPL.
- Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL.

6. Article I, Section A – Definitions
Amend the definition of "Care Management Model" to read:

Care Management Model: A health care delivery process to arrange, deliver, monitor and evaluate the member's care, including all medical and social services, with the goal of helping members achieve their self-identified goals.

7. Article I, Section A – Definitions
Remove the definition of "CFR"

8. Article I, Section A – Definitions
Move the definition of "Childless Adults (CLAs)" before the definition of "Claim"

9. Article I, Section A – Definitions
Amend the definition of "Childless Adults (CLAs)" to read:

Childless Adults: A person who is 19 to 64 years old, regardless of marital status, is not receiving Medicare and does not have any dependent children younger than 19 years who reside with him or her at least 40 percent of the time. As of April 1, 2014, childless adults are eligible for Standard Plan benefits.

10. Article I, Section A – Definitions
Amend the definition of "Communication Materials" to read:

Communication Materials: Communication materials designed to provide members or potential members with clear and concise information about the HMO's program, the HMO's network, and resources about the BadgerCare Plus and/or Medicaid SSI program.

11. Article I, Section A – Definitions
Add "Comprehensive Assessment (for Medicaid SSI members only)" as a new definition after the definition of "Complaint":

Comprehensive Assessment (for Medicaid SSI members only): A detailed evaluation where an appropriately qualified health care professional identifies a member's health care, cultural and socioeconomic needs. The assessment may entail conducting a review of the member's past medical history, analyzing member records, using diagnostic tools and patient interviews to form the basis for the development of a multidisciplinary plan of care for the member. The evaluation must include an encounter of care with the member, either face-to-face or through telephonic contact. For the purposes of an assessment, qualified health care professionals may include non-physician providers such as an advanced practice nurse, physician assistant, registered nurse or social worker, or other staff as approved in the certification application.

12. Article I, Section A – Definitions
Add "Conditional Provider Network Approval" as a new definition after the definition of "Comprehensive Care Plan (for Medicaid SSI members only)":

Conditional Provider Network Approval: Refers to the HMO provider network approval status for a county when network adequacy deficiencies are identified in current certification counties.

13. Article I, Section A – Definitions
Add "Copayment" as a new definition after the definition of "Coordination of Benefits (COB)":

Copayment: A fixed amount the HMO or provider is allowed to charge a member for part of the cost of medically necessary covered services. Allowable copayment amounts are listed in the ForwardHealth online handbook.

14. Article I, Section A – Definitions
Amend the definition of "Corrective Action Plan" to read:

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

- Plan communicated by the State to the HMO for the HMO 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 HMO.
- This also refers to the plan communicated to the State by the HMO to address a deficiency in contractual performance.

15. Article I, Section A – Definitions
Amend the definition of "Days" to read:

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

16. Article I, Section A – Definitions
Amend the definition of "Department Values" to read:

Department Values: The Department's shared values include:

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

17. Article I, Section A – Definitions
Amend the definition of "Enrollee" to read:

Enrollee (see also definition of "Member"): A BadgerCare Plus and/or Medicaid SSI member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the HMO Enrollment Rosters that the Department transmits to the HMO according to an established notification schedule. These terms are used interchangeably.

18. Article I, Section A – Definitions
Add "Fee-for-Service" as a new definition after the definition of "External Quality Review Organization (EQRO)":

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

19. Article I, Section A – Definitions
Add "ForwardHealth Handbook" as a new definition after the definition of "Formally Enrolled with a Continuing Care Provider (as cited in 42 CFR §441.60(d))":

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

20. Article I, Section A – Definitions
Amend the definition of "ForwardHealth interChange" to read:

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

21. Article I, Section A – Definitions
Amend the definition of "Health Care Professional" to read:

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

22. Article I, Section A – Definitions
Move the definitions of "HealthCheck" and "HealthCheck Other Services" after the definition of "Health Care Services"

23. Article I, Section A – Definitions
Remove the definition of "HHS"

24. Article I, Section A – Definitions
Add "High Birth Weight" as a new definition after the definition of "HHS Transaction Standard Regulation"

High Birth Weight: Defined as a birth weight greater than 4,500 grams.

25. Article I, Section A – Definitions
Move the definition of "High Risk Members" after the definition of "High Birth Weight"

26. Article I, Section A – Definitions
Move the definition of "Highest Needs Members" after the definition of "High Risk Members"

27. Article I, Section A – Definitions
Add "Language Access Services" as a new definition after the definition of "Information Gathering and Assessment (for Medicaid SSI members only)":

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

28. Article I, Section A – Definitions
Amend the definition of "Limited English Proficiency (LEP)" to read:

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

29. Article I, Section A – Definitions
Move the definition of "Medically Necessary" after the definition of "Medical Status Code"

30. Article I, Section A – Definitions
Amend the definition of "Member" to read:

Member (see also definition of "Enrollee"): A BadgerCare Plus and/or Medicaid SSI member who has been certified by the State as eligible to enroll under this Contract, and whose name appears on the HMO Enrollment Rosters that the Department transmits to the HMO according to an established notification schedule. These terms are used interchangeably.

31. Article I, Section A – Definitions
Move the definition of "Member-Centric Care" after the definition of "Member"

32. Article I, Section A – Definitions
Add "National Culturally and Linguistically Appropriate Services (CLAS) Standards" as a new definition after the definition of "Members with Special Needs"

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

33. Article I, Section A – Definitions
Add "Premium" as a new definition after the definition of "Preauthorization":

Premium: The amount a member may pay each month for Medicaid coverage.

34. Article I, Section A – Definitions
Add "Program Integrity" as a new definition after the definition of "Primary Care Provider (PCP)":

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

35. Article I, Section A – Definitions
Add "Provider Network" as a new definition after the definition of "Provider":

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

36. Article I, Section A – Definitions
Add "Rate Region" as a new definition after the definition of "Rate Cell":

Rate Region: A grouping of counties with similar rate-setting attributes such as geography, member cost, and provider networks.

37. Article I, Section A – Definitions
Remove the definition of "Serious Emotional Disturbance, Severe Emotional Disturbance, Severely Emotionally Disturbed, and SED"

38. Article I, Section A – Definitions
Amend the definition of "Social Determinants of Health" to read:

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

39. Article I, Section B – Acronyms
Add as a new Section B:

B. ACRONYMS

Acronym	Meaning
AA	Affirmative Action
AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
ACOG	American Congress of Obstetricians and Gynecologists
ADRC	Aging and Disability Resource Center
APM	Alternative Payment Models
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Organization
BBM	Bureau of Benefits Management
BC or BC+	BadgerCare or BadgerCare Plus
BFM	Bureau of Fiscal Management
CAH	Critical Access Hospital
CAP	Corrective Action Plan
CBRF	Community Based Residential Facility
CCS	Comprehensive Community Services
CDPS	Chronic Illness & Disability Payment System
CEHRT	Certified Electronic Health Record Technology
CEO	Chief Executive Officer
CESA	Cooperative Educational Service Agencies
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIP	Community Integration Program
CLA	Childless Adult
CLAS	Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COP	Community Options Program
CPT	Current Procedural Terminology
CRC	Civil Rights Compliance
CRS	Community Recovery Services
CSA	Child Support Agency
CSP	Community Support Program
CY	Calendar Year
DATA	Drug Addiction Treatment Act
DHCAA	Division of Health Care Access & Accountability
DMCPS	Division of Milwaukee Child Protective Services
DMHSAS	Division of Mental Health & Substance Abuse
DMS	Division of Medicaid Services

DOT	Directly Observed Therapy
DQA	Division of Quality Assurance
DRG	Diagnosis Related Groupings
DSPS	Department of Safety and Professional Services
DSS	Department of Social Services
DVT	Deep Vein Thrombosis
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERISA	Employee Retirement Income Security Act
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Federal Department of Health and Human Services
HIF	Health Insurance Fee
HIPAA	The Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HNA	Health Needs Assessment
HPSA	Health Professional Shortage Area
ICD	International Classification of Diseases
IDSS	Institute for Data, Systems, and Society
IFSP	Individualized Family Service Plan
IHCP	Indian Health Care Provider
IIHI	Individually Identifiable Health Information
IMD	Institutes for Mental Disease
IRS	Internal Revenue Service
LAN	Learning Action Network
LEP	Limited English Proficiency
LTC	Long Term Care
MA	Medical Assistance/Medicaid
MAPP	Medicaid Purchase Plan
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding

MY	Measurement Year
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limits
NTS	Narcotic Treatment Services
OBMH	Obstetric Medical Home
OCI	Office of the Commissioner of Insurance
OIG	Office of the Inspector General
ONC	Office of National Coordinator
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PE	Pulmonary Embolism
PHI	Protected Health Information
PIP	Performance Improvement Project
PNCC	Prenatal Care Coordination
PPACA	Patient Protection Affordable Care Act
PPR	Potentially Preventable Readmissions
P4P	Pay for Performance
QAPI	Quality Assessment Performance Improvement
RHC	Rural Health Center
SBS	School Based Services
SCHIP	State Children's Health Insurance Program
SFTP	Secure File Transfer Protocol
SIU	Special Investigations Unit
SMV	Specialized Medical Vehicles
SSA	Social Security Administration
SSI	Supplemental Security Income
TCM	Targeted Case Management
TCOC	Total Cost of Care
TMSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
UM	Utilization Management
URAC	Utilization Review Accreditation Commission
VFC	Vaccines for Children
WCAG	Web Content Accessibility Guidelines
WIC	Women, Infant, and Children
WICT	Wisconsin Interdisciplinary Care Team
WIR	Wisconsin Immunization Registry
WISHIN	Wisconsin Statewide Health Information Network

40. Article II, Section A(1) – Enrollment
Amend the first paragraph under "Medicaid SSI" to read:

Medicaid SSI
The current State Plan Amendment requires mandatory enrollment into an HMO for those service areas in which there are two or more HMOs with sufficient slots for the HMO eligible population.

41. Article II, Section B(3)(b) – Disenrollment
Amend Section B(3)(b) to read:

b. Nursing Home

For BadgerCare Plus and Medicaid SSI members in a nursing home at the time of HMO enrollment, the member, the nursing home, or the HMO may contact the HMO Enrollment Specialist for an exemption. The nursing home services would be billed to fee-for-service, and upon discharge, the exemption will end and the member may be eligible for HMO enrollment.

1) BadgerCare Plus (non-CLA)

A BadgerCare Plus (non-CLA) member who has been in a nursing home for longer than 30 days will have their medical status code changed to an institutional code, which will automatically disenroll them from the HMO. The HMO does not need to report this population to the Enrollment Specialist as the disenrollment is automatic. The HMO is responsible for nursing home costs until the disenrollment is effective.

Automatic disenrollment does not occur for the following populations and HMOs must notify the Enrollment Specialist for disenrollment:

2) Medicaid SSI

After a SSI member has been in a nursing home 90 days or longer and is expected to remain in the facility, the HMO must notify the HMO enrollment Specialist to request disenrollment . In the event the member transfers from the nursing home to a hospital and back to the nursing home, the applicable 90 day period shall run continuously from the first admission to the nursing home and shall include any days in the hospital. The HMO must wait until 90 days have occurred before requesting an exemption, which will occur the first of the next month. The HMO is responsible for nursing home costs until the disenrollment is effective.

3) BadgerCare Plus - CLA

If a member enters a nursing home while enrolled in the HMO and is in the nursing home longer than 30 days and is expected to remain in the facility, the member shall be disenrolled from the HMO. The HMO must wait until the 30 days have occurred before requesting an exemption, which will occur the first of the next month. The HMO is responsible for nursing home costs until the disenrollment is effective.

42. Article III, Section B(3)(d)(1) – Care Management Model for the Medicaid SSI Population
Add as a new last sentence to the paragraph:

Per 42 CFR 438.208(c)(3)(iv) of the Managed Care Rule, the Comprehensive Care Plan must be in accordance with Utilization Management requirements outlined in Article X (G) of this contract.

43. Article III, Section D – Screening Requirements for non-Childless Adults BadgerCare Plus Members
Amend to read:

Pursuant to 42 CFR § 438.208(b)(3), the HMO must make a best effort to conduct an initial screening of each member's needs, within 90 days of HMO enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful.

44. Article IV, Section A(7) – BadgerCare Plus and/or Medicaid SSI Services
Add as a new (d):

d. The State Plan prohibits HMOs from paying for organ transplants unless the HMO follows written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees.

45. Article IV, Section B(2) – Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies
Add as a new fourth paragraph:

Pursuant to 42 CFR 438, subpart K, the HMO will be required to submit to the Department a parity analysis of its benefit plans as part of the HMO certification application process and upon request. Clarifying instructions will be included in the certification application.

46. Article IV, Section B(3) – Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies
Amend the second sentence of the second paragraph to read:

The purpose of the participation is to ensure members have culturally competent providers and culturally appropriate treatment and that their medical needs are met.

47. Article IV, Section C(1)(b) - HealthCheck
Add as a new last paragraph for Section C(1)(b):

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

48. Article IV, Section D(2) – Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women
Add as a new last sentence to Section D(2):

The reason(s) for the member's medical home eligibility must be documented in the medical record.

49. Article IV, Section D(3) – Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women
Amend the second sentence of the first paragraph to read:

The Department currently issues payments to the HMOs and the HMOs subsequently issue the enhanced payment on to the OB medical home site.

50. Article IV, Section D(3) – Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women
Amend the second paragraph of the first bullet to read:

She must also be enrolled in the OB Medical Home within 20 weeks of her pregnancy (the clinic is responsible for obtaining all medical records for documentation). Enrollment in the OB Medical Home means being entered into the OBMH registry.

51. Article IV, Section D(3) – Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women
Amend the second to last paragraph to read:

The HMO is responsible for working with the medical home sites, external PNCC providers, hospitals and any other care provider that may or should have documentation of OB medical home services to ensure required documentation is submitted to the Department's EQRO in a timely manner. For medical home sites that provide remote access to records, the EQRO will access records that have been specified as OBMH members. If the patient is not on the record review list, the EQRO will not access those records.

52. Article IV, Section D(4) – Obstetric Medical Home Initiative (OB MH) for High-Risk Pregnant Women
Amend the second sentence of the third paragraph to read:

For medical home sites that provide remote access to records, the EQRO will access records that have been specified as OBMH members.

53. Article IV, Section H – Provider Moral or Religious Objection
Amend to Section H to read:

H. HMO Moral or Religious Objection

The HMO is not required to provide counseling or referral service if the HMO objects to the service on moral or religious grounds. If the HMO 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:

- To the Department and Enrollment Specialist so the Department can notify members of the HMO's non-coverage of service;
- With the HMO's certification application for a BadgerCare Plus and/or Medicaid SSI contract;
- Whenever the HMO adopts the policy during the term of the contract;
- It must be consistent with the provisions of 42 CFR 438.10;
- It must be provided to potential members before and during enrollment;
- It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and
- In written and prominent manner, the HMO shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the HMO because of an objection on moral or religious grounds. The HMO must inform members about how to access those services through the State.

54. Article V, Section A – Use of BadgerCare Plus and/or Medicaid SSI Enrolled Providers
Add as new to the end of the paragraph:

The DHS requires that Medicaid-enrolled providers undergo periodic revalidation. During revalidation, providers update their enrollment information with ForwardHealth, and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers who fail to revalidate are terminated from Wisconsin Medicaid.

55. Article V, Section B – Protocols/Standards to Ensure Access
Amend the second paragraph to read:

The HMO's protocols must include training and information for providers in their network, in order to promote and develop provider skills in responding to the needs of persons with limited English proficiency, mental, physical and developmental disabilities. Training should include clinical and communication issues and the role of care coordinators.

56. Article V, Section C(2) – Written Standards for Accessibility of Care
Delete Section C(2):

57. Article V, Section E – Access to Selected BadgerCare Plus and/or Medicaid SSI Providers and Covered Services
Amend Section E to read:

Per 42 CFR § 438.207, HMOs must provide assurances to the State that demonstrates that the HMO has the capacity to serve the expected enrollment in its service area per the State standards for access to care provided below. All HMO network reviews are based on the number of providers accepting new patients.

1. Primary Care Provider Network Adequacy Standards

Primary Care Providers						
Population	**Provider Specialty Codes/Descriptions**	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time**	**Drive Time**
Adult	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine	Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha	The HMO must have a PCP within 20 miles of any member residing in the county. At least one PCP must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member.	1:100	Wait times for an appointment shall be no more than 30 days. **<u>Women's Health Specialist</u>** In addition to a primary care provider, a female member may have a women's health specialist. The HMO must provide female members with direct access to a women's health specialist within the network for covered women's routine and preventive health care services.	A PCP must be within a 30 minute drive time of any member residing in these counties.
Pediatric	090 – Certified Pediatric Nurse Practitioners 092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine 345 – Pediatricians 080 – Federally Qualified Health Center (HealthCheck related) 734 – Screener (HealthCheck) 735 – Screener/Case Management (HealthCheck)					
Adult	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine	All other remaining counties	The HMO must have a PCP within 30 miles of any member residing in all other counties. At least one PCP must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member.	No standard	Wait times for an appointment shall be no more than 30 days. **<u>Women's Health Specialist</u>** In addition to a primary care provider, a female member may have a women's health specialist. The HMO must provide female members with direct access to a women's health specialist within the network for covered women's routine and preventive health care services.	A PCP must be within a 60 minute drive time of any member residing in all other counties.
Pediatric	090 – Certified Pediatric Nurse Practitioners 092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine 345 – Pediatricians 080 – Federally Qualified Health Center (HealthCheck related) 734 – Screener (HealthCheck) 735 – Screener/Case Management (HealthCheck)					

These access standards do not prevent a member from choosing a HMO when the member resides in a county that does not meet the distance standard. However, the member will not be automatically assigned to that HMO. If the member has been assigned to the HMO or has chosen the HMO and becomes dissatisfied with the access to medical care, the member may disenroll for cause from the HMO because of distance.

2. Mental Health or Substance Abuse Provider Network Adequacy Standards

Mental Health and Substance Abuse Providers						
Population	**Provider Specialty Codes/Descriptions**	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time(s)**	**Drive Time**
Adult & Pediatric	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse 120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug Abuse Counselor 123 – Certified Psychotherapist with SAC 124 – Certified Psychotherapist 126 – Qualified Treatment Trainee (QTT) 339 – Psychiatry 532 – Registered Alcohol & Drug Counselor 740 – Mental Health	Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha All other remaining counties	The HMO must have a mental health and substance abuse provider (including access to qualified treatment trainees) within a 35 mile travel distance from any member residing in the HMO service area. At least one mental health and substance abuse provider must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member.	**<u>Psychiatrist</u>** 1:900 **<u>Psychologist</u>** 1:900 No standard	No longer than 30 days for an appointment with a Mental Health provider for follow-up after an inpatient mental health stay. No more than 30 days for a non-psychiatric appointment. No more than 90 days for a psychiatric appointment. **<u>Medication-Assisted Treatment (MAT) Services:</u>** No more than 72 hours (including weekends and holidays) for appointment with prescribing and dispensing provider for medication-assisted treatment (MAT) for members presenting with opioid use disorder (OUD); including providers authorized to prescribe and dispense methadone, buprenorphine, and naltrexone for OUD. Type of medication must be based on an assessment of the individual member and choice of clinically-indicated medication (i.e. 72-hour requirement cannot be met by directing all members to naltrexone providers). To ensure adherence to MAT wait time standards, HMOs must collect and monitor data for MAT providers in their network. This monitoring should include identifying providers with legal authority to prescribe and dispense each FDA-approved medication for substance use disorders, whether these providers are actively providing MAT for members in the HMO, and the MAT capacity for each of these providers. Detailed data regarding MAT provider networks must be available upon request from the Department.	A mental health and substance abuse provider must be within a 60 minute drive time of any member residing in the county.

3. OB/GYN Network Adequacy Standards

OB/GYN Providers						
Population	**Provider Specialty Codes/Descriptions**	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time(s)**	**Drive Time**
Adult & Pediatric	095 – Nurse Practitioner/Nurse Midwife 212 – Nurse Midwife 316 – Family Practice 318 – General Practice 328 – OB/Gynecologists 350 – Licensed Midwife	Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha	The HMO must have an OB/GYN provider within 20 miles of any member residing in these counties. At least one OB/GYN provider must be in each HMO certified county must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member.	No standard	Wait times for an appointment shall be no more than 30 days. **<u>High Risk Prenatal Care Services</u>** The HMO 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 HMO provider, who is accepting new patients. **<u>Family Planning Services</u>** The HMO must ensure its network includes sufficient family planning providers to ensure timely access to covered services.	An OB/GYN provider must be within a 30 minute drive time of any member residing in these counties.
		All other remaining counties	The HMO must have an OB/GYN provider within 30 miles of any member residing in all other counties. At least one OB/GYN provider must be in each HMO certified county must be in each HMO certified county, unless there is no such provider in the county. In that case, the travel distance shall be no more than for a non-enrolled member.			An OB/GYN provider must be within a 60 minute drive time of any member residing in all other counties.

4. Hospitals

   The HMO must include a sufficient supply of non-specialized hospitals in its network so that the following requirements are met:

Hospitals						
Population	**Provider Specialty Codes/Descriptions**	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time(s)**	**Drive Time**
Adult & Pediatric	010 – Inpatient/Outpatient Hospital	Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha	The HMO must have a hospital within 20 miles of any member residing in these counties. At least one hospital must be in each HMO certified county, unless there is no hospital in the county. In that case, the travel distance shall be no more than for a non-enrolled member.	No standard	No standard	A hospital must be within a 30 minute drive time of any member residing in these counties.
		All other remaining counties	The HMO must have a hospital within 35 miles of any member residing in all other counties. At least one hospital must be in each HMO certified county, unless there is no hospital in the county. In that case, the travel distance shall be no more than for a non-enrolled member.			A hospital must be within a 60 minute drive time of any member residing in all other counties.

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.

5. Urgent Care Centers or Walk-in Clinics

The HMO must have policies and procedures to provide members access to urgent care centers or walk-in clinics. The HMO 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 5 p.m. to 7 p.m. during weekdays or 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 office open extended hours must accept and advertise that walk-in appointments are accepted. HMOs are 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; and perform minor procedures (ex. sutures, splinting) on site.
- Have the following equipment and staff trained in its use:
    - Automated external defibrillator (AED)
    - Oxygen, ambu-bag/oral airway
- At least two exam rooms.

The HMO 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.

Urgent Care Centers						
Population	**Provider Specialty Codes/Descriptions**	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time(s)**	**Drive Time**
Adult & Pediatric	No provider specialty code	Brown Dane Kenosha Milwaukee Racine Ozaukee Washington Waukesha	The HMO must have an urgent care center within 20 miles of any member residing in these counties. At least one urgent care center with extended hours available must be in each HMO certified county, unless there is no urgent care center with extended hours in the county. In that case, the travel distance shall be no more than for a non-enrolled member. Urgent care requirement would be met if the HMO elects to cover telehealth services that provide access to e-prescribing, diagnosis, and referrals.	No standard	No standard	An urgent care center must be within a 30 minute drive time of any member residing in these counties.
		All other remaining counties	The HMO must have an urgent care center within 35 miles of any member residing in all remaining counties. At least one urgent care center with extended hours available must be in each HMO certified county, unless there is no urgent care center with extended hours in the county. In that case, the travel distance shall be no more than for a non-enrolled member. Urgent care requirement would be met if the HMO elects to cover telehealth services that provide access to e-prescribing, diagnosis, and referrals.			An urgent care center must be within a 60 minute drive time of any member residing in all other counties.

6. Dental Provider Network Adequacy Standards

Dental Providers						
Population	**Provider Specialty Codes/Descriptions**	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time**	**Drive Time**
Adult **Pediatric**	271 – General Dentistry Practitioner 289 – Dental Hygienist 271 – General Dentistry Practitioner 274 – Pediatric Dentist 289 – Dental Hygienist	Kenosha Milwaukee Racine Ozaukee Washington Waukesha (Regions 5-6)	For HMOs serving BadgerCare Plus and Medicaid SSI members in regions 5 and 6, dental service coverage is required. The HMO must have a dental provider within a 25 mile distance of any member residing in the HMO service area. At least one dental provider must be in each HMO certified county, unless there is no Medicaid enrolled provider in that county. In that case, the travel distance shall be no more than for a non-enrolled member. The HMO must also consider whether the dentist accepts new patients, and whether full or part-time coverage is available.	1:1600	No more than 90 days for a routine dental appointment. Treatment must be provided within 24 hours for dental emergencies per the policy outlined in Article IV, A.8 (b.	A dental provider must be within a 30 minute drive time of any member residing in the county.
Adult **Pediatric**	271 – General Dentistry Practitioner 289 – Dental Hygienist 271 – General Dentistry Practitioner 274 – Pediatric Dentist 289 – Dental Hygienist	All other remaining counties (Regions 1-4)	For the HMO that covers dental services in regions 1-4, a dental provider must be available within a 35 mile distance of any member residing in the HMO service area. At least one dental provider must be in each HMO certified county, unless there is no Medicaid enrolled provider in that county. In that case, the travel distance shall be no more than for a non-enrolled member. The HMO must also consider whether the dentist accepts new patients, and whether full or part-time coverage is available.	No standard	If the HMO provides dental in these regions, no more than 90 days for a routine dental appointment. Treatment must be provided within 24 hours for dental emergencies per the policy outlined in Article IV, A.8 (a).	A dental provider must be within a 60 minute drive time of any member residing in the county.

7. HMO Referrals to Out-of-Network Providers for Services

   The HMO must provide adequate and timely coverage of services provided out-of-network, when the required medical service is not available within the HMO network. The HMO must coordinate with out-of-network providers with respect to payment and ensure that 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) and S.S.A 1932(b)(2)(D)].

   The HMO must use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance abuse disorder benefits that are comparable to, and applied no more stringently than, the process, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical benefits in the same classification.

   Emergency services provided out-of-network must also not have a cost to the member greater than if the emergency services were provided in-network. The HMO 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. No claims to any person or entity outside of the U.S. (including, but not limited to, a network provider, out-of-network provider, subcontractor or financial institution) U.S. will be considered in the development of actuarially sound capitation rates. Non-emergency services in Canada or Mexico may be covered by the HMO per the HMO's prior authorization policies, provided the financial institution receiving payment is located within the United States.

8. Second Medical Opinions

   The HMO must have written policies for procedures guaranteeing each member's right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand for providing 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 HMO must authorize and reimburse for a second opinion outside the network at no charge to the member, excluding allowable copayments.

9. Access to Indian Health Providers

   For Indian members enrolled in the HMO, the HMO must ensure access to an Indian Health Care Provider (IHCP), when available. Pursuant to 42 CFR § 438.14(b)(1), the HMO must have sufficient IHCPs participating in its provider network to ensure timely access to services available under the contract from such providers for Indians members.

Indian members of the HMO are allowed to receive primary care services from an IHCP provider, as long as such provider agrees to serve in the HMO network as a PCP and has capacity for additional patients. If no such provider is contracted, the HMO must allow the member to see the IHCP out-of-network as defined in 42 CFR §438.14(b)(4). If an Indian member receives services through an out-of-network IHCP, the HMO must allow the out-of-network IHCP to refer the Indian member to a provider within the HMO network for additional care.

If timely access to an IHCP cannot be ensured, the HMO may allow Indian members to access out-of-state IHCPs or the member may choose to disenroll from the HMO per the process outlined in Art. III, section C.

The HMO 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 HMO 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 447.45 and 447.46.

Indian members are exempt from payment of fees, co-payments, or premiums for services provided by an IHCP.
Indian members can be identified through 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
- A Tribal census document
- A medical record card or similar documentation that is issued by an Indian health care provider that specifies an individual is an Indian, or
- A statement of Tribal Affiliation (F-00685).

58. Article V, Section F – Network Adequacy Requirements
Amend Section F to read:

F. Network Adequacy Requirements

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

1. The anticipated BadgerCare Plus and/or Medicaid SSI enrollment.

2. The expected utilization of services, considering member characteristics and health care needs.

3. The number and types of providers (in terms of training experience and specialization) required to furnish the Contracted services.

4. The number of network providers not accepting new patients.

5. The geographic location of providers and members, distance, travel time, normal means of transportation used by members.

6. Whether network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.

7. Whether network providers have the ability to communicate with limited English proficient members in their preferred language.

8. As part of the certification application process to review network adequacy and access, each HMO will be required to document any use of telemedicine (beyond what is covered by ForwardHealth), e-visits, and/or other evolving and innovative technological solutions as part of its covered services, administrative infrastructure, and/or care management model.

The HMO must provide documentation and assurance of the above network adequacy criteria as required by the Department for pre-contract certification, annual provider network recertification, or upon request of the Department.

The HMO must submit its provider network and facility file electronically to the State's FTP monthly and when there are significant service area changes. The file must be submitted in the format designated by the Department in the HMO Provider Network File Submission Specification Guide. The HMO must also notify the appropriate Managed Care Analyst of changes related to network adequacy. Changes that could affect network adequacy have been defined by the Department as changes in the HMO's operations that would affect adequate capacity and services, including modifications to HMO benefits, geographic service areas, provider networks, payments, or enrollment of a new population into the HMO. (42 CFR 438.207(c)(2)(i-ii))

The HMO 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 HMO. The HMO must submit a member communication/transition plan for all service area reductions.

59. Article V, Section G - Provider To Member Ratio Requirement
Delete Section G.

60. Article V, Section G
Add as a new Section G:

G. Provider Network Adequacy Standard Exceptions and Conditional Approvals

1. Exceptions Process

Occasionally, HMOs are certified or request to expand in a county with limited numbers of providers that may lead to gaps in the standards described in Article V, E. In these instances, the HMO may be granted an exception to the network adequacy standard, at the Department's discretion. The HMO must provide documentation and justification for an adequate network, despite network adequacy deficiencies.

2. Conditional Provider Network Approval

If the Department's annual network adequacy review of currently certified counties identifies deficiencies per the standards articulated in Article V, E, the HMO may be placed on a conditional provider network approval. It is the Department's expectation that the HMO will work to address the access issue. The Department will review conditional provider network approvals every six months to ensure adequate access to services for BadgerCare Plus and Medicaid SSI members. The Department has the authority to place the HMO on a corrective action plan or to decertify the HMO in the county if deficiencies persist.

61. Article V, Section I – Online Provider Directory
Amend Section I to read:

The HMO must post a provider directory on their website for members, network providers, and the Department to access. The file must be updated at least monthly with hard copies available upon request from a member. The file must include the following information:

- Provider full name and phone number
- Provider gender
- Clinic or facility address
- Clinic or facility website (if available)
- Accommodations for members with disabilities
- Specialty
- Languages spoken, and
- If they are accepting new patients.

62. Article VI, Section A(2) – Marketing Plans and Informing Materials
Add as a new (e):

e. Educational materials prepared by the HMO or by their contracted providers and sent to the HMO's entire membership (i.e. Medicare, BadgerCare Plus, Medicaid SSI and commercial members) do not require the Department's approval, unless there is specific mention of BadgerCare Plus and/or Medicaid SSI. Educational materials prepared by outside entitites (ie. American Cancer Society) do not require the Department's approval.

63. Article VI, Section D(1) – Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members
Amend Section D(1) to read:

The member handbook shall be written at a sixth-grade reading comprehension level. At a minimum, the HMO must include the information provided in the Standard Member Handbook language (Addendum II), which includes information about:

a. The telephone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care.
b. Information on contract services offered by the HMO.
c. Location of facilities.
d. Hours of service.
e. Informal and formal grievance procedures, including notification of the member's right to a fair hearing.
f. Grievance and appeal procedures.
g. HealthCheck.
h. Family planning policies.
i. Policies on the use of emergency and urgent care facilities.
j. Contracted providers' telephone numbers and whether the provider is accepting new "members". Additionally, include languages spoken by the provider.
k. Changing HMOs.
l. SSI Comprehensive assessments (for Medicaid SSI members only).
m. Counseling and referral services that are not covered under the contract because of moral or religious objections.
n. How to report suspected fraud or abuse.

64. Article VI, Section D(5) - Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members
Delete Section D(5)

65. Article VI, Section D(5)(d) - Member Handbook, Provider Directory, Education and Outreach for Newly Enrolled Members
Amend the new Section D(5)(d) to read:

At a minimum, the HMO must include the information provided in the Standard Member Handbook language (Addendum II). The HMO may create member handbook language that is simpler than the standard language, but the language must be approved by the Department. The HMO must also independently arrange for the translation of any non-standard language.

66. Article VII, Section F(8) – Coordination and Continuation of Care
Amend Section F(8) to read:

8. The HMO must ensure that the care of new members is not disrupted or interrupted. Per 42 CFR438.62(a), The HMO must ensure continuity of care for members receiving health care under FFS prior to their enrollment in the HMO, and for newly enrolled members switching HMO enrollment. The HMO 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.
        i. Authorize coverage of state plan approved services with the member's current providers for the first 90 days of enrollment.

ii. 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 lower level of care, or if the HMO 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.

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

67. Article VII, Section G(1) – Cultural Competency and Culturally and Linguistically Appropriate Services (CLAS) Standards
Amend the first sentence of Section G(1) to read:

It is DHS' vision that all members who receive health care in Wisconsin will routinely and systematically receive respectful, culturally competent and confidential services.

68. Article VII, Section I – Language Access Services
Amend Section I to read:

I. Language Access Services/Auxiliary Aids and Services

The HMO must provide language access services (for limited English proficient members) and auxiliary aids and services (for hearing-impaired and vision-impaired members) 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 HMO must:

1. Offer language access services and auxiliary aids and services in all crucial situations requiring language assistance as soon as it is determined that the member is of limited English proficiency or has communication impairment.

2. Provide 24 hours a day, seven days a week access to language access services in languages spoken by those individuals eligible to receive the services provided by the HMO or its providers and auxiliary aids and services for hearing-impaired or vision-impaired individuals eligible to receive the services provided by the HMO or its providers.

3. Provide timely language access services and auxiliary aids and services to assist adequately with all necessary care, including urgent and emergency care, upon member or provider request in a specific situation where care is needed. The HMO must clearly document all such actions and results. This documentation must be available to the Department upon request.

4. Use professional language access staff (for language access services and auxiliary aids and services), 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.

5. 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.

6. Designate a staff person to be responsible for the administration of language access services and auxiliary aids and services.

7. Receive Department approval of written policies and procedures for the provision of language access services and auxiliary aids and services.

As part of the certification application, the HMO must submit the policies and procedures for language access services and auxiliary aids and services. For interpreters, a list of interpreters the HMO uses, and the language spoken by each interpreter. The HMO must also submit, as part of certification, its policy on provision of auxiliary aids and services for hearing-impaired and vision-impaired members. The policy must include a description of the HMO's process for assessing the preferred method of communication of each hearing-impaired or vision-impaired member the type of auxiliary aid(s) s/he prefers in order to access program services and benefits. Once the hearing-impaired or vision-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. For members with visual impairment, the HMO must include its policy on providing materials in Braille, larger fonts, or other alternatives.

69. Article VIII – PROVIDER APPEALS
Amend the second sentence of the first paragraph to read:

The provider has 60 calendar days from the HMO's final appeal decision to submit all relevant information pertaining to the case(s) in question.

70. Article VIII, Section A – HMO Responsibility
Amend Section A to read:

A. HMO Responsibility

1. The HMO must have adequate staff available to train and support providers on resources available in order to prevent claim processing issues and denials. Refer to Article XI, C.7.

    - The HMO must provide information to network providers of any HMO-facilitated training opportunities which may reduce denied claims and provider appeals.

- Ensure that providers know, understand and comply with all business standards regarding completion and submission of accurate, correct and timely claims. This includes correct coding and maintenance of medical record.
- Grant providers access to all online technology and communication offered by the HMO (i.e. not limited to claim and appeal submission, policy resources, HMO website). Electronic notification from the HMO constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.
- Encourage providers to access and use the ForwardHealth Portal, including online Handbooks and Provider Updates.

2. The HMO must perform ongoing monitoring of provider appeals numbers and perform provider outreach and education/training on trends to prevent future denials/partial payments, thus reducing future provider appeals to the HMO and to the Department.

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

4. HMOs must provide a clear process for claim dispute escalation which must include the below elements in their contract or MOU with providers, in their provider manual, on the HMO website, or through written notification for non-contracted providers. Written (or HIPAA 835 transaction) notification of payment or denial must occur on the date of action when the action is denial of payment.

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

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

    - A statement regarding the provider's right to appeal to the HMO, including the timeline.

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

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

5. The HMO must adhere to the following timelines:

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

- The HMO must respond in writing within 45 calendar days from the date on the appeal letter. If the HMO fails to respond within 45 calendar days, or if the provider is not satisfied with the HMO's response, the provider may seek a final determination from the Department.

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

    - Submit a completed HMO designated Appeal form or a separate letter clearly marked "appeal".

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

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

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

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

- Send the appeal to the HMO, at minimum, within 60 calendar days of the initial denial or payment notice.

- The HMO must provide a statement advising the provider of their right to appeal to the Department if all appeals actions have been exhausted with the HMO, the HMO fails to respond to the appeal within 45 calendar days from the date on the appeal letter or if the provider is not satisfied with the HMO's response to the appeal.

71. Article VIII, Section B – Provider Responsibility
Amend Section B to read:

B. Provider Responsibility

1. To reserve the right to appeal to the Department, the BadgerCare Plus and Medicaid SSI provider must exhaust all appeal rights with the HMO if they disagree with the HMO's appeal response. Failure to exhaust all reasonable methods of dispute resolution with the HMO will result in the appeal being returned unprocessed or the denial upheld.

2. Appeals to the Department must be submitted in writing within 60 calendar days of the date on the HMO's final decision notice or, in the case of no response, within 60 calendar days from the 45 calendar day timeline allotted the HMO to respond.

3. A decision to uphold the HMO's original payment denial or to overturn the denial will be made based on the documentation submitted for Departmental review. Failure to submit the required documentation or submitting incomplete/insufficient/illegible documentation may lead to an

upholding of the original denial. The decision to overturn an HMO's denial must be clearly supported by the documentation submitted for review.

4. Providers may use the Department's form when submitting an appeal for State review. All elements of the form must be completed or listed in the letter if the form is not used. The form with instructions is available at the following website: https://www.dhs.wisconsin.gov/library/F-12022.htm

5. Providers are required to submit legible copies of all of the following documentation, regardless of whether the Managed Care Program Provider Appeal form or their own appeal letter is used. Incomplete appeals will not receive Departmental review and the denial upheld. The appeal packet must contain:

   - A copy of the original claim submitted to the HMO. If applicable, include a copy of all corrected claims submitted to the HMO.
   - A copy of all of the HMO's payment denial remittance(s) showing the date(s) of denial and reason code with a description of the exact reason(s) for the claim denial.
   - A copy of the provider's written appeal to the HMO.
   - A copy of the HMO response to the appeal.
   - A copy of the medical record for appeals regarding coding issues, or emergency determination. Providers should only send relevant medical documentation that supports the appeal. Large records submitted with no indication of where supporting information is found, will not be reviewed. Large documents should be submitted on a CD.
   - A copy of any contract language that support the appeal. If contract language is submitted, indicate the exact language that supports overturning the payment denial. Contract language submitted with no indication will not be reviewed.
   - Any other documentation that supports the appeal (e.g., commercial insurance Explanation of Benefits/Explanation of Payment to support Wisconsin Medicaid as the payer of last resort).

   Appeals to the Department must be sent to:

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

   Providers should notify ForwardHealth if the HMO subsequently overturns their original denial and reprocesses the claim for which an appeal has been submitted. Notification should be faxed to ForwardHealth at 608-224-6318. This documentation will be added to the original appeal documentation to complete the record. Providers can also call Managed Care Ombudsman Program at (800) 760-0001, option 1, to check the status of a submitted appeal.

72. Article X, Section A(3) – QAPI Program

Amend Section A(3) to read:

3. The HMO must have a written QAPI work plan that is ratified by the board of directors and outlines the scope of activity and the goals, objectives, and time lines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies and results from member satisfaction surveys and performance measures. The QAPI work plan must include:

    - Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time;
    - Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the Department and MetaStar.

73. Article X, Section A(11) – QAPI Program
Amend the first paragraph of Section A(11) to read:

11. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of important aspects of care and services, utilization monitoring, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives and conducting performance improvement projects.

74. Article X, Section B(4) – Monitoring and Evaluation
Amend Section B(4) to read:

4. The HMO must also monitor and evaluate care and services in certain priority clinical and non-clinical areas. Non-clinical areas of monitoring and evaluation must include member satisfaction.

75. Article X, Section E – Member Feedback on Quality Improvement
Add as a new (2) and shift the previous (2) to (3):

2. The HMO must demonstrate monitoring of member satisfaction as an input to improving quality of care and service.

76. Article X, Section E(3) – Member Feedback on Quality Improvement
Amend the second sentence of Section E(3) to read:

3. Other ways to bring members into the HMO's efforts to improve the health care delivery system include but are not limited to focus groups, member advisory councils, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services.

77. Article X, Section F(7) – Medical Records
Amend Section F(7) to read:

7. The HMO must have adequate policies in regard to transfer of medical records to ensure continuity of care. When a member switches HMOs or providers, it is the responsibility of the HMO to facilitate and/or broker the transfer of medical records between a member's previous and current providers upon provider request.

    The HMO policy regarding transfer of medical records to ensure continuity of care policies must include:

    a. When members are treated by more than one provider.

    b. The provider-to-provider transfer may be facilitated and/or brokered between HMOs on behalf of providers.

c. How provider requests for records are received and processed.

d. The process for transmitting and receiving provider records to both other HMOs and providers.

e. This may also include transfer to local health departments subject to the receipt of a signed authorization form as specified in Subsection 4 (with the exception of immunization status information which does not require member authorization.

Direct provider-to-provider exchanges are permitted if both providers are in agreement. It is then the responsibility of the agreeing providers to administrate the member medical record transfer, including HMO notification of the transfer.

The Department encourages HMO participation in health information exchanges, such as WISHIN, to facilitate the transfer of medical records between health plans and providers. The Department considers HMOs compliant with the medical record requirements in Article X (F)(7)(a)-(e) by participating in WISHIN.

78. Article X, Section G(5) – Utilization Management (UM)
Amend Section G(5) to read:

5. Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence, current standards of medical practice, or a consensus of relevant health care professionals, and are regularly updated. This includes HMO utilization management practice for emergency and post-stabilization services.

79. Article X, Section K – Pregnant Women
Amend Section K to read:

K. Additional Services for Pregnant Women

1. Tobacco Cessation

The HMO shall encourage providers to screen every pregnant woman for tobacco use during their initial prenatal visit, regardless of when this visit occurs. This information should be documented in the medical record, the member should be advised to quit and a referral made to a smoking cessation program, e.g., First Breath, Wisconsin Quit Line or other appropriate cessation assistance program. The member's cessation efforts should be assessed at every prenatal visit and at the post-partum visit.

2. Mental Health and Substance Abuse Screening

Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant women (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant women at risk for mental health or substance abuse problems during pregnancy. The benefit has two components:

- Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems.

- Brief preventive mental health counseling and/or substance abuse intervention for pregnant women identified as being at risk for experiencing mental health or substance abuse disorders.

3. Vaccines for Pregnant and Pospartum Women

The HMO shall encourage providers to screen every pregnant and postpartum woman to determine whether she needs an influenza or Tdap vaccine and to strongly recommend all vaccines needed.

80. Article X, Section L – Healthy Birth Outcomes
Amend the title of Section L to read:

L. Improving Birth Outcomes

81. Article X, Section L(1) – Healthy Birth Outcomes
Amend the first sentence of Section L(1) to read:

The BadgerCare Plus HMO must implement the OB Medical Home initiative as detailed in Article IV, D of the contract, in the following counties: Dane, Rock, Milwaukee, Kenosha, Racine, Ozaukee, Washington, Waukesha.

82. Article X, Section L(3) – Healthy Birth Outcomes
Amend the last sentence of Section L(3) to read:
The HMO may use the Department's Birth Outcome Registry Network (BORN) to identify women who are at risk of having a poor birth outcome or had a previous poor birth outcome.

83. Article X – Quality Assessment Performance Improvement (QAPI)
Add as a new Section Q:

Q. Health Disparity Plan

Per 42 CFR 438.340(b)(6) of the Managed Care Rule, the State is required to create and implement a "plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability."

The Department will employ a phased approach. In 2019:

- DHS will develop a Health Disparities Plan based on analysis of its data on member age, gender and disability status, and establish baselines for health disparities. DHS will use baselines to identify specific focus area for HMOs. Specifically, DHS will:
    - In the second quarter of 2019, release the Health Disparities Plan identifying specific focus area for 2019 on member age, gender, and disability status.
    - In the second quarter of 2019, begin sending member race and ethnicity data to HMOs for future initiatives.
- HMOs will use the specific focus areas identified by DHS to design and implement their own initiatives to reduce health disparities in 2019 and beyond. Specifically, they will:

- In the 90 days after the release of the Health Disparities Plan, submit to DHS a 2019 action plan for their health disparities reduction initiatives.
- In the second quarter of 2019, begin receiving member race and ethnicity data from DHS for future initiatives.
- By 12/31/2019, submit a brief progress report on their initiatives.
- By 6/30/2020, submit a report (format TBD) to the Department documenting their progress on the 2019 initiatives.
- In late 2019, collaborate with DHS to establish plans and targets for health disparities reduction in Contract Year 2020, and to implement remaining aspects of the Managed Care Rule.

84. Article XI, Section B – Compliance with Applicable Law
Amend the first paragraph to read:

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations that are in effect when the Contract is signed, or that come into effect during the term of the Contract. This includes, but is not limited to Title XIX of the Social Security Act, Title XXI, SCHIP, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, The Rehabilitation Act of 1973, The American with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act of 2010, and Title 42 of the CFR.

85. Article XI, Section C(11)(g) – Access to and Audit of Contract Records
Add as a new g. and shift remaining letters down:

g. School-based Mental Health Services

The Department encourages the HMO to contract with community-based mental health agencies and/or school-based providers for the provision of mental health care to BadgerCare Plus children in the school setting. The HMO is encouraged to assist with the coordination of covered mental health services to its members (including those children with an IEP who may have mental health needs) with the school, mental health provider, and family as appropriate.

86. Article XI – HMO Administration
Add as a new Section E.

E. Party in Interest

The HMO agrees to report to the state and, upon request, to the Secretary of the U.S. Department of Health & Human Services (DHHS), the Inspector General of the U.S. DHHS, and the Comptroller General a description of transactions between the HMO and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

- Any sale or exchange, or leasing of any property between the HMO and such a party.
- Any furnishing for consideration of goods, services (including management services), or facilities between the HMO and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.
- Any lending of money or other extension of credit between the HMO and such a party.

87. Article XII, Section D(4) – Encounter Data and Reporting Requirements
Add as a new (b) and shift previous (b) down:

b. The HMO must enter itself as an other payer on the encounter, identifying the amount and the date the HMO paid its provider.

88. Article XII, Section M(1) – Program Integrity
Remove the strikethrough language of the first sub-bullet under the last bullet.

89. Article XIII, Section C – HMO Review of Study or Audit Results
Amend the first sentence to read:

The Department will submit to the HMO for a 30 business day review/comment period, any BadgerCare Plus and/or Medicaid SSI and HMO audits, HMO report card, HMO Member Satisfaction Reports, or any other BadgerCare Plus and/or Medicaid SSI HMO studies the Department releases to the public that identifies the HMO by name.

90. Article XIV, Section B(1)(h) – Subcontract Standard Language
Add as a new (h) and shift remaining items down:

h. The contractor or subcontractors shall not perform any work outside the U.S. that involves access to, or the disclosure of, Protected Health Information (PHI).

91. Article XIV, Section C – Remedies for Violation, Breach, or Non-Performance of Contract
Amend Section C to read:

C. Sanctions, Financial Penalties and Remedial Actions for Violation, Breach, or Non-Performance of Contract

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny BadgerCare Plus and/or Medicaid SSI payments to the HMO for members who enroll after the date on which the HMO has been found to have committed on of the violations identified in the federal law. State payment for members of the contracting organization is automatically denied whenever, and for as long as, federal payment for such members has been denied as a result of the commission of such violations. The state may impose sanctions if the HMO has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

In addition, the Department may pursue all sanctions and remedial actions with the HMO that is taken with FFS providers if it determines, based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source, that an HMO acts or fails to act as follows pursuant to 42 CFR 438.700:

- Fails substantially to provide medically necessary services that the HMO is required to provide, under law or under this contract, to an enrollee covered under the contract.
- Imposes on enrollees premiums or charges that are in excess of the premiums of charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to enroll a member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the Department.

- Misrepresents or falsifies information that it furnishses to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans.
- Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.
- Violates any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or any implementing regulations.

Per 42 CFR 438.724, the State must give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed above. This notice must be given no later than 30 days after the State imposes or lifts a sanction and must specify the affected HMO, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

1. Corrective Action Plan

   In addition to imposing sanctions or financial penalties, if the Department determines that the HMO is not in compliance with one or more requirements of this contract, the Department can require the HMO to complete a Corrective Action Plan (CAP). The CAP will outline the area(s) of non-compliance, follow-up recommendations/requirements, time frames for remedial action by the HMO, and any other actions the Department deems necessary to remedy the non-compliance. The HMO shall comply with all recommendations/requirements made in writing by the Department within the time frames specified by the CAP.

   Upon receipt of the CAP from the Department, the HMO shall submit a written response to the Department detailing steps for compliance, including a timeframe(s) specified by the Department.

   The Department may deny or postpone a service area expansion request from an HMO on an active CAP.

   The HMO shall be responsible for ensuring corrective action when a subcontractor or provider is not in compliance with the contract.

2. Financial Penalties

   The Department may pursue all financial penalties with the HMO that are taken with FFS providers including any civil monetary 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 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).

- If the HMO fails to comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations, the Department may impose liquidated damages in the amount of $10,000. For additional details, see Article IV, Section F of the contract.

- There will be a flat assessment of $10,000 for any HMO missing the 80% HealthCheck target. This penalty is no part of the other HMO P4P measures and withhold. For additional details, see Article IV, Section C.2(a) of the contract.

- If the HMO fails to comply with federal CLIA regulations as specified by 42 CFR Part 493, 42 CFR 263a, and Wisconsin Administrative Code, Chapter 105, DHS 105.42(1-2) and DHS 105.46, sanctions in the amount of $10,000 may be imposed. For additional details, see Article XI, Section C(11) of the contract.

The Department will provide written notice of all financial penalties that explains the basis and nature of the penalties and any due process protections the state elects to provide.

3. Suspension and Reduction fo Enrollment

   a. Suspension of New Enrollment

      Whenever the Department determines that the HMO is out of compliance with this Contract, the Department may suspend the HMO's right to receive new enrollment under this Contract. When exercising this option, the Department, must notify the HMO 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 HMO's non-compliance and provide an opportunity to enroll in another HMO.

   b. Department-Initiated Enrollment Reductions

      The Department may reduce the maximum enrollment level and/or number of current members whenever it determines that the HMO has failed to provide one or more of the Contract services required under the Contract or the HMO has failed to maintain or make available any records or reports required under this Contract that the Department needs to determine whether the HMO is providing contract services as required. The HMO will have at least 30 days to correct the non-compliance prior to the Department taking any action set forth in this paragraph. The Department may reduce enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized.

   c. Other Enrollment Reductions

The Department may also suspend new enrollment or disenroll members in anticipation of the HMO not being able to comply with federal or state law at its current enrollment level. Such suspension shall not be subject to the 30 day notification requirement.

4. Withholding of Capitation Payments and Orders to Provide Services

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

Notwithstanding the provisions of this Contract, the Department may withhold portions of capitation payments as liquidated damages or otherwise recover damages from the HMO on the following grounds:

a. Medically Necessary Covered Services

Whenever the Department determines that the HMO has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either order the HMO to provide such service, or withhold a portion of the HMO's capitation 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 HMO to provide services under this section and the HMO fails to provide the services within the timeline specified by the Department, the Department may withhold from the HMO's capitation payments an amount up to 150% of the Fee for Service amount for such services.

When it withholds payments under this section, the Department must submit to the HMO 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:

- If the Department withheld payments, it will restore to the HMO the full capitation payment; or
- If the Department ordered the HMO to provide services under this section, it will pay the HMO the actual documented cost of providing the services.

b. Payment Denials for New Members

Payments provided for under the contract will be denied for new members when, and for so long as, payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

Specifically, the State may recommend that CMS impose the denial of payment for new members to an HMO that has a contract to provide BadgerCare Plus and/or Medicaid SSI services if the State

determines that the HMO acts or fails to act as pursuant to 42 CFR 438.700. The State's determination becomes CMS' determination for purposes of Section 1903(m)(5)(A) of the Act unless CMS reverses or modifies it within 15 days. When the State decides to recommend imposing the sanctions described in 42 CFR 438.730(e), this recommendation becomes CMS' decision, for purposes of section 1903(m)(5)(B)(ii) of the Act, unless CMS rejects this recommendation within 15 days. If the State's determination becomes CMS' determination, the State will take the following options: (1) Give the HMO written notice of the nature and basis of the proposed sanction; (2) Allow the HMO 15 days from the date it receives the notice to provide evidence that it has not acted or failed to act in the manner that is the basis for the recommended sanction; (3) May extend the initial 15-day period for an additional 15 days if: (i) The HMO submits a written request that includes a credible explanation of why it needs additional time; (ii) The request is received by CMS before the end of the initial period; (iii) CMS has not determined that the HMO's conduct poses a threat to an enrollee's health or safety.

If the HMO submits a timely response to the notice of sanction, the State: (i) Conducts an informal reconsideration that includes review of the evidence by a State agency official who did not participate in the original recommendation; (ii) Gives the HMO a concise written decision setting forth the factual and legal basis for the decision; (iii) Forwards the decision to CMS. The State's decision will become CMS' decision unless CMS reverses or modifies the decision within 15 days from date of receipt by CMS. If CMS reverses or modifies the State decision, the agency sends the HMO a copy of CMS' decision.

c. Required Reports and Data Submissions

1) Encounter Data

If the HMO 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 HMO 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 HMO's capitation payments.

Additionally, if it is found that the HMO failed to submit accurate and complete encounter data prior to the submission deadlines, the Department will be considered damaged. The HMO may be held responsible for reimbursing the Department for the staffing and out-of-pocket costs incurred by the Department and its contractors associated with reviewing the delayed data submission, and developing and publishing revised rates.

The HMO must meet the Department's aggregate standards for submitting encounter data as outlined in Article XII(D) or liquidated damages may apply based on "erred" data.

The term "erred encounter record" means an encounter record that failed an edit when a correction is expected by the Department, unless the record is otherwise priced and included in the HMO 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 HMO fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages of $5 per erred encounter record per month until the

error has been corrected or the issue has been resolved to the Department's satisfaction. The liquidated damage amount will be deducted from the HMO's capitation 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 HMO 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 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, HMOs must submit a consistent volume of encounters each month based on a calendar year average.

- If it is found that an HMO submitted inaccurate or incomplete encounter data that was used in the development of the current rates, the Department may assess damages associated with the reporting error and data that the HMO failed to submit. The damages will be up to the priced amount of the inaccurate encounter records and the estimated amount or actuarial adjustment for the amount that HMO failed to submit.

  Failure to successfully report usable data using the ASC X12 837 HIPAA Compliant Transaction or the Financial Report information may result in a 1% withhold to the HMO's administration rate. The amount will be withheld from the capitation payment until the HMO is able to submit usable data.

  If the HMO is unable to submit usable data by the period of time defined by the Department when withholding the payment, the amount withheld will be forfeited.

  If either party terminates the contract during the period that payment is withheld, the amount will be automatically forfeited.

  Data is determined usable if it can be used in the rate-setting process in its entirety for the encounter data base years used to establish the rates.

  Whenever the Department determines that the HMO has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

2) Provider and Facility Network Data Submission

   Incomplete or inaccurate provider and/or facility data will subject the HMO to sanctions outlined in Article XIV, Section C.

3) Dental Claims

Per Article IV (A)(8)(c), the Department will conduct validity and completeness audits of dental claims. Upon request, the HMO 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 HMO to sanctions.

4) Fraud, Waste and Abuse

Per Article XII(M)(2), failure on the part of the HMO to cooperate or report fraud, waste and/or abuse may result in any applicable sanctions.

5) Member Assessments

Health Needs Assessment Screening (BadgerCare Plus Childless Adults only)

HMOs who do not meet their HNA Screening targets for the Childless Adults population as defined in Article III(A)(2) of this contract will be subject to financial performance penalties.

The penalty amount will be the lesser of either $250,000 or 25% of the monthly administrative capitation rate for the proportion of the BadgerCare Plus Childless Adult (CLA) membership for whom the HMO fails to meet the HNA performance target in the calendar year. For additional details see Article III (A)(2).

d. Procedures for Withholding Capitation Payments

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

- The Department will notify the HMO's contract administrator no later than the second business day after the Department's deadline that the HMO has failed to submit the required data or the required data cannot be processed.
- Beginning on the second business day after the Department's deadline, the HMO will be subject without further notification to liquidated damages per data file or report.
- If the HMO submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the HMO Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.
- If the HMO submits any other required data or report in the required format within five business days from the deadlines, the Department will rescind liquidated damages and immediately process the data or report.
- If the HMO repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the HMO to develop a CAP to comply with the Contract requirements that must meet Department approval.
- After the corrective action plan has been implemented, if the HMO continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Section C, 3.a (Suspension of New

Enrollment), or under Section C, 3.b (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.

- If the HMO 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 capitation payments otherwise due the HMO that will not be released to the HMO until all required reports or data are submitted and accepted after expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

e. Inappropriate Payment Denials

The HMO 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 capitation payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure of denial was an isolated instance or a repeated pattern or practice, and whether the health of a member was injured, threatened or jeopardized by the failure or denial. These sanctions apply not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal was made (i.e., the Department knows about the documented abuse from other sources).

f. Temporary Management

The state will impose temporary management, as provided in 42 CFR 438.706, when there is continued egregious behavior by the HMO, 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 HMO's members while improvements are made to remedy violations under 438.700 or until there is an orderly termination or reorganization of the HMO.

The state must impose temporary management (regardless of any other sanction that may be imposed) if it finds that an HMO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act, or this section of the contract. The state must also grant enrollees the right to terminate enrollment.

The state may not delay imposition of temporary management to provide a hearing before imposing this sanction.

The state may not terminate temporary management until it determines that the HMO can ensure that the sanctioned behavior will not recur.

g. HMO Subcontractors

Per Article XIV (B)(1)(i), subcontractor agrees to provide representatives of the HMO, 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 HMO and the subcontractor), and administrative records. Refusal will result in sanctions and/or financial penalties in Article XIII, Section C against the HMO 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.

h. Termination and Modification of Contract

1) Termination by Mutual Consent

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

2) Unilateral Termination

Before the State terminates an HMO contract under 42 CFR §438.708, the State must provide the HMO a pre-termination hearing. The State will give the HMO written notice of its intent to terminate, the reason for termination, and the time and place of the hearing. After the hearing, the State will give the HMO written notice of the decision affirming or reversing the proposed termination of the contract and, for affirming the decision, the effective date of termination. For an affirming decision, give enrollees of the HMO notice of the termination and information, consistent with 42 CFR §438.10, on their options for received Medicaid services following the effective date of termination.

In addition, this Contract between the parties may be terminated by either party as follows:

- 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 for a reason other than HMO non-compliance may impose an obligation upon the Department to pay the Contractor's reasonable and necessarily incurred termination expenses.

- Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of its intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the

last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the HMO.

- 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 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 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 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.

- This contract may be terminated by the HMO due to dissatisfaction with the final capitation rates, which will be effective based on negotiations with HMOs. The HMO must notify the Department within 30 days of notice of the final rates if the HMO intends to terminate its contract with the Department. The HMO must also notify the Department within 30 days if it intends to decrease its service area due to the final capitation rates. In the event of termination under this paragraph, the Contract will terminate without termination costs to either party and, for purposes of section D., will be considered a termination under paragraph 1. To assure the smooth transition of members, the termination of the Contract or the decrease in service area will be effective no less than 90 days, and no more than 120 days, after HMO notification to DHS of the intent to terminate the Contract or decrease the HMO's service area.

i. 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 failure to carry out the substantive terms of this contract by the HMO; failure to meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act; or by mutual consent with termination initiated by the HMO:

- 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.

- The HMO will be responsible for all expenses related to said notification.

- The Department will grant the HMO a hearing before termination by the Department occurs. The Department will notify the members of the hearing and allow them to disenroll from the HMO without cause.

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

   - 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.

   - The Department may be responsible for all expenses relating to said notification.

3) Where this Contract is terminated for any reason the following payment criteria will apply:

   - Any payments advanced to the HMO 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.

   - The HMO will supply all information necessary for the reimbursement of any outstanding BadgerCare Plus and/or Medicaid SSI claims within the period of time specified by the Department.

   - If a contract is terminated, recoupments will be handled through a payment by the HMO to the Department within 90 days of contract termination.

4) If a HMO initiates termination of the contract mid-year for any other reason than those listed under Article XIV, C.9(2), or initiates a major reduction in service area or populations served, the HMO will at minimum be responsible for the following requirements to assist in the smooth transition of impacted members:

   - Notification to the Department at least 90 days prior to the termination effective date.

   - Compliance with a transition plan which may include, but is not limited to, development of a communication plan for DHS approval, additional data-sharing reports for transitioning members, and timelines for outstanding financial reconciliation.

- Costs of the Department's notifications to impacted members and providers, which may include mailed notices, ForwardHealth Member and/or Provider Updates, and/or phone outreach.

- Transition costs associated with the Department's staff and IT resources necessary to facilitate transition of members out of the HMO upon contract termination.

- Pay for Performance withhold reconciliation: If a HMO terminates the contract before sufficient time has elapsed for relevant HEDIS measures to be calculated for that year (e.g., before 11 months of continuous enrollment are completed), the HMO is not eligible for any performance bonuses for the Measurement Year, and is subject to the P4P withhold for the months the HMO had enrollment during the Measurement Year. The Department reserves the right to calculate the HMO's performance against the Measurement Year's benchmarks to determine if the HMO will earn back the withhold by:

    - Applying the HMO's previous measurement year's P4P results to the termination year's performance benchmarks; or

    - If the HMO's previous year's P4P results are not available for any measures, the Department reserves the right to calculate P4P results using the most recent 12 months of complete data available (for example, using data from July 1 of the previous calendar year to June 30 of the current calendar year). The cost incurred by the Department for such calculations will be added to the transition costs listed above.

    - If a HMO does not have data that applies under the first and second bullets above, DHS will review P4P calculations on an individual basis.

j. HMO Mergers

For the purpose of this section, a merger or acquisition means a change in controlling interest of an HMO, including an asset or stock purchase.

This contract between the Health Maintenance Organization (HMO) and the State of Wisconsin and the monies which may become due may not be assigned, transferred, pledged or hypothecated in any way by the HMO, including by way of an asset or stock purchase by the HMO, without the express prior written approval of the Department.

In the event that the merger or acquisition of an HMO is approved by the Office of the Commissioner of Insurance, the Department shall allow the surviving HMO to participate in the Medicaid program unless it would be detrimental to Medicaid members or the Medicaid program, as determined by the Department through its certification standards. In order to participate in the Medicaid program, the surviving HMO must meet OCI standards, accept the terms and rates of the current HMO contract, and meet DHS certification requirements.

The Department retains the authority to determine what will occur with the non-surviving HMO's Medicaid enrollees. These determinations will be made on an individualized basis based on what is in the best interests of the membership.

HMOs must notify the Department of any proposed merger or acquisition immediately, but no fewer than 180 days prior to the proposed date of merger or acquisition, unless the Department waives the 180 day requirement at its discretion.

k. Modification

This Contract may be modified at any time by written mutual consent of the HMO 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 HMO, the HMO will receive written notice.

If the Department changes the reporting requirements as specified in Article XII, Section K during the Contract period, the HMO shall have 180 days to comply with such changes or to initiate termination of the Contract.

92. Article XV, Section D(1) – Payment Requirements/Procedures
Amend the paragraph of Section D(1) to read:

The HMO must maintain a claim processing system that can upon request identify date of receipt of the claim as indicated by its date stamp, adjudication action on all claims types (i.e., paid, denied, suspended, etc.), and date of adjudication. In addition, the claim processing system must identify, within the individual claim, the services provided and the diagnoses of the members using nationally accepted coding systems as specified in the Encounter User Guide. Finally, the claim processing system must be capable of identifying the provider of services National Provider Identifier (NPI), or atypical identifier if applicable, and their associated taxonomy numbers and CLIA numbers.

93. Article XV, Section D(3) – Payment Requirements/Procedures
Amend Section D(3) to read:

3. Payment to a Non-HMO contracted provider for Services Provided to a Disabled Member Less than Three or for Services Ordered by the Courts (BadgerCare Plus Only)

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

94. Article XVI, Section I – Coordination of Benefits (COB), Third Party Liability (TPL) and Subrogation
Add as a new (9):

9. In accordance with 42 CFR 438.3(t), the HMO must enter into a Coordination of Benefits Agreement (COBA) with Medicare, participate in the automated claims crossover process, and execute all deliverables in the agreement.

95. Article XVII, Section B(1)(a)

Amend Section B(1)(a) to read:
Pursuant to 42 CFR § 455.104 HMO's, and subcontracted disclosing entities and fiscal agents, must provide the following disclosures to the Department:

96. Article XVII, Section G – Resolution of Reporting Errors
Amend the first paragraph of Section G to read:

If the HMO discovers a reporting error, the Department's Bureau of Fiscal Management in the Division of Medicaid Services must be contacted in writing within 15 days of the discovery.

97. Addendum II
Amend "INTERPRETER SERVICES" section to read:

[Note to HMO: The Member Handbook must contain taglines in at least the top three non-English languages spoken by members in the applicable HMO Rate Region, as well as large print, explaining that written translation or oral interpretation of the document is available to the member free of charge. The non-English tagline is provided in a fillable Word Document and is available for download at: https://www.dhs.wisconsin.gov/publications/p02057.docx]

[Insert applicable non-English taglines here].

[Note to HMO: The Member Handbook must also include a large print tagline with information on how to request auxiliary aids and services, including the provision of the materials in alternative formats.]

[Name of HMO]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact [Name of entity or of contact at HMO] at 1-xxx-xxx-xxxx.

98. Addendum II
Amend the second paragraph of the "CHOOSING A PRIMARY CARE PHYSICIAN" section to read:

Women may see a women's health specialist, such as an Obstetrician and Gynecologist (OB/GYN), nurse midwife, or licensed midwife, without a referral in addition to choosing from their primary care physician.

99. Addendum II
Amend the last paragraph of the "Transportation Services" section to read:

You must schedule routine rides at least two business days before your appointment. You can schedule a routine ride by calling the NEMT manager at 1-866-907-1493 (or TTY 711), Monday through Friday, from 7:00 a.m. until 6:00 p.m. You may also schedule rides for urgent appointments. A ride to an urgent appointment will be provided in three hours or less.

100. Addendum II
Amend the "Appeals" section to read:

You have the right to appeal if you believe your benefits are wrongly denied, limited, reduced, delayed, or stopped by [HMO Name]. An appeal must be made no more than 45 days after you receive notice of services being denied, limited, reduced, delayed, or stopped.

You can appeal to the HMO, the Department and/or the State of Wisconsin, Division of Hearings and Appeals (DHA) if you believe your benefits are wrongly denied, limited, reduced, delayed, or stopped by [HMO Name]. If you make an appeal before the effectice date, the service may continue. You may need to pay for the cost of services if the hearing decision is not in your favor.

If you want a fair hearing, send a written request to:

Department of Administration
Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

You will not be treated differently from other members because you request a fair hearing. Your health care benefits will not be affected.

If you need help writing a request for a fair hearing, please call either the BadgerCare Plus and Medicaid SSI Ombuds at 1-800-760-0001 or the HMO Enrollment Specialist at 1-800-291-2002.

101. Addendum II
Add as new after the "Right to Medical Records" section:

HMO Moral or Religious Objection

The HMO will inform members of any covered Medicaid benefits which are not available through the HMO because of an objection on moral or religious grounds. [HMO Name] will inform members about how to access those services through the State.

102. Addendum II – Under the "Your Member Rights" section
Add as a new ninth bullet:

- You may switch HMOs without cause during the first 90 days of [HMO Name] enrollment.

103. Addendum II – Under the "Your Member Rights" section
Add as a new tenth bullet:

- You have the right to switch HMOs, without cause, if the State imposes sanctions or temporary management on [HMO Name].

104. Addendum II – Under the "Your Member Rights" section

Add as a new eleventh bullet:

- You have the right to receive information from [HMO Name] regarding any significant changes with [HMO Name] at least 30 days before the effective date of the change.

105. Addendum II
Add as a new "Fraud and Abuse" section after "Your Civil Rights"

Fraud and Abuse

If you suspect fraud or abuse of the Medicaid program, you may report it. Please go to www.reportfraud.wisconsin.gov.

106. Addendum V
Amend the paragraph to read:

Here's the Benefits and Cost Sharing Chart link.

107. Addendum VI – Rate Exhibits
Replace the CY2018 Rate Exhibits with the CY2019 Rate Exhibits below:

A. SSI Medicaid Only Rate Exhibits

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
New HMOs

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	1,136	2,232	1,580	2,574	1,939	5,769	15,230
Ages 40-64	2,066	3,182	2,640	3,524	2,672	9,192	23,276
Ages 65+	25	238	116	395	249	844	1,867
All Ages	3,227	5,652	4,336	6,493	4,860	15,805	40,373
2019 All Services Capitation Rate PMPM							
Ages 19-39	$385.05	$496.94	$471.19	$497.63	$538.96	$693.94	$566.01
Ages 40-64	$648.72	$777.55	$744.78	$763.20	$812.56	$1,110.31	$895.66
Ages 65+	$638.06	$768.48	$733.91	$754.56	$804.39	$1,100.82	$916.67
All Ages	$555.82	$666.35	$644.80	$657.40	$702.98	$957.82	$772.28
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$382.23	$494.95	$468.28	$495.99	$538.04	$693.43	$564.62
Ages 40-64	$644.94	$774.88	$740.87	$760.99	$811.32	$1,109.62	$893.76
Ages 65+	$637.30	$767.94	$733.13	$754.12	$804.14	$1,100.68	$916.35
All Ages	$552.40	$664.04	$641.33	$655.52	$701.92	$957.23	$770.64
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$376.03	$489.57	$462.19	$490.10	$531.02	$685.61	$557.89
Ages 40-64	$635.52	$766.77	$731.61	$752.18	$800.95	$1,098.13	$883.71
Ages 65+	$629.68	$761.63	$725.55	$747.56	$797.02	$1,093.08	$909.20
All Ages	$544.13	$657.09	$633.27	$648.00	$693.05	$947.29	$761.98
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$373.21	$487.58	$459.28	$488.46	$530.10	$685.10	$556.49
Ages 40-64	$631.74	$764.10	$727.70	$749.97	$799.71	$1,097.44	$881.81
Ages 65+	$628.92	$761.09	$724.77	$747.12	$796.77	$1,092.94	$908.88
All Ages	$540.71	$654.77	$629.81	$646.13	$691.99	$946.69	$760.34

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Anthem Blue Cross Blue Shield

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	246	218	279	291	301	655	1,990
Ages 40-64	370	259	439	285	366	1,076	2,795
Ages 65+	4	23	18	29	39	114	227
All Ages	620	500	736	605	706	1,845	5,012
2019 All Services Capitation Rate PMPM							
Ages 19-39	$515.84	$569.16	$490.04	$448.12	$506.69	$735.57	$579.10
Ages 40-64	$720.06	$773.73	$849.62	$818.94	$753.92	$1,162.38	$930.18
Ages 65+	$752.31	$790.80	$774.40	$757.25	$775.57	$1,094.97	$934.67
All Ages	$639.24	$685.32	$711.47	$637.62	$649.71	$1,006.69	$790.99
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$513.02	$567.17	$487.13	$446.48	$505.77	$735.06	$577.58
Ages 40-64	$716.28	$771.06	$845.71	$816.73	$752.68	$1,161.69	$928.17
Ages 65+	$751.55	$790.26	$773.62	$756.81	$775.32	$1,094.83	$934.37
All Ages	$635.86	$683.05	$708.02	$635.77	$648.66	$1,006.10	$789.25
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$506.82	$561.79	$481.04	$440.59	$498.72	$727.35	$570.90
Ages 40-64	$706.86	$762.95	$836.45	$807.92	$742.27	$1,150.36	$918.09
Ages 65+	$743.93	$783.95	$766.04	$750.25	$768.17	$1,087.33	$927.17
All Ages	$627.73	$676.21	$700.00	$628.47	$639.86	$996.29	$780.65
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$504.00	$559.80	$478.13	$438.95	$497.80	$726.84	$569.38
Ages 40-64	$703.08	$760.28	$832.54	$805.71	$741.03	$1,149.67	$916.07
Ages 65+	$743.17	$783.41	$765.26	$749.81	$767.92	$1,087.19	$926.87
All Ages	$624.35	$673.93	$696.55	$626.62	$638.82	$995.70	$778.91

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Care Wisconsin Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	99	74	713	24	1	911
Ages 40-64	-	113	105	1,147	12	-	1,377
Ages 65+	-	8	5	145	1	-	159
All Ages	-	220	184	2,005	37	1	2,447
2019 All Services Capitation Rate PMPM							
Ages 19-39	$503.37	$437.34	$551.13	$509.74	$514.18	$692.26	$505.55
Ages 40-64	$767.04	$746.57	$782.53	$774.18	$787.78	$1,108.63	$772.67
Ages 65+	$756.38	$794.87	$778.47	$761.32	$779.61	$1,099.14	$763.66
All Ages	N/A	$609.17	$689.36	$679.21	$610.09	$692.26	$672.64
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$500.55	$435.35	$548.22	$508.10	$513.26	$691.75	$503.79
Ages 40-64	$763.26	$743.90	$778.62	$771.97	$786.54	$1,107.94	$770.30
Ages 65+	$755.62	$794.33	$777.69	$760.88	$779.36	$1,099.00	$763.21
All Ages	N/A	$606.89	$685.93	$677.33	$609.08	$691.75	$670.62
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$494.35	$429.97	$542.13	$502.21	$506.24	$683.93	$497.91
Ages 40-64	$753.84	$735.79	$769.36	$763.16	$776.17	$1,096.45	$761.50
Ages 65+	$748.00	$788.02	$770.11	$754.32	$772.24	$1,091.40	$756.62
All Ages	N/A	$600.07	$677.99	$669.72	$600.97	$683.93	$663.05
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$491.53	$427.98	$539.22	$500.57	$505.32	$683.42	$496.15
Ages 40-64	$750.06	$733.12	$765.45	$760.95	$774.93	$1,095.76	$759.13
Ages 65+	$747.24	$787.48	$769.33	$753.88	$771.99	$1,091.26	$756.17
All Ages	N/A	$597.78	$674.57	$667.84	$599.97	$683.42	$661.03

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Group Health Coop Eau Claire

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	291	-	486	124	-	-	901
Ages 40-64	655	-	914	153	-	-	1,722
Ages 65+	9	-	44	10	-	-	63
All Ages	955	-	1,444	287	-	-	2,686
2019 All Services Capitation Rate PMPM							
Ages 19-39	$447.58	$445.04	$452.92	$367.20	$435.89	$613.97	$439.40
Ages 40-64	$728.09	$725.65	$709.19	$623.55	$709.49	$1,030.34	$708.77
Ages 65+	$678.09	$716.58	$700.18	$683.03	$701.32	$1,020.85	$694.30
All Ages	$642.14	N/A	$622.66	$514.86	N/A	N/A	$618.07
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$444.76	$443.05	$450.01	$365.56	$434.97	$613.46	$436.69
Ages 40-64	$724.31	$722.98	$705.28	$621.34	$708.25	$1,029.65	$705.06
Ages 65+	$677.33	$716.04	$699.40	$682.59	$701.07	$1,020.71	$693.58
All Ages	$638.69	N/A	$619.19	$512.96	N/A	N/A	$614.77
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$438.56	$437.67	$443.92	$359.67	$427.95	$605.64	$430.59
Ages 40-64	$714.89	$714.87	$696.02	$612.53	$697.88	$1,018.16	$695.78
Ages 65+	$669.71	$709.73	$691.82	$676.03	$693.95	$1,013.11	$686.16
All Ages	$630.26	N/A	$611.04	$505.49	N/A	N/A	$606.60
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$435.74	$435.68	$441.01	$358.03	$427.03	$605.13	$427.89
Ages 40-64	$711.11	$712.20	$692.11	$610.32	$696.64	$1,017.47	$692.07
Ages 65+	$668.95	$709.19	$691.04	$675.59	$693.70	$1,012.97	$685.43
All Ages	$626.80	N/A	$607.57	$503.59	N/A	N/A	$603.30

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Independent Care (ICare)

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	4	151	55	636	276	1,162	2,284
Ages 40-64	4	175	61	988	300	2,307	3,835
Ages 65+	-	20	3	114	34	120	291
All Ages	8	346	119	1,738	610	3,589	6,410
2019 All Services Capitation Rate PMPM							
Ages 19-39	$514.51	$536.24	$517.27	$551.00	$484.57	$723.29	$628.77
Ages 40-64	$778.18	$808.07	$806.05	$773.87	$771.52	$1,104.33	$974.56
Ages 65+	$767.52	$806.01	$789.61	$772.46	$790.72	$1,110.13	$916.32
All Ages	$646.35	$689.32	$672.17	$692.22	$642.76	$981.16	$848.70
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$511.69	$534.25	$514.36	$549.36	$483.65	$722.78	$627.74
Ages 40-64	$774.40	$805.40	$802.14	$771.66	$770.28	$1,103.64	$973.29
Ages 65+	$766.76	$805.47	$788.83	$772.02	$790.47	$1,109.99	$916.02
All Ages	$643.05	$687.07	$668.80	$690.34	$641.72	$980.54	$847.56
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$505.49	$528.87	$508.27	$543.47	$476.67	$715.12	$620.85
Ages 40-64	$764.98	$797.29	$792.88	$762.85	$759.96	$1,092.38	$962.91
Ages 65+	$759.14	$799.16	$781.25	$765.46	$783.38	$1,102.54	$909.03
All Ages	$635.24	$680.26	$661.04	$682.74	$633.09	$970.58	$838.58
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$502.67	$526.88	$505.36	$541.83	$475.75	$714.61	$619.81
Ages 40-64	$761.20	$794.62	$788.97	$760.64	$758.72	$1,091.69	$961.64
Ages 65+	$758.38	$798.62	$780.47	$765.02	$783.13	$1,102.40	$908.73
All Ages	$631.94	$678.01	$657.68	$680.86	$632.05	$969.96	$837.44

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
MHS Health Wisconsin

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	174	348	231	269	178	770	1,970
Ages 40-64	297	426	374	297	214	1,109	2,717
Ages 65+	2	27	13	21	23	97	183
All Ages	473	801	618	587	415	1,976	4,870
2019 All Services Capitation Rate PMPM							
Ages 19-39	$457.57	$460.29	$467.71	$435.68	$484.45	$704.83	$555.32
Ages 40-64	$707.72	$744.63	$743.21	$755.54	$771.67	$1,120.86	$897.29
Ages 65+	$724.48	$762.97	$746.57	$729.42	$747.47	$1,066.89	$916.68
All Ages	$615.77	$621.71	$640.30	$608.03	$647.14	$956.09	$759.69
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$454.75	$458.30	$464.80	$434.04	$483.53	$704.32	$553.88
Ages 40-64	$703.94	$741.96	$739.30	$753.33	$770.43	$1,120.17	$895.30
Ages 65+	$723.72	$762.43	$745.79	$728.98	$747.22	$1,066.75	$916.38
All Ages	$612.36	$619.41	$636.83	$606.14	$646.09	$955.50	$757.98
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$448.55	$452.92	$458.71	$428.15	$476.76	$696.88	$547.34
Ages 40-64	$694.52	$733.85	$730.04	$744.52	$760.43	$1,109.23	$885.51
Ages 65+	$716.10	$756.12	$738.21	$722.42	$740.34	$1,059.50	$909.37
All Ages	$604.13	$612.55	$628.79	$598.75	$637.65	$946.11	$749.61
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$445.73	$450.93	$455.80	$426.51	$475.84	$696.37	$545.89
Ages 40-64	$690.74	$731.18	$726.13	$742.31	$759.19	$1,108.54	$883.51
Ages 65+	$715.34	$755.58	$737.43	$721.98	$740.09	$1,059.36	$909.07
All Ages	$600.71	$610.25	$625.32	$596.86	$636.60	$945.51	$747.90

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Molina Healthcare

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	25	131	28	15	288	658	1,145
Ages 40-64	38	158	38	27	292	766	1,319
Ages 65+	-	16	3	8	22	96	145
All Ages	63	305	69	50	602	1,520	2,609
2019 All Services Capitation Rate PMPM							
Ages 19-39	$487.60	$464.39	$499.98	$488.62	$454.18	$600.47	$541.72
Ages 40-64	$751.27	$746.73	$773.57	$754.19	$706.03	$1,044.33	$911.61
Ages 65+	$740.61	$779.10	$762.70	$745.55	$763.77	$1,083.34	$976.01
All Ages	$646.64	$627.16	$662.08	$673.14	$587.65	$854.65	$752.86
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$484.78	$462.40	$497.07	$486.98	$453.26	$599.96	$540.81
Ages 40-64	$747.49	$744.06	$769.66	$751.98	$704.79	$1,043.64	$910.34
Ages 65+	$739.85	$778.56	$761.92	$745.11	$763.52	$1,083.20	$975.78
All Ages	$643.24	$624.89	$658.71	$671.38	$586.60	$854.07	$751.80
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$478.58	$457.02	$490.98	$481.09	$446.31	$592.18	$533.62
Ages 40-64	$738.07	$735.95	$760.40	$743.17	$694.52	$1,032.20	$899.74
Ages 65+	$732.23	$772.25	$754.34	$738.55	$756.47	$1,075.63	$968.48
All Ages	$635.10	$618.05	$650.81	$663.81	$578.04	$844.46	$742.88
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$475.76	$455.03	$488.07	$479.45	$445.39	$591.67	$532.71
Ages 40-64	$734.29	$733.28	$756.49	$740.96	$693.28	$1,031.51	$898.47
Ages 65+	$731.47	$771.71	$753.56	$738.11	$756.22	$1,075.49	$968.25
All Ages	$631.70	$615.79	$647.44	$662.05	$576.99	$843.88	$741.83

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Network Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	104	264	152	186	128	478	1,312
Ages 40-64	196	386	235	204	141	472	1,634
Ages 65+	1	24	7	17	12	66	127
All Ages	301	674	394	407	281	1,016	3,073
2019 All Services Capitation Rate PMPM							
Ages 19-39	$419.86	$460.08	$455.81	$523.50	$404.05	$592.76	$508.26
Ages 40-64	$731.84	$742.59	$686.42	$664.93	$664.56	$910.75	$765.37
Ages 65+	$712.24	$750.73	$734.33	$717.18	$735.37	$1,054.56	$901.48
All Ages	$623.98	$632.22	$598.30	$602.48	$548.92	$770.49	$661.22
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$417.04	$458.09	$452.90	$521.86	$403.13	$592.25	$506.79
Ages 40-64	$728.06	$739.92	$682.51	$662.72	$663.32	$910.06	$763.14
Ages 65+	$711.48	$750.19	$733.55	$716.74	$735.12	$1,054.42	$901.17
All Ages	$620.54	$629.90	$594.84	$600.60	$547.87	$769.92	$659.40
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$410.84	$452.71	$446.81	$515.97	$396.21	$584.91	$500.33
Ages 40-64	$718.64	$731.81	$673.25	$653.91	$653.10	$899.27	$753.66
Ages 65+	$703.86	$743.88	$725.97	$710.18	$728.10	$1,047.26	$894.24
All Ages	$612.24	$622.92	$586.83	$593.22	$539.29	$760.99	$651.31
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$408.02	$450.72	$443.90	$514.33	$395.29	$584.40	$498.86
Ages 40-64	$714.86	$729.14	$669.34	$651.70	$651.86	$898.58	$751.43
Ages 65+	$703.10	$743.34	$725.19	$709.74	$727.85	$1,047.12	$893.93
All Ages	$608.80	$620.59	$583.36	$591.35	$538.23	$760.42	$649.49

Exhibit 19A
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
SSI Medicaid Only
Unitedhealthcare Community Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	292	1,021	275	340	744	2,045	4,717
Ages 40-64	506	1,665	474	423	1,347	3,462	7,877
Ages 65+	9	120	23	51	118	351	672
All Ages	807	2,806	772	814	2,209	5,858	13,266
2019 All Services Capitation Rate PMPM							
Ages 19-39	$479.70	$531.96	$515.25	$477.55	$549.00	$676.51	$589.18
Ages 40-64	$750.12	$817.76	$765.34	$770.44	$812.31	$1,108.88	$934.74
Ages 65+	$746.61	$785.10	$768.70	$751.55	$769.92	$1,089.70	$937.91
All Ages	$652.23	$712.37	$676.35	$646.92	$721.36	$956.79	$812.03
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11A)							
Ages 19-39	$476.88	$529.97	$512.34	$475.91	$548.08	$676.00	$587.93
Ages 40-64	$746.34	$815.09	$761.43	$768.23	$811.07	$1,108.19	$933.06
Ages 65+	$745.85	$784.56	$767.92	$751.11	$769.67	$1,089.56	$937.63
All Ages	$648.83	$710.04	$672.89	$645.06	$720.28	$956.20	$810.57
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14A)							
Ages 19-39	$470.68	$524.59	$506.25	$470.02	$540.98	$667.83	$580.94
Ages 40-64	$736.92	$806.98	$752.17	$759.42	$800.58	$1,096.19	$922.64
Ages 65+	$738.23	$778.25	$760.34	$744.55	$762.47	$1,081.63	$930.23
All Ages	$640.60	$703.00	$664.81	$637.61	$711.11	$945.78	$801.53
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Ages 19-39	$467.86	$522.60	$503.34	$468.38	$540.06	$667.32	$579.68
Ages 40-64	$733.14	$804.31	$748.26	$757.21	$799.34	$1,095.50	$920.97
Ages 65+	$737.47	$777.71	$759.56	$744.11	$762.22	$1,081.49	$929.95
All Ages	$637.20	$700.67	$661.35	$635.75	$710.03	$945.18	$800.07

B. SSI Dual Eligible Rate Exhibits

Exhibit 19B Wisconsin Department of Health Services 2019 SSI Capitation Rate Development Final Capitation Rates SSI Dual Eligible New HMOs							
July 2018 Membership by Rate Cell	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**All Regions**
Ages 19-39	181	528	272	326	464	982	2,753
Ages 40-64	255	829	370	552	933	3,210	6,149
Ages 65+	201	643	330	424	684	2,542	4,824
All Ages	637	2,000	972	1,302	2,081	6,734	13,726
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$34.83	$79.22	$54.84
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.15	$162.79	$123.89
Ages 65+	$95.13	$75.67	$72.72	$90.53	$64.71	$156.15	$118.44
All Ages	$84.64	$68.37	$65.65	$82.52	$60.04	$148.10	$108.13
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.67	$79.11	$54.45
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$68.97	$162.67	$123.56
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.65	$156.11	$118.33
All Ages	$84.35	$67.79	$64.69	$82.13	$59.90	$148.01	$107.86
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$47.48
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$112.81
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$110.42
All Ages	$74.70	$60.20	$56.25	$71.48	$51.14	$138.83	$98.87
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$47.09
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$112.48
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$110.31
All Ages	$74.41	$59.62	$55.28	$71.09	$51.00	$138.74	$98.60

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Anthem Blue Cross Blue Shield

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	15	13	15	17	35	53	148
Ages 40-64	18	20	15	15	76	120	264
Ages 65+	15	15	9	10	43	108	200
All Ages	48	48	39	42	154	281	612
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$34.24	$78.63	$54.49
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$68.25	$161.89	$116.15
Ages 65+	$95.13	$75.67	$72.72	$90.53	$64.06	$155.50	$118.35
All Ages	$83.22	$68.14	$62.23	$75.63	$59.35	$143.73	$101.96
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.08	$78.52	$54.14
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$68.07	$161.77	$115.85
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.00	$155.46	$118.26
All Ages	$82.93	$67.56	$61.18	$75.21	$59.21	$143.64	$101.71
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$47.40
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$105.76
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$110.84
All Ages	$73.39	$59.97	$52.88	$64.96	$51.08	$135.39	$93.31
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$47.05
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$105.46
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$110.75
All Ages	$73.10	$59.38	$51.84	$64.55	$50.94	$135.30	$93.06

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Care Wisconsin Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	5	6	114	1	-	126
Ages 40-64	-	1	9	100	-	-	110
Ages 65+	-	-	2	105	3	-	110
All Ages	-	6	17	319	4	-	346
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$34.83	$79.22	$47.60
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.15	$162.79	$94.87
Ages 65+	$95.13	$75.67	$72.72	$90.53	$64.71	$156.15	$89.50
All Ages	N/A	$47.05	$64.08	$77.36	$57.24	N/A	$75.95
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.67	$79.11	$47.10
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$68.97	$162.67	$94.28
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.65	$156.11	$89.33
All Ages	N/A	$46.35	$62.93	$76.98	$57.16	N/A	$75.53
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$38.92
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$81.67
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$79.90
All Ages	N/A	$39.92	$54.25	$66.82	$49.69	N/A	$65.54
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$38.42
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$81.08
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$79.73
All Ages	N/A	$39.22	$53.10	$66.44	$49.60	N/A	$65.12

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Group Health Coop Eau Claire

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	38	-	128	28	-	-	194
Ages 40-64	54	-	125	31	-	-	210
Ages 65+	57	-	135	27	-	-	219
All Ages	149	-	388	86	-	-	623
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$34.83	$79.22	$43.10
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.15	$162.79	$86.80
Ages 65+	$95.13	$75.67	$72.72	$90.53	$64.71	$156.15	$80.75
All Ages	$85.73	N/A	$63.68	$78.98	N/A	N/A	$71.07
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.67	$79.11	$42.20
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$68.97	$162.67	$85.84
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.65	$156.11	$80.44
All Ages	$85.46	N/A	$62.73	$78.59	N/A	N/A	$70.35
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$35.19
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$74.79
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$72.09
All Ages	$75.90	N/A	$54.49	$68.24	N/A	N/A	$61.51
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$34.29
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$73.83
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$71.78
All Ages	$75.62	N/A	$53.54	$67.85	N/A	N/A	$60.80

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Independent Care (ICare)

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	-	19	4	87	74	310	494
Ages 40-64	2	125	14	292	189	1,340	1,962
Ages 65+	-	70	8	182	139	1,013	1,412
All Ages	2	214	26	561	402	2,663	3,868
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$34.98	$79.25	$65.38
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.38	$162.83	$138.05
Ages 65+	$95.13	$75.67	$72.72	$90.53	$64.87	$156.18	$134.27
All Ages	$100.82	$75.39	$70.68	$87.11	$61.49	$150.57	$127.39
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.82	$79.14	$65.17
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$69.20	$162.71	$137.81
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.81	$156.14	$134.19
All Ages	$100.43	$74.80	$69.67	$86.71	$61.35	$150.48	$127.21
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$57.87
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$126.77
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$126.13
All Ages	$88.64	$66.64	$60.68	$75.63	$52.31	$141.17	$117.74
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$57.66
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$126.54
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$126.06
All Ages	$88.25	$66.05	$59.67	$75.24	$52.17	$141.08	$117.57

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
MHS Health Wisconsin

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	43	90	46	33	27	87	326
Ages 40-64	72	111	77	51	33	170	514
Ages 65+	38	115	69	37	38	176	473
All Ages	153	316	192	121	98	433	1,313
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$35.11	$79.58	$52.43
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.58	$163.34	$111.32
Ages 65+	$95.13	$75.67	$72.72	$90.53	$65.02	$156.55	$107.20
All Ages	$85.18	$67.33	$67.09	$81.57	$58.32	$143.75	$95.21
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.95	$79.47	$51.94
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$69.40	$163.22	$110.80
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.96	$156.51	$107.04
All Ages	$84.87	$66.77	$66.14	$81.17	$58.19	$143.67	$94.83
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$44.95
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$99.88
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$99.02
All Ages	$75.00	$59.34	$57.59	$70.56	$49.44	$134.33	$85.93
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$44.46
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$99.36
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$98.86
All Ages	$74.69	$58.78	$56.63	$70.16	$49.31	$134.24	$85.55

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Molina Healthcare

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	7	11	1	4	51	68	142
Ages 40-64	1	13	2	4	67	158	245
Ages 65+	3	11	4	1	51	119	189
All Ages	11	35	7	9	169	345	576
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$35.27	$79.61	$58.04
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.82	$163.39	$131.36
Ages 65+	$95.13	$75.67	$72.72	$90.53	$65.19	$156.58	$124.11
All Ages	$67.06	$66.39	$69.63	$74.48	$58.00	$144.53	$110.91
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$35.11	$79.50	$57.83
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$69.64	$163.27	$131.18
Ages 65+	$95.01	$75.42	$72.30	$90.36	$65.13	$156.54	$124.04
All Ages	$66.76	$65.80	$68.85	$74.02	$57.86	$144.44	$110.75
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$50.49
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$119.92
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$115.85
All Ages	$58.43	$58.36	$60.42	$63.53	$48.76	$134.86	$101.47
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$50.29
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$119.73
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$115.79
All Ages	$58.14	$57.78	$59.64	$63.07	$48.62	$134.77	$101.32

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Network Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	17	84	29	15	20	42	207
Ages 40-64	28	127	62	7	17	63	304
Ages 65+	22	100	48	11	14	54	249
All Ages	67	311	139	33	51	159	760
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$33.66	$78.76	$48.82
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$67.37	$162.09	$98.50
Ages 65+	$95.13	$75.67	$72.72	$90.53	$63.43	$155.64	$94.13
All Ages	$86.11	$68.13	$68.36	$72.66	$53.07	$137.89	$83.54
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$33.50	$78.65	$48.28
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$67.19	$161.97	$97.83
Ages 65+	$95.01	$75.42	$72.30	$90.36	$63.37	$155.60	$93.92
All Ages	$85.82	$67.55	$67.39	$72.29	$52.93	$137.80	$83.05
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$41.84
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$87.92
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$86.45
All Ages	$76.08	$59.97	$58.69	$62.58	$46.03	$129.52	$74.89
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$41.29
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$87.25
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$86.24
All Ages	$75.79	$59.39	$57.72	$62.21	$45.89	$129.43	$74.40

Exhibit 19B
Wisconsin Department of Health Services
2019 SSI Capitation Rate Development
Final Capitation Rates
SSI Dual Eligible
Unitedhealthcare Community Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-39	61	306	43	28	256	422	1,116
Ages 40-64	80	432	66	52	551	1,359	2,540
Ages 65+	66	332	55	51	396	1,072	1,972
All Ages	207	1,070	164	131	1,203	2,853	5,628
2019 All Services Capitation Rate PMPM							
Ages 19-39	$50.20	$40.35	$39.82	$48.44	$34.82	$79.17	$54.48
Ages 40-64	$100.82	$80.56	$78.34	$96.50	$69.14	$162.72	$122.95
Ages 65+	$95.13	$75.67	$72.72	$90.53	$64.70	$156.10	$118.14
All Ages	$84.09	$67.54	$66.36	$83.90	$60.38	$147.87	$107.69
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 11B)							
Ages 19-39	$49.85	$39.66	$38.66	$47.98	$34.66	$79.06	$54.14
Ages 40-64	$100.43	$79.79	$77.03	$95.98	$68.96	$162.60	$122.66
Ages 65+	$95.01	$75.42	$72.30	$90.36	$64.64	$156.06	$118.05
All Ages	$83.80	$66.96	$65.38	$83.53	$60.24	$147.79	$107.46
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 14B)							
Ages 19-39	$42.16	$33.78	$32.16	$39.60	$27.78	$71.99	$47.39
Ages 40-64	$88.64	$70.61	$66.74	$83.12	$58.47	$151.84	$112.16
Ages 65+	$86.32	$68.47	$64.33	$80.85	$56.99	$148.23	$110.33
All Ages	$74.20	$59.41	$56.87	$72.93	$51.45	$138.67	$98.68
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-39	$41.81	$33.09	$31.00	$39.14	$27.62	$71.88	$47.05
Ages 40-64	$88.25	$69.84	$65.43	$82.60	$58.29	$151.72	$111.87
Ages 65+	$86.20	$68.22	$63.91	$80.68	$56.93	$148.19	$110.23
All Ages	$73.91	$58.83	$55.89	$72.56	$51.32	$138.58	$98.44

C. BadgerCare Plus Standard Rate Exhibits

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
New HMOs

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	2,629	4,926	3,972	4,563	3,248	8,316	27,654
Ages 1-14	30,629	54,327	45,487	55,327	38,102	94,354	318,226
Ages 15-20	7,251	12,264	10,422	12,854	9,161	21,355	73,307
Ages 21-44	13,448	21,982	18,981	21,247	15,071	37,720	128,449
Ages 45+	2,629	3,719	3,308	3,710	2,776	5,431	21,573
All Ages	56,586	97,218	82,170	97,701	68,358	167,176	569,209
2019 All Services Capitation Rate PMPM							
Age 0	$525.91	$441.31	$457.50	$478.68	$489.63	$522.76	$488.01
Ages 1-14	$115.10	$117.79	$123.75	$125.93	$137.06	$146.15	$130.51
Ages 15-20	$165.69	$157.40	$165.33	$168.87	$179.49	$191.15	$173.95
Ages 21-44	$261.33	$232.69	$243.69	$250.83	$260.33	$277.01	$256.57
Ages 45+	$376.68	$323.00	$338.03	$348.99	$357.81	$380.85	$355.36
All Ages	$187.57	$173.01	$181.49	$183.69	$195.64	$207.78	$190.44
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$523.67	$439.57	$454.99	$477.15	$488.77	$522.50	$486.70
Ages 1-14	113.64	$116.66	$122.11	$124.93	$136.50	$145.98	$129.66
Ages 15-20	$163.09	$155.38	$162.42	$167.10	$178.49	$190.84	$172.42
Ages 21-44	$255.57	$228.21	$237.23	$246.90	$258.12	$276.33	$253.14
Ages 45+	$370.01	$317.82	$330.56	$344.44	$355.25	$380.07	$351.20
All Ages	$184.67	$170.82	$178.30	$181.79	$194.56	$207.46	$188.77
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$525.71	$441.17	$457.31	$478.53	$489.49	$522.62	$487.86
Ages 1-14	$94.74	$103.72	$105.63	$111.31	$123.98	$132.48	$115.40
Ages 15-20	$145.42	$143.39	$147.29	$154.30	$166.47	$177.54	$158.89
Ages 21-44	$247.63	$223.41	$231.62	$240.89	$251.78	$267.72	$246.39
Ages 45+	$362.88	$313.65	$325.87	$338.98	$349.20	$371.49	$345.02
All Ages	$170.05	$160.92	$165.88	$170.94	$184.36	$195.92	$177.36
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$523.47	$439.43	$454.80	$477.00	$488.63	$522.36	$486.54
Ages 1-14	$93.28	$102.59	$103.99	$110.31	$123.42	$132.31	$114.54
Ages 15-20	$142.82	$141.37	$144.38	$152.53	$165.47	$177.23	$157.36
Ages 21-44	$241.87	$218.93	$225.16	$236.96	$249.57	$267.04	$242.96
Ages 45+	$356.21	$308.47	$318.40	$334.43	$346.64	$370.71	$340.86
All Ages	$167.14	$158.73	$162.69	$169.04	$183.29	$195.59	$175.68
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	1,906	3,257	2,486	2,959	2,303	6,324	19,234
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,245.10

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Anthem Blue Cross Blue Shield

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	278	631	607	344	652	1,238	3,750
Ages 1-14	2,566	3,625	5,559	2,919	7,223	12,957	34,849
Ages 15-20	600	723	1,212	649	1,791	3,120	8,095
Ages 21-44	1,200	1,881	2,347	1,332	3,137	5,647	15,544
Ages 45+	197	181	383	167	583	854	2,365
All Ages	4,841	7,041	10,108	5,411	13,386	23,816	64,603
2019 All Services Capitation Rate PMPM							
Age 0	$561.07	$452.54	$469.51	$486.87	$484.46	$512.59	$491.86
Ages 1-14	$143.07	$127.72	$133.39	$132.71	$132.10	$133.39	$133.19
Ages 15-20	$198.33	$167.78	$174.01	$177.37	$171.83	$176.56	$176.03
Ages 21-44	$285.63	$245.65	$252.45	$248.82	$256.02	$271.22	$261.42
Ages 45+	$450.47	$311.94	$347.83	$353.14	$365.62	$379.56	$369.85
All Ages	$221.77	$197.18	$194.22	$195.97	$193.79	$200.27	$198.89
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$558.83	$450.80	$467.00	$485.34	$483.60	$512.33	$490.62
Ages 1-14	141.61	$126.59	$131.75	$131.71	$131.54	$133.22	$132.44
Ages 15-20	$195.73	$165.76	$171.10	$175.60	$170.83	$176.25	$174.73
Ages 21-44	$279.87	$241.17	$245.99	$244.89	$253.81	$270.54	$258.42
Ages 45+	$443.80	$306.76	$340.36	$348.59	$363.06	$378.78	$366.46
All Ages	$218.85	$194.91	$191.03	$194.01	$192.68	$199.93	$197.41
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$560.87	$452.40	$469.32	$486.72	$484.33	$512.46	$491.71
Ages 1-14	$122.71	$113.65	$115.27	$118.09	$120.29	$120.69	$118.94
Ages 15-20	$178.06	$153.77	$155.97	$162.80	$160.09	$163.90	$161.93
Ages 21-44	$271.93	$236.37	$240.38	$238.88	$248.31	$262.58	$251.87
Ages 45+	$436.67	$302.59	$335.67	$343.13	$357.85	$370.85	$360.25
All Ages	$204.50	$185.77	$178.81	$183.57	$183.69	$189.33	$186.78
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$558.63	$450.66	$466.81	$485.19	$483.47	$512.20	$490.47
Ages 1-14	$121.25	$112.52	$113.63	$117.09	$119.73	$120.52	$118.19
Ages 15-20	$175.46	$151.75	$153.06	$161.03	$159.09	$163.59	$160.63
Ages 21-44	$266.17	$231.89	$233.92	$234.95	$246.10	$261.90	$248.88
Ages 45+	$430.00	$297.41	$328.20	$338.58	$355.29	$370.07	$356.85
All Ages	$201.57	$183.49	$175.63	$181.61	$182.59	$188.99	$185.30
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	163	358	120	186	502	1,043	2,372
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,200.26

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Children's Community Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	240	4	64	947	3,189	4,444
Ages 1-14	-	1,845	21	1,351	15,689	46,906	65,812
Ages 15-20	-	376	3	319	3,759	10,628	15,085
Ages 21-44	-	730	10	445	5,406	16,537	23,128
Ages 45+	-	129	-	85	1,102	2,533	3,849
All Ages	-	3,320	38	2,264	26,903	79,793	112,318
2019 All Services Capitation Rate PMPM							
Age 0	$563.70	$455.17	$472.14	$489.50	$487.11	$515.24	$505.59
Ages 1-14	$152.89	$129.32	$138.39	$133.33	$137.43	$140.64	$139.41
Ages 15-20	$203.48	$168.35	$179.97	$182.35	$180.42	$186.86	$184.70
Ages 21-44	$299.12	$227.64	$258.33	$286.20	$268.05	$272.84	$270.54
Ages 45+	$414.47	$311.39	$352.67	$381.47	$364.38	$372.45	$368.29
All Ages	N/A	$185.99	$208.37	$189.67	$191.29	$196.52	$194.83
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$561.46	$453.43	$469.63	$487.97	$486.25	$514.98	$505.10
Ages 1-14	151.43	$128.19	$136.75	$132.33	$136.87	$140.47	$139.10
Ages 15-20	$200.88	$166.33	$177.06	$180.58	$179.42	$186.55	$184.14
Ages 21-44	$293.36	$223.16	$251.87	$282.27	$265.84	$272.16	$269.32
Ages 45+	$407.80	$306.21	$345.20	$376.92	$361.82	$371.67	$366.77
All Ages	N/A	$183.82	$205.27	$187.84	$190.24	$196.21	$194.25
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$563.50	$455.03	$471.95	$489.35	$486.96	$515.09	$505.44
Ages 1-14	$132.53	$115.25	$120.27	$118.71	$123.62	$126.45	$125.30
Ages 15-20	$183.21	$154.34	$161.93	$167.78	$166.69	$172.73	$170.66
Ages 21-44	$285.42	$218.36	$246.26	$276.26	$259.03	$263.20	$261.05
Ages 45+	$400.67	$302.04	$340.51	$371.46	$355.30	$362.73	$358.76
All Ages	N/A	$174.17	$193.73	$176.56	$179.13	$183.99	$182.39
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$561.26	$453.29	$469.44	$487.82	$486.10	$514.83	$504.95
Ages 1-14	$131.07	$114.12	$118.63	$117.71	$123.06	$126.28	$124.99
Ages 15-20	$180.61	$152.32	$159.02	$166.01	$165.69	$172.42	$170.10
Ages 21-44	$279.66	$213.88	$239.80	$272.33	$256.82	$262.52	$259.83
Ages 45+	$394.00	$296.86	$333.04	$366.91	$352.74	$361.95	$357.24
All Ages	N/A	$172.00	$190.63	$174.73	$178.08	$183.67	$181.81
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	1	124	3	46	697	2,435	3,307
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,195.80

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Dean Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	36	1,422	-	-	1,458
Ages 1-14	-	5	517	18,332	2	-	18,856
Ages 15-20	-	-	83	4,238	1	-	4,322
Ages 21-44	-	-	240	6,905	1	-	7,146
Ages 45+	-	-	50	1,179	-	-	1,229
All Ages	-	5	926	32,076	4	-	33,011
2019 All Services Capitation Rate PMPM							
Age 0	$547.80	$439.27	$456.24	$473.60	$471.20	$499.33	$473.17
Ages 1-14	$136.99	$115.75	$122.21	$121.03	$118.63	$122.72	$121.06
Ages 15-20	$187.58	$155.36	$170.23	$166.24	$161.06	$167.72	$166.32
Ages 21-44	$283.22	$230.65	$252.73	$247.83	$241.90	$253.58	$247.99
Ages 45+	$398.57	$320.96	$336.77	$349.11	$339.38	$357.42	$348.61
All Ages	N/A	$115.75	$184.91	$178.31	$160.06	N/A	$178.49
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$545.56	$437.53	$453.73	$472.07	$470.34	$499.07	$471.62
Ages 1-14	135.53	$114.62	$120.57	$120.03	$118.07	$122.55	$120.04
Ages 15-20	$184.98	$153.34	$167.32	$164.47	$160.06	$167.41	$164.52
Ages 21-44	$277.46	$226.17	$246.27	$243.90	$239.69	$252.90	$243.98
Ages 45+	$391.90	$315.78	$329.30	$344.56	$336.82	$356.64	$343.94
All Ages	N/A	$114.62	$181.56	$176.43	$158.97	N/A	$176.56
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$547.60	$439.13	$456.05	$473.45	$471.06	$499.19	$473.02
Ages 1-14	$116.63	$101.68	$104.09	$106.41	$105.55	$109.05	$106.35
Ages 15-20	$167.31	$141.35	$152.19	$151.67	$148.04	$154.11	$151.68
Ages 21-44	$269.52	$221.37	$240.66	$237.89	$233.35	$244.29	$237.98
Ages 45+	$384.77	$311.61	$324.61	$339.10	$330.77	$348.06	$338.51
All Ages	N/A	$101.68	$169.39	$165.52	$148.12	N/A	$165.62
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$545.36	$437.39	$453.54	$471.92	$470.20	$498.93	$471.47
Ages 1-14	$115.17	$100.55	$102.45	$105.41	$104.99	$108.88	$105.33
Ages 15-20	$164.71	$139.33	$149.28	$149.90	$147.04	$153.80	$149.89
Ages 21-44	$263.76	$216.89	$234.20	$233.96	$231.14	$243.61	$233.97
Ages 45+	$378.10	$306.43	$317.14	$334.55	$328.21	$347.28	$333.84
All Ages	N/A	$100.55	$166.04	$163.63	$147.04	N/A	$163.69
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	0	4	34	1,000	1	2	1,041
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,126.49

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Group Health Coop Eau Claire

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	874	-	773	199	-	1	1,847
Ages 1-14	10,546	4	8,951	2,769	-	3	22,273
Ages 15-20	2,421	-	1,854	571	-	-	4,846
Ages 21-44	4,581	2	3,878	1,080	-	-	9,541
Ages 45+	857	-	636	218	-	-	1,711
All Ages	19,279	6	16,092	4,837	-	4	40,218
2019 All Services Capitation Rate PMPM							
Age 0	$533.08	$424.55	$441.52	$458.88	$456.48	$484.61	$486.74
Ages 1-14	$122.62	$101.03	$106.70	$106.84	$103.91	$108.00	$114.25
Ages 15-20	$175.14	$140.64	$147.78	$148.25	$146.34	$153.00	$161.50
Ages 21-44	$265.62	$215.93	$226.45	$217.24	$227.18	$238.86	$244.21
Ages 45+	$376.73	$306.24	$316.25	$324.86	$324.66	$342.70	$347.64
All Ages	$193.10	$139.33	$164.66	$160.69	N/A	$202.15	$177.81
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$530.84	$422.81	$439.01	$457.35	$455.62	$484.35	$484.46
Ages 1-14	121.16	$99.90	$105.06	$105.84	$103.35	$107.83	$112.78
Ages 15-20	$172.54	$138.62	$144.87	$146.48	$145.34	$152.69	$158.88
Ages 21-44	$259.86	$211.45	$219.99	$213.31	$224.97	$238.18	$238.38
Ages 45+	$370.06	$301.06	$308.78	$320.31	$322.10	$341.92	$340.94
All Ages	$190.21	$137.08	$161.44	$158.76	N/A	$201.96	$174.91
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$532.88	$424.41	$441.33	$458.73	$456.34	$484.47	$486.55
Ages 1-14	$102.26	$86.96	$88.58	$92.22	$90.83	$94.33	$95.51
Ages 15-20	$154.87	$126.63	$129.74	$133.68	$133.32	$139.39	$142.76
Ages 21-44	$251.92	$206.65	$214.38	$207.30	$218.63	$229.57	$231.60
Ages 45+	$362.93	$296.89	$304.09	$314.85	$316.05	$333.34	$334.93
All Ages	$175.54	$126.86	$149.10	$147.92	N/A	$191.87	$161.63
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$530.64	$422.67	$438.82	$457.20	$455.48	$484.21	$484.27
Ages 1-14	$100.80	$85.83	$86.94	$91.22	$90.27	$94.16	$94.04
Ages 15-20	$152.27	$124.61	$126.83	$131.91	$132.32	$139.08	$140.14
Ages 21-44	$246.16	$202.17	$207.92	$203.37	$216.42	$228.89	$225.76
Ages 45+	$356.26	$291.71	$296.62	$310.30	$313.49	$332.56	$328.24
All Ages	$172.65	$124.61	$145.88	$145.99	N/A	$191.67	$158.73
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	673	2	602	128	0	1	1,405
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$7,154.78

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Group Health Coop SC WI

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	-	150	-	-	150
Ages 1-14	-	-	1	2,116	1	2	2,120
Ages 15-20	-	-	-	527	-	-	527
Ages 21-44	-	-	1	816	-	2	819
Ages 45+	-	-	-	147	1	-	148
All Ages	-	-	2	3,756	2	4	3,764
2019 All Services Capitation Rate PMPM							
Age 0	$544.59	$436.06	$453.03	$470.39	$467.99	$496.12	$470.39
Ages 1-14	$133.78	$112.54	$119.28	$117.35	$115.42	$119.51	$117.35
Ages 15-20	$184.37	$152.15	$160.86	$155.77	$157.85	$164.51	$155.77
Ages 21-44	$280.01	$227.44	$239.22	$232.72	$238.69	$250.37	$232.77
Ages 45+	$395.36	$317.75	$333.56	$314.71	$336.17	$354.21	$314.86
All Ages	N/A	N/A	$179.25	$169.63	$225.80	$184.94	$169.68
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$542.35	$434.32	$450.52	$468.86	$467.13	$495.86	$468.86
Ages 1-14	132.32	$111.41	$117.64	$116.35	$114.86	$119.34	$116.35
Ages 15-20	$181.77	$150.13	$157.95	$154.00	$156.85	$164.20	$154.00
Ages 21-44	$274.25	$222.96	$232.76	$228.79	$236.48	$249.69	$228.85
Ages 45+	$388.69	$312.57	$326.09	$310.16	$333.61	$353.43	$310.32
All Ages	N/A	N/A	$175.20	$167.72	$224.24	$184.52	$167.77
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$544.39	$435.92	$452.84	$470.24	$467.85	$495.98	$470.24
Ages 1-14	$113.42	$98.47	$101.16	$102.73	$102.34	$105.84	$102.73
Ages 15-20	$164.10	$138.14	$142.82	$141.20	$144.83	$150.90	$141.20
Ages 21-44	$266.31	$218.16	$227.15	$222.78	$230.14	$241.08	$222.83
Ages 45+	$381.56	$308.40	$321.40	$304.70	$327.56	$344.85	$304.85
All Ages	N/A	N/A	$164.16	$156.79	$214.95	$173.46	$156.84
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$542.15	$434.18	$450.33	$468.71	$466.99	$495.72	$468.71
Ages 1-14	$111.96	$97.34	$99.52	$101.73	$101.78	$105.67	$101.73
Ages 15-20	$161.50	$136.12	$139.91	$139.43	$143.83	$150.59	$139.43
Ages 21-44	$260.55	$213.68	$220.69	$218.85	$227.93	$240.40	$218.90
Ages 45+	$374.89	$303.22	$313.93	$300.15	$325.00	$344.07	$300.32
All Ages	N/A	N/A	$160.11	$154.89	$213.39	$173.04	$154.94
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	0	0	0	97	1	0	98
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,129.24

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Independent Care (ICare)

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	10	162	41	46	127	350	736
Ages 1-14	22	1,151	381	434	747	2,085	4,820
Ages 15-20	7	249	77	105	166	459	1,063
Ages 21-44	12	570	169	208	371	1,099	2,429
Ages 45+	1	52	22	29	45	139	288
All Ages	52	2,184	690	822	1,456	4,132	9,336
2019 All Services Capitation Rate PMPM							
Age 0	$582.91	$474.38	$491.35	$508.71	$506.30	$534.43	$513.01
Ages 1-14	$172.10	$150.86	$157.60	$155.96	$153.16	$156.99	$154.96
Ages 15-20	$222.69	$190.47	$199.18	$198.90	$195.59	$201.99	$197.92
Ages 21-44	$318.33	$265.76	$277.54	$280.86	$276.63	$288.12	$279.91
Ages 45+	$433.68	$356.07	$371.88	$379.02	$374.11	$391.95	$379.99
All Ages	$296.69	$214.25	$218.28	$220.66	$227.09	$236.74	$227.53
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$580.67	$472.64	$488.84	$507.18	$505.44	$534.17	$512.09
Ages 1-14	170.64	$149.73	$155.96	$154.96	$152.60	$156.82	$154.30
Ages 15-20	$220.09	$188.45	$196.27	$197.13	$194.59	$201.68	$196.75
Ages 21-44	$312.57	$261.28	$271.08	$276.93	$274.42	$287.44	$277.40
Ages 45+	$427.01	$350.89	$364.41	$374.47	$371.55	$391.17	$377.23
All Ages	$293.83	$212.00	$215.08	$218.67	$225.97	$236.39	$226.24
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$582.71	$474.24	$491.16	$508.56	$506.17	$534.30	$512.87
Ages 1-14	$151.74	$136.79	$139.48	$141.34	$140.66	$144.16	$141.27
Ages 15-20	$202.42	$176.46	$181.14	$184.33	$183.15	$189.22	$184.30
Ages 21-44	$304.63	$256.48	$265.47	$270.92	$268.46	$279.40	$270.78
Ages 45+	$419.88	$346.72	$359.72	$369.01	$365.88	$383.17	$370.80
All Ages	$281.88	$202.58	$202.91	$208.20	$216.91	$226.22	$216.24
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$580.47	$472.50	$488.65	$507.03	$505.31	$534.04	$511.95
Ages 1-14	$150.28	$135.66	$137.84	$140.34	$140.10	$143.99	$140.61
Ages 15-20	$199.82	$174.44	$178.23	$182.56	$182.15	$188.91	$183.14
Ages 21-44	$298.87	$252.00	$259.01	$266.99	$266.25	$278.72	$268.27
Ages 45+	$413.21	$341.54	$352.25	$364.46	$363.32	$382.39	$368.03
All Ages	$279.02	$200.33	$199.71	$206.21	$215.79	$225.87	$214.96
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	1	128	19	13	82	220	463
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$5,969.56

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Mercy Care Insurance Company

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	-	-	488	2	-	490
Ages 1-14	-	-	-	5,531	10	-	5,541
Ages 15-20	-	-	-	1,488	4	-	1,492
Ages 21-44	-	-	-	2,349	6	-	2,355
Ages 45+	-	-	-	373	1	-	374
All Ages	-	-	-	10,229	23	-	10,252
2019 All Services Capitation Rate PMPM							
Age 0	$532.69	$424.16	$441.13	$458.49	$456.09	$484.22	$458.48
Ages 1-14	$121.88	$100.64	$107.38	$103.50	$103.52	$107.61	$103.50
Ages 15-20	$172.47	$140.25	$148.96	$145.41	$145.95	$152.61	$145.41
Ages 21-44	$268.11	$215.54	$227.32	$222.71	$226.79	$238.47	$222.72
Ages 45+	$383.46	$305.85	$321.66	$317.25	$324.27	$342.31	$317.27
All Ages	N/A	N/A	N/A	$161.70	$183.31	N/A	$161.75
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$530.45	$422.42	$438.62	$456.96	$455.23	$483.96	$456.95
Ages 1-14	120.42	$99.51	$105.74	$102.50	$102.96	$107.44	$102.50
Ages 15-20	$169.87	$138.23	$146.05	$143.64	$144.95	$152.30	$143.64
Ages 21-44	$262.35	$211.06	$220.86	$218.78	$224.58	$237.79	$218.79
Ages 45+	$376.79	$300.67	$314.19	$312.70	$321.71	$341.53	$312.72
All Ages	N/A	N/A	N/A	$159.76	$182.13	N/A	$159.81
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$532.49	$424.02	$440.94	$458.34	$455.95	$484.08	$458.33
Ages 1-14	$101.52	$86.57	$89.26	$88.88	$90.44	$93.94	$88.88
Ages 15-20	$152.20	$126.24	$130.92	$130.84	$132.93	$139.00	$130.85
Ages 21-44	$254.41	$206.26	$215.25	$212.77	$218.24	$229.18	$212.78
Ages 45+	$369.66	$296.50	$309.50	$307.24	$315.66	$332.95	$307.26
All Ages	N/A	N/A	N/A	$149.02	$172.74	N/A	$149.07
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$530.25	$422.28	$438.43	$456.81	$455.09	$483.82	$456.80
Ages 1-14	$100.06	$85.44	$87.62	$87.88	$89.88	$93.77	$87.88
Ages 15-20	$149.60	$124.22	$128.01	$129.07	$131.93	$138.69	$129.08
Ages 21-44	$248.65	$201.78	$208.79	$208.84	$216.03	$228.50	$208.86
Ages 45+	$362.99	$291.32	$302.03	$302.69	$313.10	$332.17	$302.72
All Ages	N/A	N/A	N/A	$147.08	$171.56	N/A	$147.14
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	0	0	0	321	2	2	325
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,131.12

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
MHS Health Wisconsin

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	101	358	154	190	129	299	1,231
Ages 1-14	1,077	4,930	1,662	2,742	808	1,969	13,188
Ages 15-20	212	1,246	406	785	183	489	3,321
Ages 21-44	514	1,804	692	992	365	1,019	5,386
Ages 45+	79	325	97	174	51	157	883
All Ages	1,983	8,663	3,011	4,883	1,536	3,933	24,009
2019 All Services Capitation Rate PMPM							
Age 0	$556.92	$448.39	$465.36	$482.72	$480.33	$508.44	$482.65
Ages 1-14	$143.41	$124.27	$124.11	$126.14	$126.44	$130.20	$127.22
Ages 15-20	$193.22	$163.54	$161.65	$167.90	$163.71	$165.02	$166.46
Ages 21-44	$283.70	$233.70	$229.69	$260.91	$227.50	$241.57	$244.04
Ages 45+	$443.27	$333.26	$370.20	$361.69	$348.87	$363.44	$359.03
All Ages	$218.11	$173.94	$178.82	$182.50	$192.00	$201.45	$185.60
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$554.68	$446.65	$462.85	$481.19	$479.47	$508.18	$481.26
Ages 1-14	141.95	$123.14	$122.47	$125.14	$125.88	$130.03	$126.20
Ages 15-20	$190.62	$161.52	$158.74	$166.13	$162.71	$164.71	$164.66
Ages 21-44	$277.94	$229.22	$223.23	$256.98	$225.29	$240.89	$240.15
Ages 45+	$436.60	$328.08	$362.73	$357.14	$346.31	$362.66	$354.52
All Ages	$215.16	$171.81	$175.67	$180.63	$190.91	$201.10	$183.68
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$556.72	$448.25	$465.17	$482.57	$480.18	$508.31	$482.50
Ages 1-14	$123.05	$110.20	$105.99	$111.52	$112.79	$117.48	$112.24
Ages 15-20	$172.95	$149.53	$143.61	$153.33	$150.13	$152.35	$151.65
Ages 21-44	$270.00	$224.42	$217.62	$250.97	$218.58	$232.92	$234.00
Ages 45+	$429.47	$323.91	$358.04	$351.68	$339.89	$354.72	$348.98
All Ages	$200.77	$161.63	$163.21	$169.57	$180.77	$190.91	$172.70
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$554.48	$446.51	$462.66	$481.04	$479.32	$508.05	$481.10
Ages 1-14	$121.59	$109.07	$104.35	$110.52	$112.23	$117.31	$111.22
Ages 15-20	$170.35	$147.51	$140.70	$151.56	$149.13	$152.04	$149.85
Ages 21-44	$264.24	$219.94	$211.16	$247.04	$216.37	$232.24	$230.12
Ages 45+	$422.80	$318.73	$350.57	$347.13	$337.33	$353.94	$344.47
All Ages	$197.83	$159.50	$160.06	$167.70	$179.68	$190.56	$170.78
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	59	293	88	118	64	172	794
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,022.50

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Molina Healthcare

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	35	330	54	48	427	1,323	2,217
Ages 1-14	221	3,125	415	542	6,680	17,176	28,159
Ages 15-20	41	604	64	120	1,530	3,482	5,841
Ages 21-44	115	1,333	186	177	2,412	6,425	10,648
Ages 45+	17	186	22	18	358	736	1,337
All Ages	429	5,578	741	905	11,407	29,142	48,202
2019 All Services Capitation Rate PMPM							
Age 0	$562.01	$453.48	$470.45	$487.81	$485.42	$513.54	$498.34
Ages 1-14	$144.01	$126.55	$129.59	$127.04	$128.15	$132.54	$130.77
Ages 15-20	$201.79	$159.33	$178.28	$186.69	$167.65	$178.70	$174.12
Ages 21-44	$301.20	$231.33	$234.24	$255.81	$239.16	$250.49	$245.88
Ages 45+	$412.78	$320.58	$350.98	$358.12	$317.41	$342.63	$334.05
All Ages	$236.42	$180.95	$191.48	$183.87	$176.23	$186.66	$184.00
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$559.77	$451.74	$467.94	$486.28	$484.56	$513.28	$497.63
Ages 1-14	142.55	$125.42	$127.95	$126.04	$127.59	$132.37	$130.36
Ages 15-20	$199.19	$157.31	$175.37	$184.92	$166.65	$178.39	$173.38
Ages 21-44	$295.44	$226.85	$227.78	$251.88	$236.95	$249.81	$244.17
Ages 45+	$406.11	$315.40	$343.51	$353.57	$314.85	$341.85	$331.94
All Ages	$233.43	$178.75	$188.28	$182.09	$175.19	$186.34	$183.20
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$561.81	$453.34	$470.26	$487.66	$485.27	$513.40	$498.20
Ages 1-14	$123.65	$112.48	$111.47	$112.42	$114.53	$118.62	$116.78
Ages 15-20	$181.52	$145.32	$160.24	$172.12	$154.10	$164.84	$160.22
Ages 21-44	$287.50	$222.05	$222.17	$245.87	$230.26	$241.02	$236.46
Ages 45+	$398.98	$311.23	$338.82	$348.11	$308.45	$333.09	$324.59
All Ages	$219.76	$169.01	$176.37	$171.03	$164.27	$174.47	$171.79
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$559.57	$451.60	$467.75	$486.13	$484.41	$513.14	$497.49
Ages 1-14	$122.19	$111.35	$109.83	$111.42	$113.97	$118.45	$116.37
Ages 15-20	$178.92	$143.30	$157.33	$170.35	$153.10	$164.53	$159.48
Ages 21-44	$281.74	$217.57	$215.71	$241.94	$228.05	$240.34	$234.75
Ages 45+	$392.31	$306.05	$331.35	$343.56	$305.89	$332.31	$322.48
All Ages	$216.77	$166.82	$173.17	$169.25	$163.23	$174.15	$170.99
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	28	216	53	34	389	1,197	1,917
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,147.94

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Network Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	77	488	148	134	150	272	1,269
Ages 1-14	906	7,296	1,735	1,506	949	1,652	14,044
Ages 15-20	205	1,796	415	316	192	359	3,283
Ages 21-44	370	2,695	679	556	438	871	5,609
Ages 45+	63	509	116	79	49	79	895
All Ages	1,621	12,784	3,093	2,591	1,778	3,233	25,100
2019 All Services Capitation Rate PMPM							
Age 0	$553.53	$445.00	$461.97	$479.33	$476.93	$505.05	$473.84
Ages 1-14	$135.94	$119.96	$121.57	$121.27	$114.88	$127.93	$121.92
Ages 15-20	$183.95	$161.56	$162.07	$165.94	$159.42	$159.08	$163.05
Ages 21-44	$260.15	$230.31	$227.92	$242.04	$223.52	$232.37	$232.94
Ages 45+	$432.42	$304.93	$339.46	$370.15	$345.08	$300.88	$325.98
All Ages	$201.72	$168.84	$174.81	$178.74	$183.34	$195.48	$177.18
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$551.29	$443.26	$459.46	$477.80	$476.07	$504.79	$472.42
Ages 1-14	134.48	$118.83	$119.93	$120.27	$114.32	$127.76	$120.88
Ages 15-20	$181.35	$159.54	$159.16	$164.17	$158.42	$158.77	$161.15
Ages 21-44	$254.39	$225.83	$221.46	$238.11	$221.31	$231.69	$228.96
Ages 45+	$425.75	$299.75	$331.99	$365.60	$342.52	$300.10	$320.98
All Ages	$198.90	$166.69	$171.68	$176.88	$182.25	$195.13	$175.21
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$553.33	$444.86	$461.78	$479.18	$476.79	$504.92	$473.69
Ages 1-14	$115.58	$105.89	$103.45	$106.65	$101.83	$115.47	$107.15
Ages 15-20	$163.68	$147.55	$144.03	$151.37	$146.44	$146.68	$148.32
Ages 21-44	$246.45	$221.03	$215.85	$232.10	$215.00	$223.91	$223.15
Ages 45+	$418.62	$295.58	$327.30	$360.14	$336.50	$292.35	$316.01
All Ages	$184.11	$156.51	$159.11	$166.02	$172.63	$185.24	$164.44
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$551.09	$443.12	$459.27	$477.65	$475.93	$504.66	$472.27
Ages 1-14	$114.12	$104.76	$101.81	$105.65	$101.27	$115.30	$106.10
Ages 15-20	$161.08	$145.53	$141.12	$149.60	$145.44	$146.37	$146.42
Ages 21-44	$240.69	$216.55	$209.39	$228.17	$212.79	$223.23	$219.17
Ages 45+	$411.95	$290.40	$319.83	$355.59	$333.94	$291.57	$311.01
All Ages	$181.28	$154.36	$155.98	$164.16	$171.53	$184.89	$162.46
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	57	362	92	59	89	170	829
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$5,950.17

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Quartz

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	-	28	523	1,029	-	-	1,580
Ages 1-14	1	148	6,705	11,841	1	-	18,696
Ages 15-20	-	22	1,583	2,576	1	-	4,182
Ages 21-44	-	65	2,723	4,285	1	-	7,074
Ages 45+	-	5	530	856	-	-	1,391
All Ages	1	268	12,064	20,587	3	-	32,923
2019 All Services Capitation Rate PMPM							
Age 0	$567.23	$458.70	$475.67	$493.03	$490.63	$518.76	$486.68
Ages 1-14	$156.42	$128.19	$142.94	$143.64	$138.06	$142.15	$143.27
Ages 15-20	$207.01	$174.79	$180.57	$183.94	$180.49	$187.15	$182.62
Ages 21-44	$302.65	$225.45	$262.76	$266.50	$261.33	$273.01	$264.68
Ages 45+	$418.00	$340.39	$337.41	$355.54	$358.81	$376.85	$348.58
All Ages	$156.42	$194.09	$197.89	$200.53	$193.29	N/A	$199.51
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$564.99	$456.96	$473.16	$491.50	$489.77	$518.50	$484.82
Ages 1-14	154.96	$127.06	$141.30	$142.64	$137.50	$141.98	$142.04
Ages 15-20	$204.41	$172.77	$177.66	$182.17	$179.49	$186.84	$180.41
Ages 21-44	$296.89	$220.97	$256.30	$262.57	$259.12	$272.33	$259.77
Ages 45+	$411.33	$335.21	$329.94	$350.99	$356.25	$376.07	$342.91
All Ages	$154.96	$191.94	$194.70	$198.65	$192.04	N/A	$197.15
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$567.03	$458.56	$475.48	$492.88	$490.49	$518.62	$486.51
Ages 1-14	$136.06	$114.12	$124.82	$129.02	$124.98	$128.48	$127.40
Ages 15-20	$186.74	$160.78	$162.53	$169.37	$167.47	$173.54	$166.74
Ages 21-44	$288.95	$216.17	$250.69	$256.56	$252.78	$263.72	$253.93
Ages 45+	$404.20	$331.04	$325.25	$345.53	$350.20	$367.49	$337.75
All Ages	$136.06	$182.73	$182.19	$187.80	$181.74	N/A	$185.71
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$564.79	$456.82	$472.97	$491.35	$489.63	$518.36	$484.65
Ages 1-14	$134.60	$112.99	$123.18	$128.02	$124.42	$128.31	$126.17
Ages 15-20	$184.14	$158.76	$159.62	$167.60	$166.47	$173.23	$164.53
Ages 21-44	$283.19	$211.69	$244.23	$252.63	$250.57	$263.04	$249.02
Ages 45+	$397.53	$325.86	$317.78	$340.98	$347.64	$366.71	$332.09
All Ages	$134.60	$180.58	$179.00	$185.92	$180.49	N/A	$183.34
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	2	15	403	684	3	3	1,110
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,104.10

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Security Health Plan of Wisconsin

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	749	38	1,254	-	-	-	2,041
Ages 1-14	8,977	320	15,869	-	2	-	25,168
Ages 15-20	2,412	75	3,860	-	-	-	6,347
Ages 21-44	3,959	151	6,340	-	1	-	10,451
Ages 45+	940	20	1,175	-	-	-	2,135
All Ages	17,037	604	28,498	-	3	-	46,142
2019 All Services Capitation Rate PMPM							
Age 0	$542.74	$434.21	$451.18	$468.54	$466.14	$494.27	$484.46
Ages 1-14	$135.59	$110.80	$121.32	$115.79	$113.57	$117.66	$126.28
Ages 15-20	$184.08	$142.88	$165.27	$158.73	$156.00	$162.66	$172.15
Ages 21-44	$292.12	$186.56	$243.51	$240.69	$236.84	$248.52	$261.10
Ages 45+	$396.56	$315.90	$341.66	$338.85	$334.32	$352.36	$365.59
All Ages	$211.13	$160.86	$178.06	N/A	$154.66	N/A	$190.04
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$540.50	$432.47	$448.67	$467.01	$465.28	$494.01	$482.07
Ages 1-14	134.13	$109.67	$119.68	$114.79	$113.01	$117.49	$124.71
Ages 15-20	$181.48	$140.86	$162.36	$156.96	$155.00	$162.35	$169.37
Ages 21-44	$286.36	$182.08	$237.05	$236.76	$234.63	$247.84	$254.93
Ages 45+	$389.89	$310.72	$334.19	$334.30	$331.76	$351.58	$358.49
All Ages	$208.18	$158.61	$174.89	N/A	$153.55	N/A	$186.97
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$542.54	$434.07	$450.99	$468.39	$466.00	$494.13	$484.27
Ages 1-14	$115.23	$96.73	$103.20	$101.17	$100.49	$103.99	$107.41
Ages 15-20	$163.81	$128.87	$147.23	$144.16	$142.98	$149.05	$153.31
Ages 21-44	$278.42	$177.28	$231.44	$230.75	$228.29	$239.23	$248.45
Ages 45+	$382.76	$306.55	$329.50	$328.84	$325.71	$343.00	$352.73
All Ages	$193.58	$149.03	$162.33	N/A	$143.09	N/A	$173.69
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$540.30	$432.33	$448.48	$466.86	$465.14	$493.87	$481.88
Ages 1-14	$113.77	$95.60	$101.56	$100.17	$99.93	$103.82	$105.84
Ages 15-20	$161.21	$126.85	$144.32	$142.39	$141.98	$148.74	$150.53
Ages 21-44	$272.66	$172.80	$224.98	$226.82	$226.08	$238.55	$242.29
Ages 45+	$376.09	$301.37	$322.03	$324.29	$323.15	$342.22	$345.64
All Ages	$190.63	$146.78	$159.16	N/A	$141.98	N/A	$170.62
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	557	21	859	4	2	1	1,444
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,931.21

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Trilogy Health Insurance

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	7	116	10	8	98	286	525
Ages 1-14	38	783	56	86	705	1,778	3,446
Ages 15-20	7	166	22	8	171	415	789
Ages 21-44	23	362	27	37	318	858	1,625
Ages 45+	4	43	4	2	43	95	191
All Ages	79	1,470	119	141	1,335	3,432	6,576
2019 All Services Capitation Rate PMPM							
Age 0	$580.71	$472.18	$489.15	$506.51	$504.11	$532.23	$513.15
Ages 1-14	$169.90	$148.66	$155.40	$153.76	$151.10	$154.34	$152.56
Ages 15-20	$220.49	$188.27	$196.98	$196.70	$193.53	$199.35	$195.85
Ages 21-44	$316.13	$263.56	$275.34	$278.66	$274.52	$285.61	$278.63
Ages 45+	$431.48	$353.87	$369.68	$376.82	$372.00	$389.45	$377.85
All Ages	$266.60	$212.96	$225.55	$212.15	$218.96	$230.60	$224.24
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$578.47	$470.44	$486.64	$504.98	$503.25	$531.97	$512.36
Ages 1-14	168.44	$147.53	$153.76	$152.76	$150.54	$154.17	$152.03
Ages 15-20	$217.89	$186.25	$194.07	$194.93	$192.53	$199.04	$194.93
Ages 21-44	$310.37	$259.08	$268.88	$274.73	$272.31	$284.93	$276.56
Ages 45+	$424.81	$348.69	$362.21	$372.27	$369.44	$388.67	$375.37
All Ages	$263.46	$210.74	$222.31	$210.26	$217.87	$230.26	$223.20
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$580.51	$472.04	$488.96	$506.36	$503.97	$532.10	$513.01
Ages 1-14	$149.54	$134.59	$137.28	$139.14	$138.46	$141.96	$139.51
Ages 15-20	$200.22	$174.26	$178.94	$182.13	$180.95	$187.02	$182.86
Ages 21-44	$302.43	$254.28	$263.27	$268.72	$266.26	$277.20	$269.89
Ages 45+	$417.68	$344.52	$357.52	$366.81	$363.68	$380.97	$369.00
All Ages	$250.31	$201.31	$210.52	$199.65	$208.43	$220.35	$213.41
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$578.27	$470.30	$486.45	$504.83	$503.11	$531.84	$512.22
Ages 1-14	$148.08	$133.46	$135.64	$138.14	$137.90	$141.79	$138.98
Ages 15-20	$197.62	$172.24	$176.03	$180.36	$179.95	$186.71	$181.94
Ages 21-44	$296.67	$249.80	$256.81	$264.79	$264.05	$276.52	$267.82
Ages 45+	$411.01	$339.34	$350.05	$362.26	$361.12	$380.19	$366.53
All Ages	$247.16	$199.09	$207.29	$197.75	$207.33	$220.01	$212.38
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	3	69	4	5	66	174	321
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,041.76

Exhibit 21A
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS, P4P, and Access Payments
BadgerCare Plus Standard
Unitedhealthcare Community Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Age 0	498	2,535	368	441	716	1,358	5,916
Ages 1-14	6,275	31,095	3,615	5,158	5,285	9,826	61,254
Ages 15-20	1,346	7,007	843	1,152	1,363	2,403	14,114
Ages 21-44	2,674	12,389	1,689	2,065	2,615	5,262	26,694
Ages 45+	471	2,269	273	383	543	838	4,777
All Ages	11,264	55,295	6,788	9,199	10,522	19,687	112,755
2019 All Services Capitation Rate PMPM							
Age 0	$555.38	$446.85	$463.82	$481.18	$478.77	$506.90	$477.25
Ages 1-14	$143.39	$124.47	$124.94	$128.37	$125.60	$132.96	$128.22
Ages 15-20	$191.32	$164.16	$165.19	$170.14	$173.10	$176.39	$170.25
Ages 21-44	$285.48	$243.43	$251.09	$264.85	$250.32	$275.67	$256.81
Ages 45+	$387.18	$337.30	$347.39	$365.06	$338.43	$391.05	$354.58
All Ages	$211.26	$179.67	$188.65	$191.01	$197.77	$213.19	$191.83
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13A)							
Age 0	$553.14	$445.11	$461.31	$479.65	$477.91	$506.64	$475.88
Ages 1-14	141.93	$123.34	$123.30	$127.37	$125.04	$132.79	$127.24
Ages 15-20	$188.72	$162.14	$162.28	$168.37	$172.10	$176.08	$168.53
Ages 21-44	$279.72	$238.95	$244.63	$260.92	$248.11	$274.99	$253.09
Ages 45+	$380.51	$332.12	$339.92	$360.51	$335.87	$390.27	$350.24
All Ages	$208.39	$177.48	$185.37	$189.08	$196.61	$212.83	$189.94
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16A)							
Age 0	$555.18	$446.71	$463.63	$481.03	$478.64	$506.77	$477.10
Ages 1-14	$123.03	$110.40	$106.82	$113.75	$113.25	$119.83	$113.52
Ages 15-20	$171.05	$150.15	$147.15	$155.57	$160.81	$163.32	$155.68
Ages 21-44	$271.78	$234.15	$239.02	$254.91	$242.25	$266.74	$247.05
Ages 45+	$373.38	$327.95	$335.23	$355.05	$330.30	$382.06	$344.78
All Ages	$193.65	$167.51	$173.25	$178.33	$187.54	$202.26	$179.28
2019 Medical Capitation Rate PMPM (From Exhibit 6A)							
Age 0	$552.94	$444.97	$461.12	$479.50	$477.78	$506.51	$475.73
Ages 1-14	$121.57	$109.27	$105.18	$112.75	$112.69	$119.66	$112.54
Ages 15-20	$168.45	$148.13	$144.24	$153.80	$159.81	$163.01	$153.96
Ages 21-44	$266.02	$229.67	$232.56	$250.98	$240.04	$266.06	$243.33
Ages 45+	$366.71	$322.77	$327.76	$350.50	$327.74	$381.28	$340.44
All Ages	$190.79	$165.32	$169.97	$176.40	$186.39	$201.90	$177.40
2019 Maternity Kick Payment Base Period Deliveries (November 2016 - October 2017)							
All Ages	362	1,665	210	263	405	903	3,808
2019 Maternity Kick Payment (From Exhibit 8)							
All Ages	$8,321.60	$5,347.74	$6,074.97	$6,131.17	$5,941.47	$6,312.29	$6,016.62

D. BadgerCare Plus Childless Adults (CLA) Rate Exhibits

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
New HMOs

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	6,077	10,243	9,004	13,091	9,065	27,803	75,283
Ages 45+	6,639	8,481	7,932	9,107	6,815	15,721	54,695
All Ages	12,716	18,724	16,936	22,198	15,880	43,524	129,978
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$230.70	$235.18	$229.13	$237.30	$244.38	$238.91
Ages 45+	$462.04	$415.96	$423.17	$413.39	$428.25	$441.26	$430.97
All Ages	$363.92	$314.61	$323.23	$304.72	$319.25	$315.49	$319.73
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$227.91	$232.03	$226.79	$235.87	$243.79	$237.13
Ages 45+	$458.27	$412.16	$418.88	$410.20	$426.30	$440.46	$428.30
All Ages	$360.63	$311.37	$319.54	$302.04	$317.59	$314.83	$317.57
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$223.03	$225.83	$221.66	$228.81	$235.31	$230.22
Ages 45+	$447.55	$405.54	$410.48	$403.25	$416.71	$428.95	$419.09
All Ages	$351.25	$305.70	$312.31	$296.16	$309.45	$305.25	$309.70
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$220.24	$222.68	$219.32	$227.38	$234.72	$228.44
Ages 45+	$443.78	$401.74	$406.19	$400.06	$414.76	$428.15	$416.42
All Ages	$347.96	$302.45	$308.63	$293.47	$307.80	$304.59	$307.54

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Anthem Blue Cross Blue Shield

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	798	1,350	1,200	1,608	1,824	4,348	11,128
Ages 45+	559	1,054	1,108	883	1,550	2,681	7,835
All Ages	1,357	2,404	2,308	2,491	3,374	7,029	18,963
2019 All Services Capitation Rate PMPM							
Ages 19-44	$238.26	$232.73	$251.85	$235.88	$234.88	$254.50	$244.50
Ages 45+	$435.64	$415.96	$419.00	$403.13	$430.89	$423.94	$422.03
All Ages	$319.57	$313.06	$332.09	$295.17	$324.93	$319.13	$317.85
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$235.49	$229.94	$248.70	$233.54	$233.45	$253.91	$242.82
Ages 45+	$431.87	$412.16	$414.71	$399.94	$428.94	$423.14	$419.63
All Ages	$316.39	$309.83	$328.40	$292.52	$323.26	$318.46	$315.87
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$227.59	$225.06	$242.50	$228.41	$226.94	$245.90	$236.06
Ages 45+	$421.15	$405.54	$406.31	$392.99	$420.11	$412.26	$410.53
All Ages	$307.32	$304.19	$321.14	$286.75	$315.68	$309.35	$308.15
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$224.82	$222.27	$239.35	$226.07	$225.51	$245.31	$234.38
Ages 45+	$417.38	$401.74	$402.02	$389.80	$418.16	$411.46	$408.12
All Ages	$304.14	$300.96	$317.44	$284.11	$314.01	$308.68	$306.16

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Children's Community Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	477	10	165	1,682	5,437	7,771
Ages 45+	-	256	9	81	1,002	2,370	3,718
All Ages	-	733	19	246	2,684	7,807	11,489
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$207.89	$235.18	$213.38	$260.26	$251.80	$250.10
Ages 45+	$462.04	$381.35	$423.17	$508.58	$454.67	$449.45	$447.39
All Ages	N/A	$268.47	$324.23	$310.58	$332.84	$311.80	$313.95
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$205.10	$232.03	$211.04	$258.83	$251.21	$249.15
Ages 45+	$458.27	$377.55	$418.88	$505.39	$452.72	$448.65	$446.02
All Ages	N/A	$265.33	$320.54	$307.96	$331.21	$311.15	$312.86
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$200.22	$225.83	$205.91	$251.43	$242.53	$241.06
Ages 45+	$447.55	$370.93	$410.48	$498.44	$442.66	$436.85	$435.15
All Ages	N/A	$259.84	$313.30	$302.23	$322.82	$301.52	$303.87
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$197.43	$222.68	$203.57	$250.00	$241.94	$240.11
Ages 45+	$443.78	$367.13	$406.19	$495.25	$440.71	$436.05	$433.78
All Ages	N/A	$256.70	$309.61	$299.61	$321.20	$300.87	$302.78

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Dean Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	-	29	2,453	-	-	2,482
Ages 45+	-	-	53	2,061	-	-	2,114
All Ages	-	-	82	4,514	-	-	4,596
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$230.70	$235.18	$237.23	$237.30	$244.38	$237.21
Ages 45+	$462.04	$415.96	$423.17	$415.85	$428.25	$441.26	$416.03
All Ages	N/A	N/A	$356.69	$318.78	N/A	N/A	$319.46
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$227.91	$232.03	$234.89	$235.87	$243.79	$234.86
Ages 45+	$458.27	$412.16	$418.88	$412.66	$426.30	$440.46	$412.82
All Ages	N/A	N/A	$352.80	$316.06	N/A	N/A	$316.72
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$223.03	$225.83	$229.76	$228.81	$235.31	$229.71
Ages 45+	$447.55	$405.54	$410.48	$405.71	$416.71	$428.95	$405.83
All Ages	N/A	N/A	$345.18	$310.10	N/A	N/A	$310.72
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$220.24	$222.68	$227.42	$227.38	$234.72	$227.36
Ages 45+	$443.78	$401.74	$406.19	$402.52	$414.76	$428.15	$402.61
All Ages	N/A	N/A	$341.29	$307.37	N/A	N/A	$307.97

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Group Health Coop Eau Claire

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	1,867	2	1,567	528	-	-	3,964
Ages 45+	1,975	-	1,430	541	-	-	3,946
All Ages	3,842	2	2,997	1,069	-	-	7,910
2019 All Services Capitation Rate PMPM							
Ages 19-44	$275.43	$230.70	$248.20	$230.70	$237.30	$244.38	$258.69
Ages 45+	$471.14	$415.96	$423.59	$374.00	$428.25	$441.26	$440.59
All Ages	$376.04	$230.70	$331.89	$303.22	N/A	N/A	$349.43
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$272.66	$227.91	$245.05	$228.36	$235.87	$243.79	$255.82
Ages 45+	$467.37	$412.16	$419.30	$370.81	$426.30	$440.46	$436.71
All Ages	$372.75	$227.91	$328.19	$300.45	N/A	N/A	$346.06
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$264.76	$223.03	$238.85	$223.23	$228.81	$235.31	$248.96
Ages 45+	$456.65	$405.54	$410.90	$363.86	$416.71	$428.95	$427.35
All Ages	$363.40	$223.03	$320.94	$294.40	N/A	N/A	$337.95
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$261.99	$220.24	$235.70	$220.89	$227.38	$234.72	$246.10
Ages 45+	$452.88	$401.74	$406.61	$360.67	$414.76	$428.15	$423.47
All Ages	$360.12	$220.24	$317.25	$291.63	N/A	N/A	$334.58

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Group Health Coop SC WI

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	-	-	1,104	-	-	1,104
Ages 45+	-	-	-	567	-	-	567
All Ages	-	-	-	1,671	-	-	1,671
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$230.70	$235.18	$213.16	$237.30	$244.38	$213.16
Ages 45+	$462.04	$415.96	$423.17	$383.44	$428.25	$441.26	$383.44
All Ages	N/A	N/A	N/A	$270.94	N/A	N/A	$270.94
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$227.91	$232.03	$210.82	$235.87	$243.79	$210.82
Ages 45+	$458.27	$412.16	$418.88	$380.25	$426.30	$440.46	$380.25
All Ages	N/A	N/A	N/A	$268.31	N/A	N/A	$268.31
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$223.03	$225.83	$205.69	$228.81	$235.31	$205.69
Ages 45+	$447.55	$405.54	$410.48	$373.30	$416.71	$428.95	$373.30
All Ages	N/A	N/A	N/A	$262.56	N/A	N/A	$262.56
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$220.24	$222.68	$203.35	$227.38	$234.72	$203.35
Ages 45+	$443.78	$401.74	$406.19	$370.11	$414.76	$428.15	$370.11
All Ages	N/A	N/A	N/A	$259.93	N/A	N/A	$259.93

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Independent Care (ICare)

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	15	637	196	212	544	2,481	4,085
Ages 45+	8	406	114	142	354	1,493	2,517
All Ages	23	1,043	310	354	898	3,974	6,602
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$222.57	$220.56	$248.70	$222.74	$253.09	$242.51
Ages 45+	$462.04	$381.35	$391.09	$474.53	$404.83	$455.60	$434.65
All Ages	$328.14	$284.38	$283.27	$339.29	$294.52	$329.17	$315.76
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$219.78	$217.41	$246.36	$221.31	$252.50	$241.25
Ages 45+	$458.27	$377.55	$386.80	$471.34	$402.88	$454.80	$432.90
All Ages	$325.02	$281.19	$279.70	$336.61	$292.89	$328.50	$314.32
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$214.90	$211.21	$241.23	$214.58	$244.46	$234.11
Ages 45+	$447.55	$370.93	$378.40	$464.39	$393.74	$443.88	$423.26
All Ages	$316.14	$275.64	$272.69	$330.75	$285.21	$319.38	$306.22
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$212.11	$208.06	$238.89	$213.15	$243.87	$232.85
Ages 45+	$443.78	$367.13	$374.11	$461.20	$391.79	$443.08	$421.52
All Ages	$313.02	$272.45	$269.12	$328.07	$283.57	$318.71	$304.78

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Mercy Care Insurance Company

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	-	-	1,081	3	-	1,084
Ages 45+	-	-	-	975	2	-	977
All Ages	-	-	-	2,056	5	-	2,061
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$230.70	$235.18	$235.43	$237.30	$244.38	$235.44
Ages 45+	$462.04	$415.96	$423.17	$404.36	$428.25	$441.26	$404.41
All Ages	N/A	N/A	N/A	$315.54	$313.68	N/A	$315.54
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$227.91	$232.03	$233.09	$235.87	$243.79	$233.10
Ages 45+	$458.27	$412.16	$418.88	$401.17	$426.30	$440.46	$401.22
All Ages	N/A	N/A	N/A	$312.80	$312.04	N/A	$312.80
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$223.03	$225.83	$227.96	$228.81	$235.31	$227.96
Ages 45+	$447.55	$405.54	$410.48	$394.22	$416.71	$428.95	$394.27
All Ages	N/A	N/A	N/A	$306.80	$303.97	N/A	$306.80
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$220.24	$222.68	$225.62	$227.38	$234.72	$225.62
Ages 45+	$443.78	$401.74	$406.19	$391.03	$414.76	$428.15	$391.08
All Ages	N/A	N/A	N/A	$304.06	$302.33	N/A	$304.05

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
MHS Health Wisconsin

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	318	888	515	874	537	2,216	5,348
Ages 45+	275	650	308	449	331	1,046	3,059
All Ages	593	1,538	823	1,323	868	3,262	8,407
2019 All Services Capitation Rate PMPM							
Ages 19-44	$248.74	$215.34	$220.11	$201.46	$182.16	$206.01	$208.32
Ages 45+	$450.66	$421.32	$381.51	$414.21	$410.02	$416.56	$416.06
All Ages	$342.38	$302.39	$280.51	$273.66	$269.05	$273.53	$283.91
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$245.97	$212.55	$216.96	$199.12	$180.73	$205.42	$206.62
Ages 45+	$446.89	$417.52	$377.22	$411.02	$408.07	$415.76	$413.52
All Ages	$339.15	$299.18	$276.94	$271.03	$267.42	$272.87	$281.90
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$238.07	$207.67	$210.76	$193.99	$173.31	$197.03	$199.68
Ages 45+	$436.17	$410.90	$368.82	$404.07	$397.99	$404.36	$404.30
All Ages	$329.94	$293.56	$269.91	$265.29	$258.99	$263.51	$274.13
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$235.30	$204.88	$207.61	$191.65	$171.88	$196.44	$197.98
Ages 45+	$432.40	$407.10	$364.53	$400.88	$396.04	$403.56	$401.77
All Ages	$326.70	$290.34	$266.34	$262.66	$257.36	$262.86	$272.13

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Molina Healthcare

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	101	753	176	166	936	3,130	5,262
Ages 45+	80	586	94	124	585	1,508	2,977
All Ages	181	1,339	270	290	1,521	4,638	8,239
2019 All Services Capitation Rate PMPM							
Ages 19-44	$251.73	$209.01	$179.91	$227.78	$217.22	$218.14	$216.34
Ages 45+	$423.35	$378.88	$398.59	$424.47	$378.88	$408.67	$397.69
All Ages	$327.58	$283.35	$256.04	$311.88	$279.40	$280.09	$281.87
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$248.96	$206.22	$176.76	$225.44	$215.79	$217.55	$215.10
Ages 45+	$419.58	$375.08	$394.30	$421.28	$376.93	$407.87	$395.78
All Ages	$324.37	$280.12	$252.50	$309.18	$277.77	$279.43	$280.39
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$241.06	$201.34	$170.56	$220.31	$208.75	$208.83	$207.44
Ages 45+	$408.86	$368.46	$385.90	$414.33	$367.36	$396.02	$385.75
All Ages	$315.23	$274.48	$245.53	$303.27	$269.75	$269.69	$271.87
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$238.29	$198.55	$167.41	$217.97	$207.32	$208.24	$206.21
Ages 45+	$405.09	$364.66	$381.61	$411.14	$365.41	$395.22	$383.85
All Ages	$312.01	$271.25	$241.98	$300.57	$268.12	$269.03	$270.40

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Network Health Plan

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	307	1,223	523	653	539	2,030	5,275
Ages 45+	241	1,007	354	336	297	890	3,125
All Ages	548	2,230	877	989	836	2,920	8,400
2019 All Services Capitation Rate PMPM							
Ages 19-44	$208.06	$221.89	$215.54	$217.21	$208.40	$203.35	$211.36
Ages 45+	$453.39	$403.60	$393.17	$443.34	$396.80	$408.30	$411.22
All Ages	$315.95	$303.94	$287.24	$294.03	$275.33	$265.82	$285.71
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$205.29	$219.10	$212.39	$214.87	$206.97	$202.76	$209.58
Ages 45+	$449.62	$399.80	$388.88	$440.15	$394.85	$407.50	$408.47
All Ages	$312.74	$300.70	$283.63	$291.41	$273.72	$265.16	$283.57
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$197.39	$214.22	$206.19	$209.74	$199.89	$194.62	$202.88
Ages 45+	$438.90	$393.18	$380.48	$433.20	$385.23	$396.45	$399.75
All Ages	$303.60	$295.03	$276.54	$285.66	$265.73	$256.14	$276.12
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$194.62	$211.43	$203.04	$207.40	$198.46	$194.03	$201.10
Ages 45+	$435.13	$389.38	$376.19	$430.01	$383.28	$395.65	$396.99
All Ages	$300.39	$291.79	$272.93	$283.03	$264.12	$255.48	$273.98

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Quartz

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	-	32	969	2,413	-	-	3,414
Ages 45+	-	14	1,013	1,718	-	-	2,745
All Ages	-	46	1,982	4,131	-	-	6,159
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$230.70	$237.46	$239.03	$237.30	$244.38	$238.51
Ages 45+	$462.04	$415.96	$422.75	$422.42	$428.25	$441.26	$422.51
All Ages	N/A	$287.08	$332.16	$315.30	N/A	N/A	$320.52
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$227.91	$234.31	$236.69	$235.87	$243.79	$235.93
Ages 45+	$458.27	$412.16	$418.46	$419.23	$426.30	$440.46	$418.91
All Ages	N/A	$283.99	$328.43	$312.60	N/A	N/A	$317.48
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$223.03	$228.11	$231.56	$228.81	$235.31	$230.50
Ages 45+	$447.55	$405.54	$410.06	$412.28	$416.71	$428.95	$411.43
All Ages	N/A	$278.58	$321.10	$306.72	N/A	N/A	$311.14
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$220.24	$224.96	$229.22	$227.38	$234.72	$227.93
Ages 45+	$443.78	$401.74	$405.77	$409.09	$414.76	$428.15	$407.83
All Ages	N/A	$275.48	$317.37	$304.02	N/A	N/A	$308.11

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Security Health Plan of Wisconsin

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	1,549	124	2,639	-	-	-	4,312
Ages 45+	2,314	71	2,609	-	-	-	4,994
All Ages	3,863	195	5,248	-	-	-	9,306
2019 All Services Capitation Rate PMPM							
Ages 19-44	$270.19	$210.82	$242.95	$229.13	$237.30	$244.38	$251.81
Ages 45+	$474.78	$408.13	$436.50	$413.39	$428.25	$441.26	$453.83
All Ages	$392.74	$282.66	$339.17	N/A	N/A	N/A	$360.22
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$267.42	$208.03	$239.80	$226.79	$235.87	$243.79	$248.81
Ages 45+	$471.01	$404.33	$432.21	$410.20	$426.30	$440.46	$449.79
All Ages	$389.37	$279.50	$335.46	N/A	N/A	N/A	$356.66
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$259.52	$203.15	$233.60	$221.66	$228.81	$235.31	$242.04
Ages 45+	$460.29	$397.71	$423.81	$403.25	$416.71	$428.95	$440.34
All Ages	$379.78	$273.99	$328.16	N/A	N/A	N/A	$348.46
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$256.75	$200.36	$230.45	$219.32	$227.38	$234.72	$239.03
Ages 45+	$456.52	$393.91	$419.52	$400.06	$414.76	$428.15	$436.30
All Ages	$376.42	$270.83	$324.44	N/A	N/A	N/A	$344.89

Exhibit 21B
Wisconsin Department of Health Services
2019 BadgerCare Plus Capitation Rate Development
Final Capitation Rates Including CDPS and P4P
BadgerCare Plus Childless Adults
Trilogy Health Insurance

July 2018 Membership by Rate Cell	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	All Regions
Ages 19-44	24	427	44	37	425	1,924	2,881
Ages 45+	10	194	19	17	240	798	1,278
All Ages	34	621	63	54	665	2,722	4,159
2019 All Services Capitation Rate PMPM							
Ages 19-44	$256.72	$216.02	$235.18	$229.13	$222.01	$223.96	$223.01
Ages 45+	$462.04	$372.28	$423.17	$413.39	$415.43	$406.98	$404.06
All Ages	$317.11	$264.84	$291.88	$287.14	$291.82	$277.62	$278.64
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$253.95	$213.23	$232.03	$226.79	$220.58	$223.37	$221.89
Ages 45+	$458.27	$368.48	$418.88	$410.20	$413.48	$406.18	$402.48
All Ages	$314.04	$261.73	$288.38	$284.53	$290.20	$276.96	$277.38
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$246.05	$208.35	$225.83	$221.66	$213.88	$215.57	$214.74
Ages 45+	$447.55	$361.86	$410.48	$403.25	$404.37	$395.58	$392.84
All Ages	$305.31	$256.31	$281.52	$278.83	$282.63	$268.34	$269.47
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$243.28	$205.56	$222.68	$219.32	$212.45	$214.98	$213.62
Ages 45+	$443.78	$358.06	$406.19	$400.06	$402.42	$394.78	$391.26
All Ages	$302.25	$253.20	$278.02	$276.22	$281.01	$267.69	$268.21

Exhibit 21B Wisconsin Department of Health Services 2019 BadgerCare Plus Capitation Rate Development Final Capitation Rates Including CDPS and P4P BadgerCare Plus Childless Adults Unitedhealthcare Community Plan							
July 2018 Membership by Rate Cell	**Region 1**	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**	**All Regions**
Ages 19-44	1,098	4,330	1,136	1,797	2,575	6,237	17,173
Ages 45+	1,177	4,243	821	1,213	2,454	4,935	14,843
All Ages	2,275	8,573	1,957	3,010	5,029	11,172	32,016
2019 All Services Capitation Rate PMPM							
Ages 19-44	$235.76	$245.16	$206.63	$221.26	$254.56	$273.99	$251.39
Ages 45+	$441.10	$430.79	$421.92	$419.54	$438.36	$469.15	$444.20
All Ages	$342.00	$337.03	$296.95	$301.16	$344.25	$360.20	$340.78
2019 Medical & Dental Capitation Rate PMPM (From Exhibit 13B)							
Ages 19-44	$232.99	$242.37	$203.48	$218.92	$253.13	$273.40	$249.63
Ages 45+	$437.33	$426.99	$417.63	$416.35	$436.41	$468.35	$441.73
All Ages	$338.71	$333.74	$293.32	$298.48	$342.57	$359.52	$338.69
2019 Medical & Chiropractic Capitation Rate PMPM (From Exhibit 16B)							
Ages 19-44	$225.09	$237.49	$197.28	$213.79	$245.83	$264.44	$242.60
Ages 45+	$426.61	$420.37	$409.23	$409.40	$426.49	$456.18	$432.27
All Ages	$329.35	$328.00	$286.20	$292.62	$333.99	$349.14	$330.53
2019 Medical Capitation Rate PMPM (From Exhibit 6B)							
Ages 19-44	$222.32	$234.70	$194.13	$211.45	$244.40	$263.85	$240.83
Ages 45+	$422.84	$416.57	$404.94	$406.21	$424.54	$455.38	$429.80

All terms and conditions of the January 1, 2018 through December 31, 2019 contract and any prior amendments that are not affected by this amendment shall remain in full force and effect.

HMO Name	**Department of Health Services**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date