CONTRACT FOR SERVICES

Between

Department of Health Services

and

Dane County

July 1, 2020 – June 30, 2022

CONTRACT TABLE OF CONTENTS

Page No.

Table of Contents

Between Department of Health Services and Dane County

ARTICLE I

THIS CONTRACT is made and entered into for the period of July 1, 2020, through June 30, 2022, by and between the Department of Health Services (hereinafter Department) and the County Board Supervisors of the County of Dane (hereinafter the County) for the purpose of providing and/or purchasing mental health services for severely emotionally disturbed children who are BadgerCare Plus members enrolled in the County's special managed care program known as Children Come First (CCF).

WHEREAS THE DEPARTMENT wishes to purchase with periodic fixed payments on a risk basis, as defined in 42 CFR §438.2, the "Contract Services" and "Administrative Services" specifically described below; and

WHEREAS the County is able and willing to provide and/or purchase such services.

NOW THEREFORE, in consideration of the mutual covenants hereinafter set forth, the Department and the County agree as follows:

I. DEFINITIONS

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to BadgerCare Plus, in reimbursement for services that fail to meet professionally recognized standards for health. Abuse also includes client or member practices that result in unnecessary costs to Medicaid.

Administrative Services: An obligation of the County under this Contract other than Contract Services.

Advance Directive: An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated.

Adverse Benefit Determination: Includes any of the following:

- The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service.
- The failure to provide services in a timely manner.
- The failure of the County to act within the standard resolution timeframes for grievances and appeals as detailed in the *Member Grievances and Appeals Guide*.

- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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

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

BadgerCare Plus:
Effective January 1, 2014, the following populations are eligible for BadgerCare Plus:

- All children (ages 18 and younger) with incomes at or below 306 percent of the Federal poverty level (FPL).
- Pregnant women with incomes at or below 306 percent of the FPL.
- Parents and caretaker relatives with incomes at or below 100 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.

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

CFR: Code of Federal Regulations.

Child and Family Treatment Team: Treatment team of individuals which includes both professionals and significant people important in the lives of the child and family.

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

Cold Call Marketing: Any unsolicited personal contact by the County, with the purpose of marketing.

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

Contractor: The County is considered a contractor of the State and incorporated herein by reference.

Copayment: A fixed amount the County 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.

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

Department: The Wisconsin Department of Health Services (DHS).

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

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

Emergency Medical Condition:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
    - Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
    - Serious impairment of bodily functions, or
    - Serious dysfunction of any bodily organ or part.

- With respect to a pregnant woman who is in active labor:
    - Where there is inadequate time to effect a safe transfer to another hospital before delivery, or
    - Where transfer may pose a threat to the health or safety of the woman or the unborn child.
- A psychiatric emergency involving a significant risk of serious harm to a member or others.

- A substance abuse emergency exists if there is significant risk of serious harm to a member or others, or there is likelihood of return to substance abuse without immediate treatment.

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

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

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

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

Encounter Record: An electronically formatted list of utilization data elements per encounter in a computer readable format as specified in ADDENDUM II for the Quarterly Utilization Report.

Enrollment Area: Refers to Dane County and is the geographic area within which a member's parent, guardian or primary caregiver must reside in order to enroll in the County's Managed Care Program under this Contract. A member may enroll regardless of where the member's parent, guardian, or primary caregiver lives when the member is legally the responsibility of the County.

Excluded Services: Services that Medicaid does not pay for.

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

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

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

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

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

HHS: The federal Department of Health and Human Services.

HIPAA: The Health Insurance Portability and Accountability Act of 1996.

Home Health Care: Home health skilled nursing and therapy services, including medication management, are provided to a recipient who, due to his/her medical condition, is unable to leave home to obtain necessary medical care and treatment and therefore, must receive this care at home.

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

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

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

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

Marketing: Any communication, from the County to a Medicaid member who is not enrolled, that can reasonably be interpreted as intended to influence that member to enroll in the County's program.

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

Medicaid: The Wisconsin Medical Assistance Program operated by the Wisconsin Department of Health Services under Title XIX of the federal Social Security Act, Ch. 49, Wis. Stats., and related state and federal rules and regulations. The Medicaid program is referred to as "BadgerCare Plus" throughout this contract.

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

Member: A BadgerCare Plus recipient who has been certified by the state as eligible to enroll under this Contract, and whose name appears on the County Enrollment Reports which the Department will transmit to the County every month in accordance with an established notification schedule.

Members with Special Health Care Needs: Term used in clinical diagnostic and functional development to describe individuals who require additional assistance for conditions that may be medical, mental, developmental, physical or psychological. All County members meet these criteria and must have a timely treatment or care plan developed for each member with the member's providers and include member participation.

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

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

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

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

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

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

Preauthorization: The written authorization issued by the Department or the County to a provider prior to the provision of a service. Also known as 'prior authorization'. Wis. Admin Code DHS 101.03(134).

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

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

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

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

Program Integrity: As defined by CMS, it is the commitment to combating Medicaid provider fraud, waste, and abuse which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid 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.

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

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

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

Recipient: Any individual entitled to benefits under Title XIX and Title XXI of the Social Security Act, and under the Medicaid State Plan as defined in Chapter 49, Wis. Stats.

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

Risk: The possibility of monetary loss or gain by the County resulting from service costs exceeding or being less than payments made to it by the Department.

Serious Emotional Disturbance, Severe Emotional Disturbance, Severely Emotionally Disturbed, and SED: A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Service Authorization: Service authorization request means a managed care member's request for the provision of a service to the County.

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

Special Health Care Needs Assessment: The assessment performed by the County's appropriately qualified health care professionals to determine a member's special health care needs and to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.

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

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

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

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

Terms that are not defined above shall have their primary meaning identified in the Wisconsin Administrative Code (Wis. Admin. Code), Chapters DHS 101-108.

ARTICLE II

II. DELEGATIONS OF AUTHORITY

The County shall oversee and remain accountable for any functions and responsibilities that it delegates to any subcontractor. For all major or minor delegation of function or authority:

A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate.

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

C. The County shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once a year.

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

E. If the County delegates the selection of providers to another entity, the County retains the right to approve, suspend, or terminate any provider selected by that entity.

ARTICLE III

III. COVERED POPULATION

The eligible population consists of those BadgerCare Plus eligible children and adolescents who meet the following criteria:

A. RESIDENCY----The child/adolescent and the parents, guardian or primary caregivers of the eligible children and adolescents will live in Dane County.

B. AGE----Eligible children and adolescents will be from birth through 18 years of age.

C. SEVERE EMOTIONAL DISTURBANCE----Eligible children will be determined to have severe emotional disturbance as defined in this Contract.

D. IMMINENT RISK OF PLACEMENT----Eligible children will be in an out-of-home placement or at imminent risk of admission to a psychiatric hospital, or placement in a residential care center or juvenile correction facility.

E. NON-NURSING HOME----Eligible children shall not be residents of a nursing facility at the time of enrollment.

F. NON-PSYCHIATRIC HOSPITAL----Eligible children shall not be residing in a psychiatric hospital or a psychiatric unit of a general hospital at the time of enrollment.

ARTICLE IV

IV. FUNCTIONS AND DUTIES OF THE COUNTY

In consideration of promises of the Department contained in this Contract, the County shall:

A. PROVISION OF CONTRACT SERVICES

1. Promptly provide or arrange for the provision of all services as described in this Contract attached hereto and included herein.

2. Be liable, when emergencies and County referrals to out-of-area or non-affiliated providers occur, for payment only to the extent that Medicaid pays, including Medicare deductibles, or would pay its fee-for-service providers for services to BadgerCare Plus members. For outpatient hospital services the Department will provide each managed care program per diem outpatient rates based on the BadgerCare Plus fee-for-service equivalent. This condition does not apply to: (1) Cases where prior payment arrangements were established; and (2) Specific subcontract agreements. The County is not required to make retroactive payment adjustments consistent with the Wisconsin BadgerCare Plus Maximum Allowable Fee Schedule and hospital reimbursement made by the State of Wisconsin for fee-for-service providers, including but not limited to, payments for inpatient and outpatient hospital services.

3. Changes to BadgerCare Plus-covered services mandated by federal or state law subsequent to the signing of this Contract will not affect the Contract services for the term of this Contract, until agreed to by mutual consent, or unless the change is necessary to continue receiving federal funds or is due to the action of a court of law.

   The Department may incorporate into the Contract any change in covered services mandated by federal or state law into the Contract effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the County at least 30 days' notice before the intended effective date of any such change that reflects service increases and the County may elect to accept or reject the service increases for the remainder of that Contract year.

   The Department will give the County 60-day notice of any such change that reflects service decreases, with a right of the County to dispute the amount of the decrease within those 60 days. The County has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in

coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in State Appropriations.

This Contract is contingent upon authorization of state and federal law and any material amendment or repeal of same affecting relevant funding to, or authority of, the Department shall serve to terminate this agreement except as further agreed by the parties hereto. Nothing contained in this Contract shall be construed to supersede the lawful power or duties of either party.

4. Be responsible for the provision and payment of all Contract services provided to all BadgerCare Plus members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage. Additionally, the County agrees to provide, or authorize provision of, services to all BadgerCare Plus members with valid ForwardHealth ID cards indicating County enrollment without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the cards and the reports will be reported to the Department for resolution. The County shall continue to provide and authorize provision of all Contract services until the discrepancy is resolved. This includes members who were PEND/CLOSE on the Initial Report and held a valid ForwardHealth ID card indicating County enrollment, but did not appear as a CONTINUE on the Final Report.

5. Assist members in scheduling and obtaining HealthCheck services from their regular provider of primary health care, or other certified HealthCheck service provider.

6. The actual provision of any service must be approved by the members of the Child and Family Treatment team as to the medical necessity and appropriateness of the service, except that the County must provide assessment and evaluation services ordered by a court. The County shall not establish any monetary limit or time limit on mental health and substance abuse treatment where it has been determined that this treatment is medically necessary. Decisions to provide or not to provide or authorize medical services shall be based solely on medical necessity and appropriateness as defined in DHS 101.03(96m) and the recommendations of the child and family treatment team. Disputes between the County and members about medical necessity and appropriateness can be appealed through the County member appeal system and ultimately to the Division of Hearing and Appeals (DHA) for a binding determination. Parents must be informed of the

grievance and appeal procedures in writing, as detailed in the *Member Grievances and Appeals Guide*.

7. The County and its providers and subcontractors must not bill a BadgerCare Plus member for medically necessary BadgerCare Plus services covered under the County Contract and provided during the member's period of the County enrollment, except for allowable co-payments on medications and services established by the Department. The County has the right to waive the member's co-payment for provided services. This provision shall continue to be in effect even if the County becomes insolvent. The County must ensure that a member will not be billed for BadgerCare Plus-covered services provided out of the County's network.

8. In addition, the County or its subcontractors or providers is not required to provide counseling or referral service if the County objects the service on moral or religious grounds. If the County 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:

    a. To the Department;
    b. With the County's certification application for a BadgerCare Plus contract;
    c. Whenever the County adopts the policy during the term of the contract;
    d. It must be consistent with the provisions of 42 CFR 438.10;
    e. It must be provided to potential members before and during enrollment;
    f. It must be provided to members within ninety (90) calendar days after adopting the policy with respect to any particular service; and
    g. In written and prominent manner, the County shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus but which are not available through the County program because of an objection on moral or religious grounds. Member will be informed of their right to disenroll due to unavailable services.
    h. Member will be informed of their right to disenroll if services are unavailable due to an objection on religious or moral grounds.

9. Children Come First, for members ages 18 years and older, must maintain written policies and procedures related to advance directives. Written information provided must reflect changes in state law as soon

as possible, but no later than 90 days after the effective date of the change. An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. Children Come First must:

a. Provide written information at the time of enrollment to all adults receiving medical care through the Children Come First regarding:

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

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

    3) Children Come First's written policies respecting the implementation of such rights.

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

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

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

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

10. The County must have written policies regarding member rights, including free exercise of rights without adverse action by the County or the providers. The County must notify members of their rights in the member handbook upon enrollment and annually. The County must comply with any applicable federal and state laws regarding enrollee rights, and must ensure its staff and providers consider those rights when providing services.

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

B. TIME LIMIT FOR DECISION ON CERTAIN REFERRALS

Payment for covered services pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-County provider extends until the County issues a written denial of referral. This requirement does not apply if the County issues a written denial of referral within seven (7) days of receiving the request for referral.

C. EMERGENCY CARE

a. Coverage of Payment of Emergency Services

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

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

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

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

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

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

b. Coverage and Treatment of Post-Stabilization Care Services

1) The PIHP is financially responsible for:

a) Emergency and post-stabilization services obtained within or outside the PIHP's network that are pre-approved by the PIHP. The PIHP is financially responsible for post-stabilization care services consistent with the provision of 42 CFR § 438.114(C).

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

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

a. A network physician assumes responsibility for the member's care at the treating hospital or through transfer;
b. The treating physician and PIHP reach agreement; or,
c. The member is discharged.

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

3) The PIHP must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he/she had obtained the services through the PIHP. A member who has an emergency mental health condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

c. Additional Provisions

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

2) When emergency services are provided by non-affiliated providers, the PIHP is liable for payment only to the extent that BadgerCare Plus and/or Medicaid SSI pays, including Medicare deductibles, or would pay, FFS providers for services to BadgerCare Plus and/or Medicaid SSI populations. For more information on payment to non-affiliated providers see Article IV, Section A, part 2. The PIHP must not make any payments to providers with a financial institution outside the United States. In no case will the PIHP be required to pay more than billed charges.

This condition does not apply to:

a) Cases where prior payment arrangements were established; and
b) Specific subcontract agreements.

D. 24-HOUR COVERGE

Provide all emergency contact and post-stabilization services as defined in this Contract 24 hours each day, seven (7) days a week, either by the County's own facilities or through arrangements approved by the Department with other providers. The County shall have one (1) toll-free telephone number that members or individuals acting on behalf of a member can call at any time to obtain authorization for emergency care. Through this number, members

must have access to individuals authorizing treatment as appropriate. A response to such a call must be provided within 30 minutes, or the County will be liable for the cost of medically necessary services covered under this Contract that are related to that illness or injury incident, regardless of whether treatment is in-or out-of-plan and whether the condition is emergency, urgent, or routine.

The County must be able to communicate with a caller in the language spoken by the caller or the County will be liable for the cost of subsequent care related to that illness or injury incident whether treatment is in-or out-of-plan and whether the condition is emergency, urgent, or routine.

These calls must be logged with time, date and any pertinent information related to persons involved, resolution and follow-up instructions.

The County shall notify the Department of any changes of this one telephone number for emergency calls within seven (7) working days of change.

E. THIRTY-DAY PAYMENT REQUIREMENT

The County must pay at least 90% of adjudicated clean claims from subcontractors for covered medically necessary services within 30 days of receipt of bill, 99% within 90 days, and 100% of the claims within 180 days of receipt, except to the extent subcontractors have agreed to later payment. The County agrees not to delay payment to subcontractors pending subcontractor collection of third party liability unless the County has an agreement with their subcontractor to collect third party liability.

F. COUNTY CLAIM RETRIEVAL SYSTEM

The County must maintain a claim retrieval system that can on request identify date of receipt, provider, action taken on all provider claims (i.e., paid, denied, other), and when action was taken. County shall date stamp all provider claims upon receipt. In addition, the County shall maintain a claim retrieval system that can identify, within the individual claim, services provided and diagnoses of members with nationally accepted coding systems: HCPCS including Level I CPT codes, Level II, and Level III HCPCS codes with modifiers, ICD-10 diagnosis and procedure codes, and other national code sets such as place of service, type of service, and EOB codes or a mutually agreed upon code set that allows cross-walking between codes.

G. PROVIDER APPEALS TO THE DEPARTMENT

1. Providers must appeal first to the County and then to the Department if they disagree with the County’s payment or nonpayment of a claim.

The County must notify providers in writing of the County's decision to pay or deny the original claim. This notification should include:

a. A specific explanation of the payment amount or a specific reason for the non-payment.

b. A statement regarding the provider's appeal rights to the County.

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

d. An explanation of the process the provider should follow when appealing the County's decision.

    1) Include a separate letter or form clearly marked "Appeal."

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

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

    4) Address the letter or form to the person and/or function at the County that handles Provider Appeals.

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

e. A statement advising the provider of the provider's right to appeal to the Department if the County fails to respond to the appeal within 45 days or if the provider is not satisfied with the County's response to the request for reconsideration. Appeals to the Department must be submitted in writing within 60 days of the County's final decision or, in the case of no response, within 60 days from the 45 day timeline allotted the County to respond.

    Appeals regarding Children Come First to the Department can be faxed or mailed to:

    BadgerCare Plus and Medicaid SSI
    Managed Care Unit – Provider Appeal
    P.O. Box 6470
    Madison, WI 53716-0470

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

3. After a provider has appealed to the County according to the terms described in Subsection 1 above, and the provider disputes the determination, the provider may appeal to the Department for the final determination. Appeals must be submitted to the Department within 60 days of the date of written notification of the County's final decision resulting from a request for reconsideration or, if the County fails to respond, within 60 days from the 45-day timeline allotted the County to respond. In exceptional cases, the Department may override the County's time limit for the submission of claims and appeals. The Department will not exercise its authority in this regard unreasonably. The Department will accept written comments from all parties to the dispute prior to making a final decision. The Department has 45 days from the date of receipt of all written comments to inform the provider and the County of the final decision. If the Department's decision is in favor of the provider, the County will pay the provider(s) within 45 days of receipt of the Department's final determination. The County must accept the Department's determinations regarding appeals of disputed claims.

H. MEMBER APPEALS

County must provide written notification to providers on member appeal procedures.

I. PAYMENTS FOR DIAGNOSIS OF WHETHER AN EMERGENCY CONDITION EXISTS

Pay for appropriate diagnostic tests or evaluations utilized to determine if an emergency exists. Payment for emergency services continues until the patient is stabilized and can be safely discharged or transferred.

J. MEMORANDA OF UNDERSTANDING (MOU) FOR EMERGENCY SERVICES AND POST-STABILIZATOIN SERVICES

Negotiate in good faith MOUs with emergency care providers to ensure prompt and appropriate delivery of and payment for emergency services.

Such MOUs shall provide for:

1. The process for determining whether an emergency exists.

2. The requirements and procedures for contacting the County before the provision of urgent or routine care.

3. Agreements, if any, between the County and the provider regarding indemnification, hold harmless, or any other deviation from malpractice or other legal liability which would attach to the County or provider in the absence of such an agreement.

4. Payments for appropriate diagnostic tests or evaluations to determine if an emergency exists.

5. Assurance of timely and appropriate provision of and payment for emergency services.

Unless a Contract or MOU specifies otherwise, the County is liable to the extent that the fee-for-service system would have been liable for the emergency situation. The Department reserves the right to resolve disputes between the County, hospitals and urgent care centers regarding emergency situations based on fee-for-service criteria.

K. EQUALITY IN THE DELIVERY OF SERVICES

The County must provide Contract services to BadgerCare Plus members under this Contract in the same manner as those services are provided to other children with serious emotional disturbances by Dane County under Medicaid fee-for-service.

The County must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

L. ENROLLMENT

The County shall accept, as enrolled, all persons who appear as members on County Enrollment Reports. Enrollment in the County's Managed Care Program shall be voluntary by the member. Signed and completed enrollment forms will be submitted to the Department's Medicaid Fiscal Agent the day the County's RISE and Dane County staff determines the child is at imminent risk of out-of-home placement. The Department's Medicaid Fiscal Agent will determine if a member is BadgerCare Plus eligible, through 18 years of age, does not have a nursing home authorization, and is not residing in a psychiatric hospital. The Department's Medicaid Fiscal Agent will have five

(5) working days to process the County enrollment to final disposition. Final disposition means that:

1. The County enrollment is approved and updates are applied to the members eligibility segment; or

2. The County enrollment is denied and the County is notified.

If determined eligible, members are enrolled effective on the date the enrollment form is received by the Department's Medicaid Fiscal Agent.

Services can begin immediately. Enrollment can be any day of the month. If the member is enrolled in a BadgerCare Plus HMO, the Medicaid Fiscal Agent Analyst will enroll the member with a start date effective the date the enrollment request was received. By enrolling the member, s/he will automatically be disenrolled from the other BadgerCare Plus HMO, and will receive all non-County provided BadgerCare Plus services on a fee-for-service basis.

The County shall accept referrals of eligible children and adolescents at any time during the time this agreement is in effect. The County will accept BadgerCare Plus members in the order in which they apply without restriction, except as otherwise noted herein. The County will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability.

Enrollment opportunities will remain open and available without restriction within the total enrollment limits set by this Contract, except that the County may set reasonable limits on the number of eligibles to be enrolled on a monthly basis to ensure a manageable rate of growth and ability to provide medically necessary care. The County shall develop a policy with approval from the Department on how to determine which child to serve when there is a waiting list.

A referral can originate from County social workers, parents, other agency staff or Emergency Services Unit staff, schools or community-based providers. A referral is a request to enroll in the wraparound system of care. Requests for services or specific requests for CCF enrollment are directed to CCF or the Emergency Services Unit (most often when screening a child for a voluntary psychiatric hospitalization or an emergency detention). The five (5) steps to enroll a child into CCF are:

1. Request for CCF enrollment.

2. Administration of a standardized risk assessment tool to determine if the child is at risk for out-of-home placement and/or psychiatric hospitalization.

3. Determination of severe emotional disturbance (SED).

4. Referral of the child to RISEfor a comprehensive assessment and possible CCF enrollment.

5. RISE determination of the most appropriate service delivery, including possible CCF enrollment with approval from DCDHS.

The County chooses the standardized risk assessment tool for the initial screen; however, the Department must approve the tool. Steps to enroll a child are described below specific to who requested services and the agency that received the request.

Dane County Department of Human Services Ongoing Social Workers:

When a child already has a County social worker, parents, other agencies and youth crisis staff directs requests for CCF services to the child's social worker. The social worker shall review historical records regarding the child and family for the presence of a possible SED. If the child has a documented SED diagnosis, the social worker will administer the standardized risk assessment tool to assess the likelihood that the child will be placed in an institution (the initial screen). If the initial screen meets the predetermined threshold and there is documentation of a SED, the social worker shall refer the case to RISE.

If there is no documentation of an SED, the social worker shall administer the initial screen. If the child meets the threshold of the initial screen, the social worker shall assist the family in arranging for a certified psychologist or psychiatrist to determine if SED exists. SED verification must occur within 25 business days of the initial screen. If the assessment verifies the presence of an SED, the social worker shall refer the case to RISE.

Once referral to RISE status is reached, the child is required to have a RISE review the following week unless there is written documentation that the parent waived the RISE process. RISE shall review the child and family history leading up to the current situation and the results of the initial screen and determine the most appropriate services and supports for the child and family.

RISE:

1. Parents, school, staff and community agencies may also contact the Emergency Services Unit of Dane County to initiate a child's enrollment in CCF. In these instances, Youth Crisis staff would contact the CCF intake worker or previously assigned Dane County Department of Human Services ongoing worker and work through the enrollment process as described in the previous section.

2. Emergency Services Worker

   Youth Crisis staff can also request CCF enrollment if the child has a SED and meets the predetermined threshold of the standardized risk assessment tool. Emergency Services Workers then contact the CCF Intake Worker, and work in conjunction with the CCF Intake Worker to facilitate the referral to CCF. The Emergency Services Worker and CCF Intake Worker follow the same procedures for referral outlined above for DCDHS Ongoing Social Workers.

Other requirements related to enrollment include:

1. Timeline
   Once a request for services or a specific request for CCF enrollment is made, a contact with the child and family must be made within five (5) business days. At the initial contact, the County or Emergency Services Worker should administer the standardized risk assessment tool. Within five (5) business days, the worker should determine if there is a SED determination on record. If the child meets both the threshold of the standardized risk assessment tool and the SED determination, the child is referred to RISE for review the following week.

   If there is no documentation of a SED, the County or Emergency Services Worker has 25 business days to obtain a SED determination. All requests for CCF enrollment should be determined within 30 business days of the initial contact.

2. Parent Notification

   If the parent(s) specifically requests CCF enrollment, the parent(s) shall be able to file a appeal for each step in the enrollment process in which a decision is made. The County is obligated to develop appeal procedures with Department approval. Parent(s) requesting CCF will be provided the appeal procedures in writing. In addition, the parent(s) should be mailed an invitation to participate in the RISE review. The invitation should inform the parent(s) that a family

advocate is available to accompany the parent(s) to RISE as well as the telephone number to Wisconsin Family Ties.

3. Documentation

   Records will be kept on all children with a SED that come before RISE. Information recorded includes the following:

   a. Child's name.
   b. The person who initially requested services or CCF.
   c. The agency receiving the initial request.
   d. Date the SED was verified.
   e. The person that verified the SED.
   f. Date the standardized risk assessment tool was administered and the rating.
   g. The person who administered the standardized risk assessment tool.
   h. The date the RISE review was requested.
   i. The date the RISE review occurred.
   j. The result of the RISE review.

4. Monitoring Process

   Written notifications explaining the results of the RISE review, and how that decision was made will be sent to all parents with children with a SED. The parent(s) of a child(ren) with a SED who are reviewed RISE will be mailed the policy and procedure to appeal their decision.

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

M. APPEAL OF DENIAL OF ENROLLMENT IN THE COUNTY CHILDREN COME FIRST MANAGED CARE PROGRAM

The County will maintain and operate an appeal procedure that includes the right to a fair hearing when the County denies enrollment in the Children Come First managed care program. The procedure includes:

1. A written notification to the applicant's parent/guardian or authorized representative explaining the reason for denial.

2. A statement advising the applicant about his/her right to request first an appeal to the County, then an appeal via a fair hearing through the

Division of Hearings and Appeals (DHA), consistent with the process in the *Member Grievances and Appeal Guide,* which is fully incorporated herein by reference.

3. Submission of a copy of the written notification to the Contract monitor in the Division of Medicaid Services. Notification includes the full name, address and Medicaid ID of the applicant appealing the denial.

4. Providing the Contract monitor in the DMS with the name, address and telephone number of the person who is responsible for processing appeals for the denial of enrollment.

5. A statement indicating the actions that the County requires to consider the appeal and that are consistent with County's appeal procedure. The procedure must comply with the required timeframes in the *Member Grievances and Appeals Guide.*

6. Notification of the County decision to the DMS.

If the County upholds their decision, the applicant will be notified of the right to a fair hearing with the DHA.

N. DISENROLLMENT

The County can initiate disenrollment in the Managed Care Program for one of the following reasons (the effective date is the first day of the second month following the request):

1. The member has made substantial progress towards his/her individual goals and no longer is in need of the services provided by the CCF managed care system.

2. All members shall have the right to disenroll from the County pursuant to 42 CFR §438.56(b)(1), if the member feels s/he can no longer abide by the service plan and s/he has exhausted all available options provided by the County. A voluntary disenrollment shall be effective no later than the first day of the second month after the month in which the member requests termination. The County shall promptly forward to the Department or its designee all oral or written requests from members for disenrollment.

3. Other reasons for disenrollment initiated by the County include:

    a. Corrections placement, except stayed correctional orders.

b. Residency change.

c. Member is 19 years old or older.

d. Member enrolls in another Medicaid program

4. The County may request, and the Department may approve, disenrollment for specific cases where there is just cause. "Just Cause" is defined as a situation where enrollment would be harmful to the interests of the member, or where the County cannot provide the member with appropriate medically necessary Contract services for reasons beyond its control. Examples of "Just Cause" disenrollment include:

   a. Parent, guardian or member repeatedly do not carry out the agreed upon plan of care.

   b. Parent, guardian or member refuses to sign the plan of care authorizing services.

   c. Parent, guardian or member demand a treatment determined unnecessary by the child and family treatment team.

   d. A juvenile court order affecting the member explicitly contradicts the plan of care developed by the child and family team.

   e. Member is missing from the community for at least 30 days, (e.g., runaway).

   f. Member is unlikely to be available for case management due to extended institutional placement. To be considered under this just cause provision, the member must be enrolled in CCF for at least one (1) year, been in an institution for a minimum of 10 consecutive months, and been recommended for continued, extended inpatient treatment by institution psychiatric staff.

   If the Department fails to make a disenrollment determination within the time frame specified the disenrollment is considered approved.

O. ENROLLMENT/DISENROLLMENT PRACTICES

The County must permit the Department to monitor its enrollment and disenrollment practices under this Contract. The County will not discriminate in enrollment/disenrollment activities between individuals on the basis of

health status or requirements for health care services, including those who have AIDS or are HIV-Positive. This includes a member with a diminished mental capacity who is uncooperative and displays disruptive behavior due to the member's special needs. The County will notify the Department's Medicaid Fiscal Agent in writing of all disenrollments and the reason for disenrollment.

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

This section does not prevent the County from assisting in the disenrollment process for individuals who the Department determines should be assigned a different medical status code. Members may disenroll for other reasons, such as poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in serving the member's health care needs. When a member's change in circumstance has been identified and verified by the County, the County must provide prompt written notification and proof of the change to DHS or the appropriate entity as designated by DHS. Changes in circumstance include:

a. Change in the enrollee's residence when the enrollee is no longer in the County's service area.

b. The death of an enrollee.

P. PRE-EXISTING CONDITIONS

The County shall assume responsibility for all Contract services of each member as of the effective date of coverage under the Contract. The aforementioned responsibility shall not apply in the case of persons hospitalized at the time of initial enrollment.

Q. HOSPITALIZATION AT THE TIME OF ENROLLMENT OR DISENROLLMENT

1. The County will not enroll members under the terms of this Contract when the member is hospitalized. The Department will assume financial responsibility and will reimburse all BadgerCare Plus covered services on a fee-for-service basis.

   The County may begin to provide services during the time of the hospitalization but will not be eligible to receive capitation payments, until the member's date of discharge.

2. The financial liability of the County for members disenrolled while they are hospitalized ends on the date of disenrollment.

3. Discharge from one hospital and admission to another within 24-hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-92 manual.

R. NON-DISCRIMINATION

The County must comply with all applicable federal and state laws relating to non-discrimination and equal employment opportunity, including s. 16.765, Wis. Stats., Federal Civil Rights Act of 1964, regulations issued pursuant to that Act and the provisions of Federal Executive Order 11246 dated September 26, 1985, and assure physical and program accessibility of all services to persons with physical and sensory disabilities pursuant to Section 504 of the Federal Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable Department regulations (45 CFR part 84) and all guidelines and interpretations issued pursuant thereto, and the provisions of the Age Discrimination and Employment Act of 1967 and Age Discrimination Act of 1975.

Chapter 16.765 requires that in connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employee or applicant for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s. 51.01(5) sexual orientation or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Except with respect to sexual orientation, the Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the non-discrimination clause.

With respect to provider participation, reimbursement, or indemnification, the County will not discriminate against any provider who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to prohibit the County from including providers to the extent necessary to meet the needs of the Medicaid population or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities.

The County will not prohibit or otherwise restrict a healthcare professional from advising or advocating on behalf of a member who is his or her patient:

a. For the members' health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
b. For any information the member needs in order to decide among all relevant treatment options.
c. For the risks, benefits, and consequences of treatment or non-treatment.
d. For the members right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about further treatment decisions.
e. The County must have written policies 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.

S. AFFIRMATIVE ACTION (AA) AND EQUAL OPPORTUNITY, AND CIVIL RIGHTS COMPLIANCE (CRC)

All recipients of federal and/or state funding to administer programs, services and activities through the Wisconsin Department of Health Services must comply with the Department's CRC Plan requirements. Information about these requirements can be found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

Certain Recipients and Vendors must also comply with Wis. Stats., s.16.765, and Administrative Code DHS 50, which require the filing of an Affirmative Action Plan (AA Plan).

The Affirmative Action Plan is NOT part of the CRC Plan.

1. Affirmative Action Plan

    a. For agreements where the County has 50 employees or more and will receive $50,000 or more, the County shall complete the AA plan. The County with an annual work force of less than 50 employees or less than $50,000 may be exempt from submitting the AA plan.

        The AA Plan is written in detail and explains the County's program. To obtain instructions regarding the AA Plan requirements go to http://vendornet.state.wi.us/vendornet/contract/contcom.asp

b. The County must file its AA plan every 3 years and includes all programs. The plan must be submitted to:

Department of Health Services
Division of Enterprise Services
Bureau of Procurement and Contracting
Affirmative Action Plan/CRC Coordinator
1 West Wilson Street, Room 672
P.O. Box 7850
Madison, WI 53707
dhscontractcompliance@dhs.wisconsin.gov

Compliance with the requirements of the AA Plan will be monitored by DHS.

2. Civil Right Compliance (CRC) Plan

a. The County receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of 2020-2021. The County with fifty (50) or more employees AND who receive over $50,000 in funding must complete a Civil Rights Compliance Plan (CRC Plan). The CRC Plan is to be kept on file and made available upon request to any representative of the Department of Health Services. The instructions and template to complete the requirements for the CRC Plan are found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

For technical assistance on all aspects of the Civil Rights Compliance, the County is to contact the:

Department of Health Services
Civil Rights Compliance
Attn: Civil Rights Compliance Officer
1 West Wilson Street, Room 651
P.O. Box 7850
Madison, WI 53707-7850
Telephone:(608) 267-4955 (Voice)
711 or 1-800-947-3529 (TTY)
Fax: (608) 267-1434
Email: DHSCRC@dhs.wisconsin.gov

b. The County that is subcontracting federal or state funding to other entities must obtain a CRC LOA from their

subcontractors. The CRC LOA must be kept on file and produced upon request or at the time that an on-site monitoring visit is conducted. Subcontractors with fifty (50) or more employees AND who receive over $50,000 in funding must complete a CRC Plan. The CRC Plan is to be kept on file and produced upon request by DHS or at the time the County conducts an on-site monitoring visit.

c. The County agrees to not discriminate in the provision of services or benefits on the basis of age, color, disability, national origin, race, religion or sex/gender. This policy covers enrollment, access to services, facilities, and treatment for all programs and activities. All employees of the County are expected to support goals and programmatic activities relating to nondiscrimination in service delivery.

d. The County agrees not to exclude qualified persons from employment otherwise. The County agrees to not discriminate on the basis of the conscience rights of health care providers as established and protected following Federal Health Care Provider Conscience Protection Laws: the Church Amendments; the Public Health Service Act Section 245; the Weldon Amendment; and the Affordable Care Act.

e. The County agrees to comply with all of the requirements contained in the Department CRC Plan and to ensure that their subcontractors comply with all CRC requirements during this Contract period. The instructions and template to complete the CRC Plan requirements can be found at http://dhs.wisconsin.gov/civilrights/Index/HTM.

f. The Department will monitor the Civil Rights and Affirmative Action compliance of the County. The Department will conduct reviews to ensure that the County is ensuring compliance by its subcontractors or grantees. The County agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the County, interview with staff, clients, and applicants for services, subcontractors, grantees, and referral agencies. The reviews will be conducted according to Department procedures. The Department will also conduct reviews to address immediate concerns of complainants.

g. The County agrees to cooperate with the Department in developing, implementing and monitoring corrective action

plans that result from complaint investigations or monitoring efforts.

T. CULTURAL COMPETENCY

A. Mission, vision, and goals

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

B. The County must address the special health needs of members who are low income or members of population groups needing specific culturally competent services. The County must incorporate in its policies, administration and service practice elements such as:

a. Recognizing members' beliefs,
b. Addressing cultural differences in a competent manner, and
c. Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds.
d. Permitting members to change provider's based on the provider's ability to provide culturally competent services.
e. Culturally competent grievance and appeal protocols.

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

The County must encourage and foster cultural competency among providers. When appropriate the County must permit members to choose providers from among the County's network based on linguistic/cultural needs. The County must permit members to change primary care providers based on the provider's ability to provide services in a culturally competent manner. Members may submit grievances to the County and/or the Department regarding their inability to obtain culturally appropriate care, and the Department may, pursuant to such a grievance, permit a member to disenroll from the program into fee for service.

U. MENTAL HEALTH EDUCATION AND PREVENTION

(1) The treatment team shall inform all members, parents and involved family members of contributions which they can make to the maintenance of their own mental health and the proper use of mental health care services; (2) Have a program of mental health education and prevention available and within reasonable geographic proximity to its members. The program shall include mental health education and anticipatory guidance provided as a part of the normal course of service delivery.

The program shall provide:

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

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

3. Mental health-related educational materials in the form of printed, audiovisual, and/or personal communication.

4. Information to child and involved family members on mental disease and severe emotional disturbance and their prevention and management, including specific information for persons who have or who are at risk of developing such health problems.

5. Promotion of the mental health education and prevention program, including use of languages understood by the population served and use of facilities accessible to the population served.

6. Information on preventative services in addition to those offered by entities under Contract with the County.

7. Provide information about family support and advocacy services through Family Ties or other similar groups in the area.

Educational materials produced by the County must be at a sixth (6^{th}) grade comprehension level and reflect sensitivity to the diverse cultures served. Also, if the County uses materials produced by other entities, the County must review these materials for grade level comprehension level and for sensitivity to the diverse cultures served. Finally, the County must make all reasonable efforts to locate and use culturally appropriate educational material.

V. MEMBER HANDBOOK, PROVIDER DIRECTORY, EDUCATION AND OUTREACH FOR NEWLY ENROLLED MEMBERS

The county is required to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code of Federal Regulations Part 438.10 and 42 CFR 438.104, as contained in the *HMO and PIHP Communication Outreach and Marketing Guide*, Updated January 1, 2020, which is fully incorporated herein by reference.

W. CHOICE OF HEALTH PROFESSIONAL

Offer each member covered under this Contract the opportunity to choose to receive services from any provider affiliated with the County, to the extent possible and appropriate.

X. .QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT (QAPI)

1. The County Quality Assessment/Performance Improvement (QAPI) program must conform to requirements of 42 CFR, Part 438, Medicaid Managed Care Requirements, Subpart D, Quality Assessment and Performance Improvement. The program must also comply with 42 CFR 438 which states that the County must have a QAPI system that:

    a. Is consistent with the utilization control requirement of 42 CFR 456.

    b. Provides for review by appropriate mental health professionals of the process followed in providing mental health services.

    c. Provides for systematic data collection of performance and patient results.

    d. Provides for interpretation of this data to the practitioners.

    e. Provides for making needed changes.

2. Quality Assessment/Performance Improvement Program

    a. The County must have a comprehensive QAPI that protects, maintains, and improves the quality of mental health care provided to Wisconsin BadgerCare Plus Program members. The County must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of

mental health care and services provided to its BadgerCare Plus population.

b. The County must have documentation of all aspects of the QAPI program available for Department review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the County is in compliance with Contract requirements. The review and audit may include: On-site visits; staff and member interviews; mental health case record reviews; review of all QAPI procedures, reports, committee activities, including credentialing and recredentialing activities, corrective actions and follow up plans; peer review process; review of the results of the member satisfaction surveys, and review of staff and provider qualifications.

c. The County must have a written QAPI work plan that is ratified by the CCF QAPI Committee 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.

d. The County is ultimately accountable to the Department for the quality of mental health care provided to County members. Oversight responsibilities of the governing body shall include, at a minimum:

    1) Approval of the overall QAPI program and an annual QAPI plan;
    2) Designating an accountable entity or entities within the organization to provide oversight of QAPI;
    3) Review of written reports from the designated entity on a periodic basis which includes a description of QAPI activities, progress on objectives, and improvements made;
    4) Formal review on an annual basis of a written report on the QAPI program;
    5) Directing modifications to the QAPI program on an ongoing basis to accommodate review findings; and
    6) Issues of concern within the County managed care program.

e. QAPI committee shall be in an organizational location within the County such that it can be responsible for all aspects of the QAPI program. The Committee membership must be

interdisciplinary and be made up of both providers and administrative staff of the County, including:

1) A variety of human service professions (e.g., social work, mental health, AODA, etc.).

2) A variety of qualified mental health professionals (e.g., psychiatry, psychology, etc.).

3) County management or governing body.

4) At least 50% of the committee should be parents of current or previous members.

5) Members of the County must be able to contribute input to the QAPI committee. The County must have a system to receive member input on quality improvement, document the input received, document the County's response to the input, including a description of any changes or studies it implemented as the result of the input and document feedback to members in response to input received. The County response must be timely.

f. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the CCF Commission.

g. Documentation of QAPI committee minutes and activities must be available to the Department upon request.

h. QAPI activities of County providers and subcontractors, if separate from County QAPI activities, shall be integrated into the overall County QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, are incorporated into all provider and subcontractor contracts and employment agreements. The County QAPI Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts.

i. Other management activities (Utilization Management, Risk Management, Customer Service, Grievances and Appeals, etc.) must be integrated with the QAPI program. Psychiatrists and

other mental health care practitioners and institutional providers must actively cooperate and participate in the County's quality activities.

j. The County remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the County delegates any activities to contractors, the conditions listed in this Contract must be met.

k. There is evidence that County management representatives and providers participate in the development and implementation of the QAPI plan of the County. This provision shall not be construed to require that County management representatives and providers participate in every committee or subcommittee of the QAPI program.

l. The County must designate a senior executive to be responsible for the operation and success of the QAPI program. The designated individual shall be accountable for the QAPI activities of the County's own providers, as well as the County's subcontracted providers.

m. 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 mental health care and services, facilitating appropriate use of preventive services, monitoring provider performance, provider credentialing, involving members in QAPI initiatives, and conducting performance improvement projects.

n. Written documentation listing the staffing resources that are directly under the organizational control of the person who is responsible for QAPI (including total FTEs, percent of time dedicated to QAPI, background and experience, and role) must be available to the Department upon request.

3. Monitoring and Evaluation

a. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Quality indicators listed and described in this Contract must be used to monitor adherence to practice guidelines. Standardized quality indicators must be used to assess improvement, assure achievement of minimum performance levels, monitor adherence to guidelines, and

identify patterns of over-utilization and under-utilization. The measurement of quality indicators selected by the County must be supported by appropriate data collection and analysis methods to improve clinical care and services.

b. Provider performance must be measured against practice guidelines and standards adopted by the QAPI committee. Areas identified for improvement must be tracked and corrective actions taken when warranted. The effectiveness of corrective actions must be monitored until problem resolution occurs. Re-evaluation must occur to assure that the improvement is sustained.

c. The County must use appropriate clinicians to evaluate the data on clinical performance, and multi-disciplinary teams to analyze and address data on systems issues.

d. The County must also monitor and evaluate mental health care and services in certain priority clinical and non-clinical areas as specified.

e. The County must make documentation available to the Department, upon request, regarding quality improvement and assessment studies on CCF performance, which relate to the enrolled population.

f. The County must develop or adopt practice guidelines that are disseminated to providers and to members as appropriate or upon request. The guidelines should be based on reasonable clinical evidence or consensus of mental health professionals; consider the needs of the members developed or adopted in consultation with network providers, and reviewed and updated periodically. These guidelines shall include the County's policy on the use of restraint on members.

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

4. Provider Selection (credentialing) and Periodic Evaluation (recredentialing)

   a. The County must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides

services to the County's members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment as a ForwardHealth-enrolled provider, where applicable. The County's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

b. The County must also have a mechanism for considering the provider's performance. The recredentialing method must include updating all the information (except medical education) utilized in the initial credentialing process. Performance evaluation must include information from the QAPI system, reviewing member complaints, and the utilization management system.

c. The County must have a formal process for peer review of care delivered by providers and active participation of the County's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The County must supply documentation of its peer review process upon request. The County may delegate this responsibility to meet the standards outlined in this Contract.

d. The selection process must not discriminate against providers such as those serving high-risk populations or who specialize in conditions that require costly treatment. The County must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners from practitioners in the County's network. If the County declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

e. If the County delegates selection of providers to another entity, the County retains the right to approve, suspend, or terminate any provider selected by that entity.

f. The County must have written policies that allow it to suspend or terminate any provider for quality deficiencies. There must also be an appeals process available to the provider that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC §11101 etc. Seq.).

g. In addition to the requirements in this section, the names of individual practitioners and institutional providers who have been terminated from the County provider network as a result of quality issues must be immediately forwarded to the Department and reported to other entities as required by law (42 USC §11101 etc. Seq.).

h. Institutional Provider Selection: For each provider, other than an individual practitioner, the County determines, and verifies at specified intervals, that the provider is:

1) Licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and

2) Reviewed and approved by an approved accrediting body (if the provider claims accreditation); or is determined by the County to meet standards established by the County itself.

5. Accreditation

Per 42 CFR 438.332, the County must report to the Department if it is accredited by a private independent accrediting agency. CMS has recognized the following entities as private independent accrediting agencies: The National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC). Counties that have received accreditation by a private independent accrediting agency must provide the state with a copy of its most recent accreditation review, as part of the County certification application process. This copy must contain:

a. County accreditation status:
b. Name of the CMS-recognized accreditation entity;
c. The effect start and end dates of accreditation;
d. The lines of business/specific member population for which the accreditation was achieved (e.g., commercial and/ or Medicaid, etc.);
e. The specific accreditation status of the County, including survey type and level (as applicable); and
f. Accreditation results from the accreditation entity, including recommended actions or improvements, correction action plans and summaries of findings.

The Department will post the accreditation status of all Counties on its website including the accreditation entity, accreditation program, and the accreditation level. The Department will update this accreditation status annually.

6. Member Feedback on Quality Improvement

    a. The County must have a process to maintain a relationship with its members that promotes two-way communication and contributes to quality of care and service. The County must show a commitment to treating members with respect and dignity.

    b. The County is encouraged to find additional ways to involve BadgerCare Plus members in quality improvement initiatives and in soliciting member feedback on the quality of care and services the County provides. Other ways to bring BadgerCare Plus members into the County's efforts to improve the health care delivery system includes, but is not limited to: Focus groups, consumer advisory councils, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services. All efforts to solicit feedback from members must be prior approved by the Department.

7. Mental Health Records

    a. The County must have policies and procedures for participating provider medical records content and documentation that have been communicated to providers and a process for evaluating its providers' mental health records based on the County's policies. These policies must address patient confidentiality, organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use.

    The County must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential member information.

    Those policies must include information with respect to disclosure of member-identifiable medical record and/or enrollment information, and specifically provide that:

        1) The members may review and obtain copies of medical records information that pertains to them.

2) The policies above must be made available to members upon request.

b. Member mental health records must be maintained in an organized manner (by the County, and/or by the County's subcontractors) that permits effective patient care. They must reflect all aspects of patient care and be readily available for patient encounters, for administrative purposes, and for Department review.

c. Because counties are considered contractors of the state and are therefore (only for the limited purpose of obtaining mental health records of its members) entitled to obtain mental health records according to DHS 104.01(3), Wis. Adm. Code the Department will require Medicaid-certified providers to release relevant records to the County to assist in compliance with this section. Where counties have not specifically addressed photocopying expenses in their provider contracts or other arrangements, the counties are liable for charges for copying records only to the extent that the Department would reimburse on a fee-for-service basis.

d. The County must have written confidentiality policies and procedures in regard to confidential member information. Policies and procedures must be communicated to County staff, members, and providers. The transfer of mental health records to out-of-plan providers or other agencies not affiliated with the County (except for the Department) are contingent upon the receipt by the County of written authorization to release such records signed by the member or, in the case of a minor, by the member's parent, guardian, or authorized representative.

e. The County must have written quality standards and performance goals for participating provider mental health record documentation and are able to demonstrate, upon request of the DHS, that the standards and goals have been communicated to providers. The County must actively monitor established standards and provide documentation of standards and goals upon request of the Department.

f. Mental health records must be readily available for Countywide QAPI and Utilization Management (UM) activities and provide adequate medical and other clinical data required for QAPI-UM, and Department use.

g. The County must have adequate policies in regard to transfer of mental health records to ensure continuity of care when members are treated by more than one (1) provider. This may include transfer to local health departments subject to the receipt of a signed authorization form.

h. Minimum mental health record documentation per chart entry or encounter must conform to the DHS 106.02, (9)(b),Wis. Adm. Code; mental health record contents, and contain, at least, the following items:

1) Date.
2) Department (if the organization is departmentalized).
3) Practitioner's signature and profession (for example, PT, MD, RN, DDS).
4) Written case note of each interaction with child, family member, or collateral contact and the contents of the interaction.
5) Objective findings (if applicable).
6) Clinical impression.
7) Disposition, recommendations, and instructions to consumers.
8) Written record of each of the treatment team meetings including subject matters discussed, members present, and conclusions, if any.

8. Notice of Adverse Benefit Determination

Notices of adverse benefit determinations must adhere to the content and timeframe requirements detailed in the *Member Grievances and Appeals Guide*.

9. Utilization Management (UM)

a. The County must have documented policies and procedures for all UM activities that involve determining medical necessity, and the approval or denial of mental health services. Qualified mental health professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The County may not deny coverage, penalize providers, or give incentives or payments to providers or enrollees that are intended to reward inappropriate restrictions on care or result

in the under-utilization of services. Criteria used to determine medical necessity and appropriateness must be communicated to providers. The criteria for determining medical necessity may not be more stringent than DHS 101.03 (96m), Wis. Adm. Code.

b. If the County utilizes telephone triage, nurse lines or other demand management systems, the County must document review and approval of qualification criteria of staff and of clinical protocols or guidelines used in the system. The system's performance will be evaluated annually in terms of clinical appropriateness.

c. The prior authorization policies must specify time frames for responding to requests for initial and continued service determinations, specify information required for authorization decision, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the County must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (inter-rater reliability).

   Within the time frames specified, the County must give the member or their authorized representative and the requesting provider written notice of:

   1) The decision to deny, limit, reduce, delay or terminate a service along with the reasons for the decision.

   2) The member's grievance and appeal rights, as detailed in the *Member Grievances and Appeals Guide.*

   3) Denial of payment, at the time of any action affecting the claim.

   The notice(s) must adhere to the timing and content requirements detailed in the *Member Grievances and Appeals Guide*.

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

   1) Within 14 days of the receipt of the request, or;

2) Within three (3) working days if the physician indicates or the County determines that following the ordinary time frame could jeopardize the member's health or ability to regain maximum function.

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

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

d. Criteria for decisions on coverage and medical necessity shall be clearly documented, based on reasonable medical evidence, current standards of mental health practice, or a consensus of relevant mental health care professionals, and regularly updated.

e. The County oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.

10. External Quality Review Contractor

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

b. The County must assist the Department and the external quality review organization under contract with the Department in identification of provider and member information required to carry out annual, external independent reviews of access, timeliness and quality outcomes based on on-site or off-site reviews. This includes arranging orientation meetings for physician office staff concerning medical chart review, and encouraging attendance at these meetings by County and physician office staff as necessary. The provider of service may elect to have charts reviewed on-site or off-site.

c. The purposes of the EQRO review are:

1) To validate data and information including performance measures submitted by the counties to the Department for the purpose of quality assessment. Validation may include the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

2) To validate County Performance Improvement Projects (PIPs) to ensure that PIPs are designed, conducted and reported in a methodologically sound manner.

3) To review compliance with structural and operation standards established by the state.

4) To provide DHS and the County with information about their performance that is not available from other sources of data.

5) To provide information that will aid DHS and the County in interpreting other sources of data, such as encounter data.

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

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

8) To provide information that will be useful to DHS in fulfilling its oversight role for developing the County's contract requirements.

d. When the external quality review organization under contract with the Department identifies an adverse quality finding that needs to be followed up on, the County must:

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

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

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

e. The County will facilitate training provided by the Department to its providers.

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

11. Performance Improvement Priority Areas and Projects

a. The County must develop and ensure implementation of program initiatives to address the specific clinical or non-clinical needs of the County's enrolled population served under this agreement. The Department strongly advocates the development of collaborative relationships among the County, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas.

Annually, for the priority areas specified by the Department and listed below, the County must monitor and evaluate the quality of care and services through at least one performance improvement project. The County may propose an alternative topic to be addressed by making a request in writing to the Department. The proposed intervention topic must be submitted by December 1 of each contract year, with technical assistance provided by DHS and the EQRO. The County will have the full calendar year as the intervention year, with the final report due by July 1 of the following year. The County must ensure that improvements are sustained through periodic audits of relevant data and maintenance of the interventions that resulted in the improvement.

The report for each performance improvement project should include consideration of each of the ten performance improvement project criteria outlined in Addendum III in order for the Department to evaluate the soundness and results of the projects submitted. The BCAP quality framework (outlined below) is allowable as an alternative format for performance improvement project design and reporting. Other formats may be used as well, as long as the ten performance improvement project criteria outlined in Addendum III are addressed.

BCAP Framework:

1. Identification
2. Stratification
3. Outreach
4. Intervention
5. Rapid Cycle Improvement
6. Measurement and Evaluation
7. Sustainability and Diffusion

b. The County must implement a performance improvement project in the area if a quality improvement opportunity is identified. The County must report to the Department on each of these areas, including those areas where the County will not pursue a performance improvement project.

c. Clinical and Non-Clinical Priority Areas

<u>Clinical Priority Areas</u>

Clinical Priority Areas include prevention and/or care of acute and high-volume/high-risk services for improved continuity and coordination of care.

<u>Non-Clinical Priority Areas include</u>

1) Grievances and appeals;
2) Access to and availability of services;
3) Member satisfaction with County customer service;
4) Satisfaction with services for members with special health care needs;
5) Cultural competency of the County and its providers.

In addition, the County may be required to conduct performance improvement projects specific to the County and to participate in one (1) annual statewide project that may be specified by the Department.

d. The Department's Approved Performance Measures

The Department will evaluate the County's performance using the Department's approved performance measures, based on County-supplied encounter data and other relevant data (for selected measures). Evaluation of County performance on each measure will be conducted on timetables determined by the Department. The technical specifications for each measure are established by the Department with County and other stakeholder input.

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

Unless otherwise noted within a specific performance improvement measure, the Department may specify minimum performance levels and require that the County develop a plan to respond to levels below the minimum performance levels. Additions, deletions or modifications to the Performance Improvement Measures must be mutually agreed upon by the parties. The Department will give 90 days' notice to the County of its intent to change any of measures, technical specifications or goals. The County shall have the opportunity to comment on the measure specifications, goals and implementation plan within the 90-day notice period. The Department reserves the right to require the County to report such performance measure data as may be deemed necessary to monitor and improve County-specific or program-wide quality performance.

Y. ACCESS TO PREMISES

The County must allow duly authorized agents or representatives of the state or federal government access to the County or County subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the County's or subcontractor's contractual activities and will produce all records requested as part of such review or audit within a reasonable time, but not more than ten working days. Upon request for such right of access, the County or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the performance of County's or subcontractor's activities. The County will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

Z. SUBCONTRACTS

The County must assure that all subcontracts are in writing, comply with the provisions of this Contract, and include any general requirements of this Contract that are appropriate to the service or activity identified, and to ensure that all subcontracts do not terminate legal liability of the County under this Contract. The County may subcontract for any function covered by this Contract, subject to the requirements of this Contract.

1. Subcontract Standard Language

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

a. Subcontractor uses only BadgerCare Plus-enrolled providers in accordance with this Contract.

b. No terms of this subcontract are valid which terminate legal liability of the County.

c. Subcontractor agrees to participate in and contribute required data to County Quality Assessment/Performance Improvement programs.

d. Subcontractor agrees to abide by the terms of this Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the County in accordance with this Contract.

e. Subcontractor agrees to submit County encounter data in the format specified by the County, so that the County can meet the Department specifications required by this Contract. The County will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

f. Subcontractor agrees to comply with all non-discrimination requirements.

g. Per 42 CFR 438.3(k), subcontractor agrees to comply with all audit and record retention and inspection requirements of 42 CFR 438.230(c)(3)(i-iv) and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements. Specifically, the State (including the Office of Inspector General), CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the County's contract with the State. This right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

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

i. Per 42 CFR 438.230, subcontractor agrees to provide representatives of the County, as well as duly authorized agents or representatives of the Department (including the Office of the Inspector General) 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 County and the subcontractor), and administrative records. If the State (including the Office of the Inspector General), CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. Refusal will result in sanctions or penalties against the County for failure of its subcontractor to permit access to a Department or federal DHHS representative.

Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

j. Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in this Contract.

k. Subcontractor agrees to ensure confidentiality of family planning services.

l. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus benefits (e.g., COB recovery procedures that delay or prevent care).

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

n. Subcontractor agrees not to bill BadgerCare Plus members for medically necessary services covered under this Contract and provided during the members' period of County enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are eligible under BadgerCare Plus. This provision will remain in effect even if the County becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the County, County provider or County subcontractor can bill.

   The standard release form signed by the member at the time of services does not relieve the County and its providers and subcontractors from the prohibition against billing a BadgerCare Plus member in the absence of a knowing assumption of liability for a non-covered service. The form or other type of acknowledgment relevant to BadgerCare Plus member liability must specifically state the admissions, services, or procedures that are not covered by BadgerCare Plus.

o. Within 15 business days of the County's request subcontractors must forward medical records pursuant to grievances or appeals to the County. If the subcontractor does not meet the 15 business day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

p. Subcontractor agrees to abide by the terms regarding appeals to the County and to the Department regarding the County's nonpayment for services providers render to members.

q. Subcontractor agrees to abide by the County marketing/informing requirements. Subcontractor will forward to the County for prior approval all flyers, brochures, letters and pamphlets the subcontractor intends to distribute to its members concerning its County affiliation(s), or changes in affiliation, or relating directly to the BadgerCare Plus population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the County and the Department.

r. Subcontractor agrees to abide by the County's restraint policy, which must be provided by the County. Members have the right to be free from any form of restraint or seclusion used as a means of force, control, ease or reprisal.

AA. COMPLIANCE WITH APPLICABLE LAWS, RULES, OR REGULATIONS

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, which 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 and Title XXI of the Social Security Act and Title 42 of the CFR, except as specified in Article IV, Section A., 3.

Federal funds must not be used for lobbying. Specifically and as applicable, the Contractor agrees to abide by the Copeland Anti-Kickback Act, the Davis-Bacon Act, the Byrd Anti-Lobbying Amendment, federal contract work hours and safety standards requirements, the federal Clean Air Act and the Federal Water Pollution Control Act.

BB. USE OF FORWARDHEALTH-ENROLLED PROVIDERS

Except in emergency situations, the County must use only ForwardHealth enrolled providers for the provision of covered services. The Department reserves the right to withhold from capitation rate development the monies related to services provided by non-enrolled providers, at the FFS rate for those services, unless the County can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was ForwardHealth enrolled at the time the County reimbursed the provider for service provision. The Wis. Adm. Code, Ch. DHS 105 and the ForwardHealth Handbook, contains information regarding provider enrollment requirements. The County must require every physician providing services to members to have a Provider Number or National Provider Identifier (NPI). The

Department requires that ForwardHealth-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.

For services not covered under the BadgerCare Plus state plan, the County must have written policies to ensure safety, provider and employee qualifications, services description and intent (e.g., use of state certified provider or accredited by a national organization) and ensure they are available for review.

The County includes the following:

- A director, officer, or partner of the County
- A subcontractor of the County as governed by 438.230
- A person with beneficial ownership of five person or more of the County's equity
- A network provider or person with an employment, consulting or other arrangement with the County for the provision of items and services that are significant and material to the County's obligation under its contract with the State.

The County may not knowingly have a relationship with the following:

- An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101 of a person described in the preceding bullet.
- An individual or entity that is excluded from participation in a Federal health care program under section 1128 or 1128A of the Act.
    - Section 1128 describes the following:
        - Convictions that result in mandatory exclusion from Federal health care programs.
        - Convictions that result in permissive exclusion from Federal health care programs.
        - Requirements relative to notification, the effective date, and period of exclusion that must be given to providers.
        - Notice given to state agencies, including state licensing agencies
        - Processes surrounding notice, hearing, and judicial review.

        - Applications for termination of exclusion
        - Applicable definitions, including the definition of immediate family member and member of household
    - Section 1128A describes the following:
        - Reasons for which a civil monetary penalty can be imposed
        - Processes related to the imposition of civil monetary penalties.
        - Applicable definitions.

The State must do the following if a prohibited relationship exists between the County and an aforementioned entity:

- Notify the Secretary of the noncompliance.
- Continue an existing agreement with the County unless the Secretary, in consultation with the Inspector General, directs otherwise
- Refrain from renewing or otherwise extending the duration of an existing agreement with the County unless the Secretary, in consultation with the Inspector General, provides to the state and to Congress a written statement describing compelling reasons for renewing or extending the agreement despite the prohibited affiliations.
- Nothing in this section must be construed to limit or otherwise affect any remedies available under section 1128, 1128A, or 1128B of the Act.

The State must review all ownership and control disclosures submitted to by the County, as well as any subcontractors. The State must ensure that the County and its subcontractors:

- Provide written disclosure of any prohibited affiliations
- Provide written disclosures of information on ownership and control. As per 42 CFR 455.104, entities must provide the following information:
    - Name and address of any person with an ownership or control interest
    - Date of birth and Social Security Number (in the case of an individual)
    - Other tax identification number (in the case of a corporation)
    - Whether the individual or corporation with an ownership or control interest in the disclosing entity is related to another person with ownership
    - The name of any other disclosing entity in which an owner of the disclosing entity has an ownership or control interest.
    - The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity.

- Report to the state within 60 calendar days when it has identified capitation payments or other payments in excess of amounts specified in the contract

Federal Financial Participation (FFP) is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

CC. COORDINATION AND CONTINUATION OF CARE

The County must have systems in place to ensure well-managed consumer care, including at a minimum:

1. Management and integration of mental health care and community support services through a primary care coordinator.

2. Development of a child and family treatment team for each member, which includes both professionals and significant people important in the lives of the child and family. Team members should be chosen by the child, and parent (or guardian or primary care giver, whichever is applicable). The members of the team shall be documented in the case record and any change of team membership shall be recorded. Family can request a change in the members of the team, including the care coordinator, without negative consequences. The County must treat a request for membership change as a grievance, and adhere to the notification and timeframe requirements detailed in the *Member Grievances and Appeals Guide.* The ability for a family to request a change in membership without reproach should be detailed in the grievances and appeals procedures written in the family handbook.

3. Upon enrollment, the child and family treatment team will promptly perform or compile an assessment to identify the child and family's strengths and needs.

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

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

1) Authorize coverage of state plan approved services with the member's current providers for the first 90 days of enrollment.
2) Authorize approved prior authorizations at the utilization level previously authorized for 90 days. Exceptions to the 90-day requirement will be allowed in situations where the member agrees to change providers, the member agrees to a level of care, or if the PIHP can document that continuing the care would result in abuse, safety or quality concerns. This does not extend authorizations beyond the time or visits previously approved.
3) The 90-day continued access requirement only applies to services and authorizations covered under the state plan. In-lieu of services and authorizations are exempt.

c. The PIHP must have a detailed automated system for collecting all information on member contacts by care coordinators, case managers and any other staff that has a direct impact on the member's access to services.
d. The PIHP shall assist members who wish to receive care through an HMO or return to the FFS system by making appropriate referrals and by assisting in the transfer of medical records to new providers.

5. The County will use a standardized plan of care for all members. Within the standardized format, the child and family treatment team will develop an individualized service and support plan of care based upon the strengths and needs of the child and family as identified in the assessment. This plan of care will be developed within 30 days of enrollment, and it will detail the intended providers and treatment actions. Each plan shall have measurable short-term and long-term goals and measurable program completion criteria. At least every three months, the treatment team will meet to review and, if necessary, revise the plan of care to meet the changing needs of the child and family. The case record shall document for each child and family team meeting the issues discussed, action to be taken or conclusions reached, and members attending.

6. Assure a crisis plan is included in the plan of care for emergency situations, including an education process to help assure that members and providers know where and how to obtain medically necessary care in emergency situations.

7. Assure that each plan of care will be reviewed and signed by a licensed psychiatrist or psychologist. For the purpose of this Contract, a psychologist is a person who is a licensed psychologist and who is listed or able to be listed in the national register of health care providers in psychology. A parent or guardian shall also sign each plan of care and the County shall make every effort to have the member and other team members sign the plan. The County shall involve and engage the member and his or her parent, guardian, or primary caregiver in the process used to select providers and treatment options. The purpose of the participation is to get a good match between the member's needs and the provider(s) who will seek to meet these needs. This section does not require the County to use providers who are not qualified to treat the individual member or who are not contracted providers. If a specific service or support by a non-contracted provider is determined necessary by the child and family treatment team, efforts should be made to contract with the provider identified.

8. Assure an adequate network of qualified providers to provide the services identified in the annual utilization report in this Contract. The County will develop a cooperative working relationship with providers or agencies involved in the provision to members of health services other than mental health and community support services (i.e., physical health care).

9. Have systems to assure provision of a clinical determination within 10 working days, at the request of the member, of the medical necessity and appropriateness of a member to continue with mental health (MH) or substance abuse providers who are not subcontracted by the County. If the County determines that the member does not need to continue with the non-contracted provider, it must develop a transition plan to ensure an orderly transition of care.

10. The County shall clearly specify referral requirements and authorize approved services and supports identified within the plan of care to providers and subcontractors and keep copies of referrals (approved and denied) in a central file or the patient's medical records.

11. Enrollment beyond 16 months requires child and family specific written justification within the individual chart.

12. All children must have a written transition plan at the time of disenrollment.

13. Assess the training needs of direct providers, such as the care coordinators, and arrange for the training needs of key individuals, including parents and other team members.

14. Provide names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member service area, including identification of providers that are not accepting new members. Include any restrictions on the member freedom of choice among network providers. Provide information on the amount, duration, and scope of benefits available under the contract.

15. Provide the procedures for obtaining benefits including authorization requirements.

16. Provide the extent to which, and how, members may obtain benefits from out of network providers.

17. The County must submit documentation to the Department assuring adequate capacity and services to provide Contract required services upon request and as follows, but no less frequently than:

    - At the time the contract is entered.
    - At any time there has been a significant change in the County's operations or provider network that would affect adequate capacity and services, including changes in services, benefits, geographic service area, or payments, or
    - Enrollment of a new population into the County program, with Department approval.

18. Make available written information in each prevalent non-English language (as identified in the HMO and PIHP Communication Outreach and Marketing Guide) free of charge. The Care Coordinator must inform members of this written information as needed during the care plan development. Provide notice of adverse action on the date of action when the action is a denial of payment, to the member or provider.

19. Per 42 CFR § 438.208(b)(2), the County must coordinate the services it provides to members:
    - Between settings of care, including appropriate discharge planning for hospital or institutional stays.
    - With services provided by another HMO or program.
    - With services a member receives through Medicaid Fee-for-Service.

- With services a member receives through community and social support providers.

20. Information Sharing for New Members:
    - Counties must have policies and procedures to utilize member-specific information provided by DHS to prevent duplication of activities and as input into any needs stratification or care plan development activities. This may include results of any screens completed by the member, claims/encounter history, FFS prior authorization data, high-risk pregnancy indicators, and upcoming non-emergency medical transportation trips. (Pursuant to 42 CFR § 438.208(b)(4))

    - Share with other HMOs (which may include Medicare or commercial plans, or members transitioning to a new BadgerCare Plus or Medicaid SSI HMO) serving the member the results of its identification and assessment of any member with special health care needs (see Art. I for definition of special health care needs assessment) so that those activities need not be duplicated as described in 42 CFR § 438.208(b)(4).

DD. PHYSICIAN INCENTIVE PLAN

A physician incentive plan is any compensation arrangement between the County and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the County.

The County shall fully comply with the physician incentive plan requirements set forth in 42 CFR s. 422.208, 422.210, and 438.6(h).

EE. INELIGIBLE ORGANIZATIONS

Upon obtaining information or receiving information from the Department or from another verifiable source the County must exclude from participation in the County's Managed Care Program all organizations which could be included in any of the categories defined in 1 through 3) of this section (references to the Act in this section refer to the Social Security Act):

1. Entities Which Could Be Excluded Under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has direct or indirect ownership or control interest of 5% or more in the entity has:

a. Been convicted of the following crimes:

    1) Program related crimes, (i.e., any criminal offense related to the delivery of an item or service under Medicare or Medicaid (see Section 1128(a)(1) of the Act));

    2) Patient abuse (i.e., criminal offense relating to abuse or neglect of patients in connection with the delivery of health care (see Section 1128(a)(2) of the Act));

    3) Fraud, (i.e., a state or federal crime involving fraud, theft, embezzlement, breach of judiciary responsibility, or other financial misconduct in connection with the delivery of health care or involving an act or omission in a program operated by or financed in whole or part by federal, state or local government (see Section 1128(b)(1) of the Act));

    4) Obstruction of an investigation, (i.e., conviction under state or federal law of interference or obstruction of any investigation into any criminal offense described in subsections a, b, or c (see Section 1128(b)(2) of the Act)); or

    5) Offenses relating to controlled substances, (i.e., conviction of a state or federal crime relating to the manufacture, distribution, and prescription or dispensing of a controlled substance (see Section 1128(b)(3) of the Act)).

b. Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person described above) from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order 12549 or under guideline implementing such order.

c. Been assessed a civil monetary penalty under Section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other

violations of payment practice standards. (See Section 1128(b)(8)(B)(ii) of the Act.)

2. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in GG. 1. A substantial contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

    a. The administration, management, or provision of medical services;

    b. The establishment of policies pertaining to the administration, management, or provision of medical services; or

    c. The provision of operational support for the administration, management, or provision of medical services.

3. Entities that employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A, for the Provision (directly or indirectly) of health care, Utilization Review, medical social work or administrative services. For the services listed, County must exclude from contracting any entity which employs, contracts with, or contracts through an entity which has been excluded from participation in Medicaid by the Secretary under the authority of Section 1128 or 1128A of the Act.

4. CCF agree to disclose the following information to the State:

    a. The name and address of any individual or corporation with an ownership or controlling interest. The address must include the primary business location and PO Box address.

    b. In the case of an individual include the date of birth and social security number.

    c. In the case of a corporation include the tax identification number.

    d. Identify whether the person or corporation with a controlling interest is related to another person with a controlling interest such as a spouse, parent, child or sibling or whether the person has a 5% or more controlling interest in the entity.

    e. Also CCF must disclose the name, address, DOB, SSN of any managing employee of the entity.

f. Disclosures are due upon submission of the provider application, upon execution of the Managed Care contract, upon re-certification of the Managed Care Organization, within 35 days of any change in ownership.

g. Sanctions for failure to provide disclosures will result in not participating in the Federal financial participation.

The County attests by signing this Contract, that it excludes from participation in the County all organizations which could be included in any of the above categories.

5. If the State learns that the County has a prohibited relationship with a person or entity that is debarred, suspended, or excluded from participation in federal healthcare programs, the State:

a. Must notify the Secretary of the noncompliance.

b. May continue an existing agreement with the County unless the Secretary directs otherwise.

c. May not renew or extend the existing agreement with the County unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

FF. COUNTY ATTESTATION

The County Executive Officer, the County Financial Officer, or designee must attest to the best of their knowledge, to the truthfulness, accuracy, and completeness of all data submitted to the Department at the time of submission. This includes provider network files, encounter data, or any other data for which the County paid claims. The attestation form in Addendum XII should be submitted to the Bureau of Children's Services at the time the file or data is submitted.

GG. FRAUD, WASTE AND ABUSE INVESTIGATIONS

The County must have administrative and management arrangements and/or procedures, and a mandatory compliance plan that are designed to guard against fraud, waste and abuse. The County's compliance structure, activities, and performance are subject to audit/review by the Office of Inspector General (OIG). The County is required to respond to any corrective action or performance improvement activities specified in the written report to the County within the timeframes specified.

The arrangements or procedures must include the following:

1. Written policies, procedures, and standards of conduct that articulate the County's commitment to comply with all applicable Federal and State standards.

2. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with contract requirements. This position reports directly to the Chief Executive Officer and the board of directors.

3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the County's compliance program, including compliance with contract requirements.

4. The development and implementation of an effective training and education program for the compliance officer, the County's senior management, and the County's employees on the federal and state standards and requirements, including program integrity, under the contract.

5. The documentation of effective lines of communication between the compliance officer, senior management, and the County employees.

6. The enforcement of program integrity standards and contract requirements through well-publicized interdisciplinary guidelines.

7. The establishment and implementation of procedures and a system with dedicated staff for:

    a. Routine internal monitoring and auditing of compliance risks related to the provider network, including both prepayment and post-payment program integrity strategies;
    b. Prompt response to compliance issues, both internal and related to the provider network, as they are raised;
    c. Timely investigation of potential compliance problems, both internal and related to the provider network, identified in the course of self-evaluation and audits,
    d. Correction of such problems promptly and thoroughly (to include coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and
    e. Ongoing compliance with the requirements under the contract.

The County must have provisions for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the State.

The County must submit the Quarterly Program Integrity Reporting Log to OIG on a quarterly basis. The log must be completed thoroughly and accurately and is due no later than the last business day of the month following the end of the calendar year quarter (April, July, October, and January). The Quarterly Program Integrity Reporting Log consists of the following three separate reporting components:

a. Program Integrity Log; Captures complaints regarding fraud, waste, and abuse received by the County warranting preliminary investigation.
b. Provider Education Log; Captures education given to network providers related to billing practices, billing errors, or fraud, waste, and abuse. The County should differentiate between education that originates from a complaint, training requested by the provider, and regularly scheduled training opportunities. It is unnecessary to capture education regarding subject matter unrelated to program integrity.
c. Overpayment Recovery Log; Captures pertinent information regarding all overpayment recoveries, not just those recovered due to fraud, waste, and abuse, regardless of which entity identified the overpayment.

The County will submit the template to the Department at DHSOIGManagedCare@wisconsin.gov. OIG will evaluate the submitted reports and may follow up with the County to obtain additional information, provide technical assistance, or request further action. The County must add the quarter's data to the previous report such that at the end of the year, the fourth quarter's report contains the data for the entire calendar year.

The County must have provisions for the prompt notification to the state when it receives information about changes in an enrollee's circumstances that may affect the enrollee's eligibility including changes in the enrollee's residence or the death of an enrollee.

The County must report providers terminated for cause by the County, as well as providers the County identifies as excluded, to County. The County must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of

the email should include the name of the provider, NPI and MA ID numbers, date of termination/exclusion, and reason for termination or exclusion.

Pursuant to 42 CFR 455.20, the County must have a method for verifying, on a quarterly basis, whether paid services have been delivered by network providers and that those services were received by the appropriate Medicaid member.

a. The County must verify the provision of services with members for 100 paid encounters each quarter.
b. The County must maintain appropriate records of these verifications.
c. DHS will verify compliance with this requirement.

If the County makes or receives annual payments under the contract of at least $5,000,000, there must be a provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Act, including information about right of employees to be protected as whistleblowers.

a. Whistleblowers should report program integrity concerns to the DHS OIG. Whistleblowers may make a report through the hotline (877-865-3432) or through the online portal (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx). The County is responsible for ensuring employees have access to this information.
b. DMS and OIG are responsible for collaborating to investigate and resolve all reports made by whistleblowers.

The County must have a process for prompt reporting to the Department the number of complaints of fraud, waste and abuse that warrant preliminary investigation, which must include the following details:

a. Name, ID number
b. Source of complaint
c. Type of provider (if applicable)
d. Nature of complaint
e. Approximate dollars involved

f. Legal and administrative disposition of the case, when available.

The County must report all allegations of fraud, waste, and abuse, including credible allegations of fraud, directly to the DHS OIG within 15 business days of the County's identification of the issue. The County may make a report through the hotline (877-865-3432), through the online portal (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx), or through the DHS Fraud email (dhsfraud@dhs.wisconsin.gov).

a. Reports of fraud, waste or abuse from an County should not be made anonymously, and these reports may be subject to open records laws.
b. The County should collect preliminary information including available data, statements from appropriate parties, and other materials supporting the allegations. Following the report of the alleged fraud, waste and abuse, the County should continue to investigate the allegations of fraud unless otherwise directed by DHS OIG, Department of Justice Medicaid Fraud Control and Elder Abuse Unit, or other law enforcement or regulatory entity.
c. The County collaborates with OIG to complete the credible allegation of fraud referral (F-02296) and compile appropriate exhibits.
d. The County should only report allegations of Medicaid fraud to OIG. It is unnecessary to report violations that occurred in any non_Medicaid program's commercial line of business, or otherwise did not result in the loss of Medicaid funds.
e. Failure on the part of the County to cooperate with these directives or report fraud, waste, or abuse may result in any applicable sanctions under Article XIV, Section C.

Pursuant to 42 CFR 455.23, the authority of determining credible allegations of fraud rests with the Department of Health Services. All reports of potential Medicaid fraud must first be made to the Department's OIG.

- If the County forwards a report of potential Medicaid fraud to any additional state or federal agency, the

County shall notify the OIG of that referral.

The County must have a documented process outlining the County's response to information in the provider file from the Department notifying the County of suspension of payment. The provider file sent by the Department to the County will have an added field that will indicate the outcome of the credible allegation of fraud investigation. The values are:

- A – ACA suspension of payment is currently active. The County must suspend payment based on the effective date for the start of the investigation.
- C – The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.
- T – The provider has been terminated due to the outcome of the credible allegation investigation. The contract's termination date will be listed in the provider file.

The County must have a written process documenting its response to email notification of provider payment suspensions from the DHS OIG resulting from credible allegations of fraud, including but not limited to how the payments are suspended in the County's claims processing system and any required internal communications.

- The County must have clearly defined criteria, policies, and procedures in place for suspending providers within their network independent of payment suspensions issued by the DHS OIG. These policies and procedures must include notification of Bureau of Children's Services and OIG within 24 hours of the suspension of payments.

The County agrees to cooperate with the Affordable Care Act (ACA) suspension of payment requirements, and with the Department on fraud, waste and abuse investigations. The County is prohibited from

paying for an item or service furnished by an individual or entity to whom the state has suspended payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments. The Inspector General must review and authorize any request for a good cause exception.

Pursuant to 42 CFR s. 438.608, the County must recover all overpayments made to network providers, including those overpayments attributed to fraud, waste, and abuse, identified by the County. The County and any subcontractor must report to the Department within 60 calendar days when it has identified a capitation or other payment in excess amounts specified in the contract. The County recovers the payments and retains the funds for all overpayments identified by the County.

The County must have a documented process requiring the network providers to return any overpayments they received. The County must share the documented process with all providers in the County's network. The County must require the network providers to return overpayments within 60 days of the provider receiving written notification of the overpayment. The County must appropriately reflect the recovery of all overpayments in the County's encounter data and on Tab 3 of the Quarterly Program Integrity Report. Subcontract language must require network providers to follow the same requirements when they self-identify an overpayment they have received.

HH. SCHOOL-BASED SERVICES (SBS) PROVIDERS

The County must use its best effort to sign a MOU with all SBS providers in the County service area to ensure continuity of care and to avoid duplication of services. School based services are paid FFS by BadgerCare Plus when provided by a BadgerCare Plus-certified SBS provider. However, in situations where a member's course of treatment is interrupted due to school breaks, after school hours, or during the summer months, the County is responsible for providing and paying for all BadgerCare Plus-covered services.

II. HOSPITAL PAYMENTS

The County is exempt from making hospital access payments.

JJ. ADVANCE DIRECTIVES

1. The County must comply with the requirements of 42 CFR 422.128 for maintaining written policies and procedures for advance directives for all adults age 18 or greater. The written information should be regarding:

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

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

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

KK. PROVIDER NETWORK AND ACCESS REQUIREMENTS

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

A. Protocols/Standards to Ensure Access

The County must have written protocols to ensure that members have access to screening, diagnosis and referral and appropriate treatment for those conditions and services covered under BadgerCare Plus programs.

The County'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.

For members with special health care needs, where a course of treatment or regular case monitoring is needed, the County must have

mechanisms in place to allow members to directly access a specialist, as appropriate, for the member's condition and identified needs.

B. Written Standards for Accessibility of Care

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

   a. Waiting times for care at facilities;
   b. Waiting times for appointments;
   c. Statement that providers' hours of operation do not discriminate against BadgerCare Plus members; and
   d. Whether or not provider(s) speak the member's language.

2. The County may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient, for the following:

   a. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
   b. Any information the enrollee needs in order to decide among all relevant treatment options.
   c. The risks, benefits, and consequences of treatment or non-treatment.
   d. The enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

These minimum requirements shall not release the County from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members.

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

C. Monitoring Compliance

The County must develop policies and procedures regarding wait times for appointments and care. The County shall conduct surveys and site visits to monitor compliance with these standards and shall

make them available to DHS upon request. If issues are identified, either by the County or by the Department, the County must take corrective action so that providers meet the County's standards and improve access for members. The Department will investigate complaints received of Counties that exceed standards for waiting times for care and waiting time for appointments.

D. Access to Selected BadgerCare Plus Providers and Covered Services

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

1. Mental Health or Substance Abuse Provider Network Adequacy Standards

Provider Specialty Codes/Descriptions	**Counties Served**	**Distance**	**Provider to Member Ratio**	**Appointment Wait Time(s)**	**Drive Time**
112 – Licensed Psychologist (PhD) **117 – Psychiatric Nurse** **120 – Licensed Psychotherapist** **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**	Dane	The County 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 County service area. At least one mental health and substance	Psychiatrist 1:100 Psychologist 1:100	No longer than 14 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. Medication-Assisted Treatment (MAT) Services: No more than 72 hours (including weekends and holidays) for appointment with prescribing and dispensing provider for medication-assisted	A mental health and substance abuse provider must be within a 30 minute drive time of any member residing in the county.

		abuse provider must be in each County 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.		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, Counties 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 County, and the MAT capacity for each of these providers. Detailed data regarding MAT provider networks must be available upon request from the Department.	

2. Hospitals

The County must include a sufficient supply of non-specialized hospitals in its network to ensure access to emergency or inpatient psychiatric treatment, so that the following requirements are met:

Provider Specialty Codes/Descriptions	Counties Served	Distance	Drive Time
010 – Inpatient/Outpatient Hospital	Dane	The County must have a contract or agreement with a hospital within 20 miles of any member residing in the county.	A hospital must be within a 30 minute drive time of any member residing in these 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.

3. County Referrals to Out-of-Network Providers for Services

The County must provide adequate and timely coverage of services provided out-of-network, when the required medical service is not available within the County network. The County 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 County 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 County 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 County per the County's prior authorization policies, provided the financial institution receiving payment is located within the United States.

4. Second Medical Opinions

   The County 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 County must authorize and reimburse for a second opinion outside the network at no charge to the member, excluding allowable copayments.

5. Access to Indian Health Providers

   For Indian members enrolled in the County, the County must ensure access to an Indian Health Care Provider (IHCP), when available. Pursuant to 42 CFR § 438.14(b)(1), the County 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 County are allowed to receive services from an IHCP provider, as long as such provider agrees to serve in the County network and has capacity for additional patients. If no such provider is contracted, the County 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 County must allow the out-of-network IHCP to refer the Indian member to a provider within the County network for additional care.

   If timely access to an IHCP cannot be ensured, the County may allow Indian members to access out-of-state IHCPs or the member may choose to disenroll from the County.

   The County must pay all IHCPs, whether participating in the network or not, at a minimum, the full Medicaid fee-for-service payment rate for provision of services or items to Indian members. The County must make payments to all IHCPs in its network in a timely manner as required for

payments to practitioners in individual or group practices under 42 CFR 438.14(c)(1).

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:

1. ForwardHealth medical status code
2. Letter from Indian Health Services identifying the individual as a tribal member
3. Tribal enrollment/membership card
4. Written verification or a document issued by the Tribe indicating tribal affiliation
5. Certificate of degree of Indian blood issued by the Bureau of Indian Affairs
6. A Tribal census document
7. A medical record card or similar documentation that is issued by an Indian health care provider that specifies an individual is an Indian, or
8. A statement of Tribal Affiliation (F-00685).

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

E. Network Adequacy Requirements

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

1. The anticipated BadgerCare Plus enrollment with particular attention to children with serious emotional disturbance.

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

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

F. Provider Network Adequacy Standard Exceptions and Conditional Approvals

1. Exceptions Process

The County may experience a temporary gap in provider networks where it does not meet the standards described in Article IV, E. In these instances, the County may be granted an exception to the network adequacy standard, at the Department's discretion. The County must provide documentation and justification for an adequate network, despite network adequacy deficiencies, and a description of what it is doing to increase its network capacity to meet the standard.

2. Conditional Provider Network Approval

If the Department's annual network adequacy review identifies deficiencies per the standards articulated in Article IV, E, the County may be placed on a conditional provider network approval. It is the Department's expectation that the County 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 members. The Department has the authority to place the County on a corrective action plan if deficiencies persist.

LL. National or State Emergency

A. Declaration of National or State Emergency

In the event of a Federal or State declared emergency or disaster, DHS has the ability to modify or waive contractual obligations and regulations on health plans that DHS determines to be specifically related to or impacted by the declared emergency or disaster. DHS will maintain documentation of any modifications to or waivers of contract requirements, including effective and end dates for each change. DHS reserves the right to identify flexibilities or waivers of contract requirements for DHS responsibilities, if DHS is impacted by the emergency or disaster. This may include, but is not limited to, extension of deadlines or timeframes for DHS or subcontractor activities.

B. Health Plan Responsibilities in the Event of a Federal or State Declared Emergency:

By June 30, 2021, and annually thereafter, DHS will require health plans to submit a plan to maintain business operations in the event of a state or federal declaration of disaster or State of Emergency. The health plan must cooperate

with DHS' efforts to ensure minimal disruption to the ForwardHealth program and the members served.

1. Continuity of Operations

a) Business Continuity Plan

The health plan must maintain a business continuity plan which includes a collection of resources, actions, procedures, and information that is developed, tested, and held in readiness for use to continue operations in the event of a major disruption of operations due to a federal or state declared disaster or State of Emergency. Business Continuity Plans shall address, at a minimum, the following:

1. A description of how the health plan will organize and assign the urgency with which activities and processes will need to be resumed in the event of a disruption including:
    a. Member's access to services. The health plan must:
        i. Establish provisions to ensure that members are able to see Out-of-Network Providers if the member has a permanent address in the federal or state declared disaster areas and are unable to access In-Network providers.
        ii. Establish provisions to ensure that members are able to use telehealth services if the member has a permanent address in the federal or state declared disaster areas.
        iii. Provide detailed plans it will use to ensure that prior authorizations are extended and transferred without burden to new providers if directed by DHS, and the means by which the health plan will identify the location of members who have been displaced.
        iv. Report status of members and issues regarding member access to covered services as directed by DHS.
2. Claims Payment
    a. The health plan must ensure timely provider claims processing and payment consistent with DHS contract requirements and health plan-provider contract policies.
    b. The health plan must establish provider contract language that addresses relaxed health plan timely filing requirements for provider service claims provided in good faith with reasonable submission delay due to a

Federal or State declared disaster or emergency and submit to DHS for review.

c. The health plan must honor unauthorized provider claims consistent with ongoing treatment due to demonstrated patient need or urgent patient need occurring during a Federal or State declared disaster or emergency period where heath plan authorization communications and processes were delayed or failed.
d. The health plan will provide a communication and interim plan for approval by DHS should they experience a disruption that risks the ability to meet the claims processing/payment timeline requirements.

3. Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.
4. Inclusion of a risk assessment that reviews the probability and impact of various threats to the health plan's operations. This involves stress testing the health plan's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the health plan in refining its business impact analysis and in developing a business continuity strategy.
5. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.
    a. Health Plans must ensure that proper training is provided for each role under this provision.
6. Criteria for executing the business continuity plan, including escalation procedures.
    a. A detailed communication plan with members, employees, providers, the Department, and other stakeholders including: Coordinating with DHS or any other local, state, or federal agencies as needed during the disaster or emergency response. This coordination may vary based on type of situation; however, anticipated coordination includes, but is not limited to:
        i. Designating a Point of Contact (POC) for continuity of operations specifically related to

disaster preparedness in order to communicate the health plan's response to the DHS emergency preparedness POC.

ii. Designating a POC to support members residing in Tribal Lands where applicable.
iii. Participating in meetings with DHS or other agencies
iv. Assisting with impacted member or provider communications
v. Facilitate effective communication with members, providers and staff regarding the impact of the disaster as well as a process by which inquiries may be submitted and addressed.
vi. Implementing policy, process, or system changes at the direction of DHS, keeping DHS informed on the progress of the implementation
vii. Additional communication and/or reporting requirements through the duration of the emergency
viii. The health plan must notify DHS of any contract flexibilities or extensions needed during the course of the emergency or disaster. DHS will maintain a health plan emergency/disaster response guide to document any such approved flexibilities or revised deadlines, outside the contract amendment process.
ix. Permission from DHS, contingent on approval of content, to do one-time member outreach via text message to those who have not opted into text messaging, to inform members about the disaster or emergency, offer PIHP resources or contact information, and instructions on how to opt into text messaging.

7. Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.

    a. Including the ability of providers and suppliers to provide ongoing services for maintaining critical operations, and

b. The level of ongoing monitoring and oversight provided by the PIHP.

8. Recovery time for each major business function, based on priority.
9. Business workflow and workaround procedures, including alternate processing methods and performance metrics.
10. Recording and updating business events information, files, and data, once business processes have been restored.
11. Documentation of security procedures for protection of data through web-based cloud application.
12. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
13. A description of an annual testing and evaluation plan.
14. A description of the health plan familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The health plan will negotiate the role of the health plan and the county roles in emergency response.
    a. Health plans must ensure annually the readiness of the plan by conducting exercises carrying out the plan's provisions, evaluate its performance and make necessary updates. The health plan must coordinate with local emergency management departments, local agencies and DHS prior to an event to understand local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

15. A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.
    a. Care Coordination
        i. The health plan must ensure that care coordination for all members are compliant with the health plan's emergency recovery plan. In particular, care coordination for members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if covered service are disrupted or interrupted.
16. Emergency Recovery Plan
    a. The Emergency Recovery Plan shall address, at a minimum, the following recovery aspects related to the

management information system and where appropriate, use web-based cloud applications:

i. Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.
ii. Communication plan for critical personnel, key stakeholders and business partners involved in the health plan's management information system.
    1. Including the health plan's ability to provide continuous services to members and maintain critical operations in the even employees are unavailable to work remotely for extended periods of time.
iii. Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).
iv. Full and complete back-up copies of all data and software.
v. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
vi. Policies and procedures for purging outdated backup data.
vii. Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.

Upon DHS request, PIHPs shall submit an 'After Emergency Report' to DHS after the federal or state declared disaster is completed to provide feedback on success and challenges faced during the emergency.

ARTICLE V

V. FUNCTIONS AND DUTIES OF THE DEPARTMENT

In consideration of the functions and duties of the County contained in this Contract, the Department shall:

A. ELIGIBILITY DETERMINATION

Verify, at the time of enrollment, that members identified on the enrollment requests from the County are:

1. BadgerCare Plus eligible, if all other enrollment eligibility requirements are met.

2. Under 19 years of age.

3. Not currently residing in a psychiatric hospital.

4. Residents of Dane County.

5. Verified that the individuals enrolled in the County meet the definition of severely emotionally disturbed.

6. At imminent risk of placement in a psychiatric hospital, a residential care center, or a juvenile correction facility.

7. Have been screened as eligible for services by the County.

B. ENROLLMENT

Promptly notify the County of all BadgerCare Plus members enrolled under this Contract. Notification shall be effected through the County Enrollment Reports. All members listed as an ADD or CONTINUE on either the Initial or Final County Enrollment Report are members of the County Managed Care Program during the enrollment month. The reports shall be generated in the sequence specified under the County Enrollment Reports. These reports shall be available through electronic file transfer capability and shall include medical status codes.

C. DISENROLLMENT

Promptly notify the County of all BadgerCare Plus members no longer eligible to receive services through the County under this Contract. Notification shall be effected through the County Enrollment Reports, which the Department will transmit to the County for each month of coverage throughout the term of the Contract. The reports shall be generated in the sequence under COUNTY ENROLLMENT REPORTS. Any member who was enrolled in the County's Managed Care Program in the previous enrollment month, but does not appear as an ADD or CONTINUE on either the Initial or Final County Enrollment report for the current enrollment month, is disenrolled from the County's Managed Care Program effective the last day of the previous enrollment month. Members will be disenrolled if either:

1. Member loses BadgerCare Plus eligibility.
2. Member loses Dane County eligibility.
3. Member is disenrolled upon their request.
4. Member completes the program.
5. Court ordered correctional placements.
6. Member is 19 years of age or older.
7. The Department approves a Just Cause Disenrollment.

D. ENROLLMENT ERRORS

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

E. COUNTY ENROLLMENT REPORTS

For each month of coverage throughout the term of the Contract, the Department will transmit "County Enrollment Reports" to the County. These reports will provide the County with ongoing information about its BadgerCare Plus members and disenrollees and will be used as the basis for the monthly capitation claims. County Enrollment Reports will be generated in the following sequence:

1. The Initial County Enrollment Report will list all of the County's members and disenrollees for the enrollment month that are known on the date of report generation. The Initial County Enrollment Report will be available to the County on or about the twenty-first day of each month. A capitation claim shall be generated for each member listed as an ADD or CONTINUE on this report. Members who appear as PENDING on the Initial Report and are reinstated into the County prior to the end of the month will appear CONTINUE on the Final Report, and a capitation claim shall be generated according to the conditions of this Contract.

2. The final County Enrollment Report will list all of the County's members for the enrollment month that were not included in the Initial County Enrollment Report. The Final County Enrollment Report will be available to the County by the first day of the capitation month. A capitation claim shall be generated for each member listed as an ADD or CONTINUE on this report according to the conditions of this Contract. Members in PENDING status will not be included on the final report.

3. Members will be enrolled effective the date the enrollment request is received by the Department. The County will not receive a regular capitation payment for the month of enrollment. The DHS will reimburse the County for partial months of enrollment through payment of a daily rate. The daily rate will be equal to the monthly capitation multiplied by 12 and divided by 365.

F. COUNTY REVIEW

Submit to the County for prior approval materials that describe the County and that will be distributed by the Department or the County to members.

G. COUNTY REVIEW OF STUDY OR AUDIT RESULTS

Submit to the County for a 30 business day review/comment period, any Medicaid audits, comparison reports, consumer satisfaction reports, or any other studies the Department releases to the public. The County may request

an extension and the Department will exercise reasonable discretion in making the determination to waive the 30 business day review/comment requirement.

H. FRAUD, WASTE AND ABUSE TRAINING

The Department will provide fraud, waste and abuse detection training to the County annually.

ARTICLE VI

VI. PAYMENTS TO COUNTY

A. CAPITATION RATES

In consideration of full compliance by the County with Contract requirements, the Department agrees to pay the County monthly payments based on the capitation rate specified and subject to the conditions of this Contract. Capitation payments will only be made for Medicaid-eligible enrollees. The capitation rates shall be prospective and based on an actuarially sound methodology as required by federal regulations. The capitation rate shall not include any amount for recoupment of losses incurred by the County under previous Contracts nor does it include services that are not covered under the State Plan.

No payment shall be made to a network provider other than by the County for services covered under this contract, except when these payments are specifically required by the State in Title XIX of the Act, in 42 CFR chapter IV, or when the State makes direct payments to network providers for graduate medical education costs approved under the State plan.

1. Supplemental Payment for Psychosocial Rehabilitation Services

   As of July 1, 2021, expanded services are available to CCF members under the Psychosocial Rehabilitation Services category. These services will not be included in the capitation rates effective July 1, 2021. Instead, costs for these services will be reimbursed through a supplemental payment. Encounters for these services should be submitted via the 837 batch process as with all other encounters for covered services.

   Services and Service Codes included in the supplemental payment (refer to the 'Service Guide' for additional details on appropriate services and procedure codes):
   H2017 – Psychoeducation, Physical Health Monitoring Services, and Wellness Management and Recovery Services
   H2014 – Individual Skill Development and Enhancement Services
   H2023 – Employment Related Skill Training Services

   Supplemental payments will be made every six months. The Department will query encounters for eligible codes in

'Pay' status and calculate the payment based on the 'HMO Paid' amount on the encounter record. To account for claims lag and processing time to submit encounters, the first supplemental payment will not be processed before June 2022 for dates of service (DOS) July 1, 2021 through December 31, 2021. Payments will then be made every six months for the subsequent six-month DOS span. The Department will notify CCF when the payment will process and provide a file listing the encounters included in the payment through the SFTP.

B. ACTUARIAL BASIS OF CAPITATION RATE

The capitation rate is calculated on an actuarial basis recognizing the payment limits set forth in federal law 42 CFR §438.6(c).

C. RENEGOTIATION

The monthly capitation rates set forth in this article are recalculated on an annual basis. The County will have 30 calendar days from the date of the written notification to accept the new capitation rates in writing or to initiate termination or non-renewal of the Contract. The capitation rates are not subject to renegotiation once they have been accepted, unless such renegotiation is required by changes in federal or state laws, rules or regulations.

D. REINSURANCE

The County may obtain a risk-sharing arrangement from an insurer other than the Department for coverage of members under this Contract, provided that the County remains substantially at risk for providing services under this Contract.

E. RESPONSIBILITY TO PROVIDE SERVICES

The County is responsible for the provision of Contract and administrative services covered under this Contract from the date the member is enrolled in the County, regardless of whether or not the County receives a capitation payment for that member for the initial month pursuant to the conditions agreed upon.

F. PAYMENT SCHEDULE

Capitation payments to the County shall be based on current enrollment when the capitation cycle runs on the first Friday of each month. The EFT payment is settled the following Friday and weekly auto-adjust reports are run for any

changes. The County receives 'Initial' and 'Final' enrollment reports each month showing members as ADD, CONTINUE, DISENROLLED, or PEND ('Initial' report only).

G. COORDINATION OF BENEFITS (COB)

The County must actively pursue, collect and retain all monies from all available resources for services to members covered under this Contract except where the amount of reimbursement the County can reasonably expect to receive is less than the estimated cost of recovery. For purposes of both COB and TPL, and pursuant to the federal Deficit Reduction Act (P.L. 109-171, Sec. 6035), the County shall use cost avoidance when possible, except as otherwise permitted herein. Specifically, the County is prohibited from referring enrollees to publicly supported health care resources in order to avoid costs. COB recoveries will be done by post-payment billing (pay and chase) for certain preventive pediatric services. Post-payment billing will also be done in situations where the third party liability is derived from a parent whose obligation to pay is being enforced by the state Child Support Enforcement Agency and the provider has not received payment within 30 days after the date of service.

1. Cost-effectiveness of recovery is determined by, but not limited to time, effort, and capital outlays required to perform the activity. The County must be able to specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party, or describe the process by which the County determines seeking reimbursement would not be cost effective, upon request of the Department. COB activities include pursuit of the County's subrogation rights under Chapter 49 of the Wisconsin Statutes.

2. To assure compliance, records shall be maintained by the County of all COB collections and reports shall be made annually on the form designated by the Department. The County must be able to demonstrate that appropriate collection efforts and appropriate recovery actions were pursued. The Department has the right to review all billing histories and other data related to COB activities for members. The County must seek from all members' information on other available resources.

    a. Other available resources may include, but are not limited to, all other state or federal medical care programs which are primary to Medicaid, group or individual health insurance, ERISAs, service benefit plans, the insurance of absent parents who may have insurance to pay medical care for spouses or

minor members, and subrogation/workers compensation collections.

b. Subrogation collections are any recoverable amounts arising out of settlement of personal injury, medical malpractice, product liability, or Worker's Compensation. State subrogation rights have been extended to County, as a health plan, under s. 49.89(9),. After attorneys' fees and expenses have been paid, the County shall collect the full amount paid on behalf of the member.

3. Where the County has entered a risk-sharing arrangement with the Department, the COB collection and distribution shall follow the procedures described in this Contract. Act 27; Laws of 1995 extended assignment rights to counties under s. 632.72.

4. COB collections are the responsibility of the County or its subcontractors. Subcontractors must report COB information to the County. County and subcontractors shall not pursue collection from the member but directly from the third party payer. Access to medical services will not be restricted due to COB collection.

5. The following requirement shall apply if the Contractor (or the Contractor's parent firm and/or any subdivision or subsidiary of either the Contractor's parent firm or of the Contractor) is a health care insurer (including, but not limited to, a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Commissioner of Insurance and/or a third-party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):

    a. Throughout the Contract term, these insurers and third-party administrators shall comply in full with the provision of s.49.475 of the Wis. Stats. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.

    b. Throughout the Contract term, these insurers and third-party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin BadgerCare Plus members.

6. If, at any time during the Contract term, any of the insurers or third party administrators fail, in whole or in part, to collect from third party payers, except as otherwise permitted herein, the Department may take the remedial measures specified in this Contract.

H. RECOUPMENTS

The Department will not normally recoup County per capita payments when the County actually provided service. However, if the BadgerCare Plus member cannot use County facilities, the Department will recoup the County capitation payments. Such situations are described more fully below.

1. The Department will recoup the County capitation payments for the following situations where an member's County status has changed before the first day of a month for which a capitation payment has been made:

    a. Member moves out of the County's service area; or
    b. Member enters a public institution; or
    c. Member dies.

2. The Department will recoup the County capitation payments for the following situations where the Department initiates a change in a member's County enrollment status on a retroactive basis, reflecting the fact that the County was not able to provide services. In these situations, recoupments for multiple month's capitation payments are more likely:

    a. For the correction of computer or human error, where the person was never really enrolled in the County.

    b. Disenrollments of members for reasons of pregnancy and continuity of care.

3. If a member moves out of the County, as verified by the eligibility worker, the member will be disenrolled from CCF on the date the member moved unless the member continues under the jurisdiction of the Dane County Juvenile Court despite having moved from the County. If the eligibility worker is unable to verify the member's move, the County must mail a "Certified Return Receipt Requested" letter to the member to verify the move. The member must sign for the letter. A copy of the letter and the signed return receipt must be sent to the Department or its designee within 20 days of the member's signature date. If these criteria are met, the effective date of the disenrollment is the first of the month in which the returned registered receipt requested letter was sent. Documentation that fails to meet the

20-day criteria will result in disenrollment the first of the month in which the County supplied information to the Department or its designee. This policy does not apply to extended service area requests that have been approved by the County unless the member moves out of the extended service area or the County's service area. Any capitation payment made for periods of time after disenrollment will be recouped.

I. BILLING MEMBERS

BadgerCare Plus programs must comply with ForwardHealth policy regarding the 5% cost share cap for enrolled members, as required under Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented in 42 CFR §447.56(f)). If the County elects to charge copays to members, they must provide at least a 6 month notice to DHS and submit a member communication plan for approval before implementation.

J. Unauthorized Activities

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

ARTICLE VII

VII. REPORTS AND DATA

A. ACCESS TO AND/OR DISCLOSURE OF FINANCIAL RECORDS

The County and any subcontractors shall make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of County or subcontractors that relate to the County's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this Contract. The County shall comply with applicable recordkeeping requirements specified inDHS 105.02(1)-(7) Wisconsin Administrative Code, as amended.

B. PERIODIC REPORTS

The County agrees to furnish within the Department's time frame and within the Department's stated form and format, information and/or data from its records to the Department, and to the Department's authorized agents, which the Department may require to administer this Contract, including but not limited to the following:

1. Copies of all written grievances and appeals by BadgerCare Plus members processed by the County through its grievance and appeal system, and actions taken to resolve them. This includes the Member Grievance and Appeal report template found in Section 12.3 of the *Member Grievances and Appeals Guide*.

2. Summaries of amounts recovered through the Coordination of Benefits for services rendered to members under this Contract in the format specified.

3. Member utilization and outcome data in the formats described in Addendum II and Addendum X.

4. Oral complaint logs must be available on request.

5. Any other data, documentation, or information relating to the performance of the entity's obligations as required by the state or Secretary.

C. FINANCIAL REPORT

The County is required to submit financial reports per the schedule and instructions provided in the financial report template. The County should refer to the *Annual HMO Financial Audit Guide* for additional guidance.

The County is required to submit a letter from its internal auditor or vendor verifying the financial report meets CMS Citation 438.3(m) and was audited in accordance with generally accepted accounting principles and generally accepted auditing standards.

The letter must be on official County letterhead and be of sufficient quality to allow the Department to post it to the ForwardHealth Portal per the CMS requirement.

Additionally, the County must provide the Department all work papers used to verify that the financial report template was accurate per the CMS citation 438.3(m).

If the County's auditor is unable to verify the accuracy of the financial template the County must notify the department immediately with a plan which will allow them to submit a template which is verifiable per the CMS citation.

The letter and work papers must be submitted to the Department no later than 60 days prior to June 30th each year or upon a mutually agreed upon due date. The materials must be sent to both DHSDMSBRS@dhs.wisconsin.gov and DHSOIGManagedCare@dhs.wisconsin.gov.

The Financial Report Template can be found on the ForwardHealth Portal. Medical Loss Ratio (MLR) requirements and further detail is located within the Financial Report Template.

If the County is unable to deliver any of the required materials by the due date, they must request an extension within five business days by emailing the request to: DHSDMSBRS@dhs.wisconsin.gov. The County must provide an alternative due date as part of the request.

The County will be responsible for using the most updated version of the guide posted to the website. Questions on the financial reports should be directed by email to: DHSDMSBRS@dhs.wisconsin.gov.

The Department will conduct an independent audit of the accuracy, truthfulness and completeness of the financial data submitted by, or on behalf of, the County no less frequently than once every three years.

The County must comply timely with all reasonable requests made by the independent auditor. This includes but is not limited to providing them on-site work space and access to materials and staff necessary to perform the audit.

The following costs are excluded from rate setting:

- Advertising and Marketing, unless permissible as part of the HMO and PIHP Communication, Outreach, and Marketing Guide
- Lobbying
- Charitable Contributions and Donations
- Regulatory Fines and Penalties
- Travel Costs beyond those necessary to provide member healthcare services or economical administration of operate in the Wisconsin Medicaid program
- Entertainment

Unallowable costs must be segregated and excluded from allowable administrative costs in the PIHP's submitted budget projection. The department reserves the right to make adjustments to financial submissions for costs deemed unallowable based on Department or auditor review.

D. ENCOUNTER DATA AND REPORTING REQUIREMENTS

The PIHP is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. PIHP staff will participate with the Department in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA and MSIS/TMSIS requirements applicable to the PIHP. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual PIHP meetings with the Department to address changes in requirements, local applications or databases. The PIHP must cooperate with the Department on data submission protocol and testing. The Department or its designees reserves the right to conduct on-site inspections and/or audits

prior to awarding the Contract and anytime thereafter. Per 42 CFR 438.602(e), the Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

1. 1. Data Management and Maintenance: The PIHP must have a system that is capable of providing information on utilization, processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, grievance and appeals, and meeting reporting requirements. The required formats and timelines are specified in Article XII, Section J. The PIHP must:

    a. Participate in PIHP encounter technical workgroup meetings scheduled by the Department.

    b. Capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contact. The original claim submitted by the provider must be stored and retrievable upon request by either the Department or CMS.

    c. Have a database which is a complete and accurate representation of all services the PIHP provided during the Contract period.

    d. Be responsible for monitoring the integrity of the database, and facilitating its appropriate use for such required reports as encounter data and targeted performance improvement studies.

    e. Be responsible for maintaining unique identifiers assigned by the Department or its designee such as the identification number assigned to each submitted encounter. The PIHP must maintain all national code sets and Department specific fields as defined in ForwardHealth and the HMO Encounter User Guide.

    f. Be responsible for updating and testing new versions of national codes sets and/or state specific code set.

    g. Not alter encounters with dates of service older than two years of the current year. For example, if the current calendar year is 2015, the PIHP must not alter encounters with a date of service of 2012 or older.

    h. Comply with section 6504(a) of the Affordable Care Act, including operating systems that allow the Department to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the Department to meet the requirements of section 1903(r)(1)(F) of the Act.

i. Verify the accuracy and timeliness of data reported by providers, including data from network providers the PIHP is compensating on the basis of capitation payments.

j. Screen the data received from providers for completeness, logic, and consistency.

k. Ensure that it is the sole entity to make payments to network providers for covered services, except in specific instances.

2. Program Integrity and Data Usage: The County shall establish written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable data processing and safeguarding requirements and standards under the contract, and all applicable Federal and state requirements. This documentation must be kept current and be provided to the department upon request.

    a. This requirement extends to all subcontractors to the extent that the subcontractor is delegated responsibility by the County. The County is responsible for ensuring that data usage agreements and procedures are in place with providers and contractors that facilitate complete, accurate and timely encounter submissions to the Department.

    b. The Department retains the right to analyze encounter data and use it for any purpose it deems necessary. The Department will ensure that the analysis does not violate the integrity of the reported data submitted by the County.

3. Testing and Certification Requirements: The electronic test encounter data files are subject to Department review and approval before production data is accepted by the Department. Production encounters or other documented encounter data must be used for the test data files.

    a. The PIHP must notify the Department of all significant personnel changes and system changes that may impact the integrity of the data, including new claims processing vendors and significant changes in personnel.

    b. A new PIHP must test the encounter data set until the Department is satisfied that the PIHP is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable. A new PIHP must become certified to submit compliant encounters within six months of their start date.

c. The PIHP must provide a three-month notice to the Department in advance of transition to a new claims processing system and/or third party administrator. The new system must become certified by the Department or its designee to submit compliant encounters within six months of its start date.

4. Data Exchange Requirements: All encounter submissions must be in a HIPAA compliant ASC X12 transaction format.

   a. The County must follow the data specifications defined in the Encounter User Guide and must submit encounters that conform to national standards as well as specific Departmental requirements.

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

   c. The County must process all the County specific files as defined in the Report Matrix on ForwardHealth. All enrollment, encounters, response, capitation, provider, error reports and special program files must be processed in a timely and accurate manner.

5. . Performance Requirements: The County must submit accurate and complete encounter data that the Department can use for rate-setting, Federal Reporting, special programs and any other purpose deemed necessary by the Department. The County must track metrics used by the Department to confirm that data is accurate and complete. Any deficiencies in the metrics must be reported to the Department within 15 days of the County identifying the problem. The County must complete a quarterly progress report due on April 30th, July 30th, October 30th and January 30th. The Progress Report and Template is posted to the Managed Care section in ForwardHealth. The completed progress report and/or any deficiencies in the metrics should be submitted to DHSDMSBRS@dhs.wisconsin.gov.

6. Non-Compliance Resolution Process: The Department shall have the right to audit any records of the PIHP and to request any additional information. If at any time the Department determines that the PIHP has not complied with any requirement in this section, the Department will issue a corrective action to the PIHP. The PIHP shall comply within the timeframe defined in the corrective action. If the PIHP fails to comply, the Department may pursue action against the PIHP as provided under Article IX.

E. ACCESS TO AND AUDIT OF CONTRACT RECORDS

Throughout the duration of the Contract, and for a period of ten years after termination of the Contract, the County shall provide duly authorized representatives of the state (including the Office of the Inspector General) or

federal government access to all records and material relating to the Contractor's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules, or regulations.

F. RECORDS RETENTION

The County shall retain, preserve and make available, upon request, all records relating to the performance of its obligations under the Contract, including claim forms, for a period of not less than ten years from the date of termination of the Contract. Records involving matters, that are the subject of litigation, shall be retained for a period of not less than ten years following the termination of litigation or audit.

Upon expiration of the ten (10) year retention period, the subject records shall, upon request, be transferred to the Department's possession. No records shall be destroyed or otherwise disposed of without the prior written consent of the Department.

G. INSURANCE INFORMATION DISCLOSURE

The following requirements shall apply if the contractor (or the contractor's parent firm and/or any subdivision or subsidiary of either the contractor's parent firm or of the Contractor) is a health care insurer (including but not limited to a group health insurer and/or health maintenance organization) licensed by the Wisconsin Office of the Insurance Commissioner and/or a third party administrator for a group or individual health insurer(s), health maintenance organization(s), and/or employer self-insurer health plan(s):

1. Throughout the Contract term, these insurers and third party administrators shall comply in full with the provisions of s. 49.475 of Wis. Stats. Such compliance shall include the routine provision of information to the Department in a manner and electronic format prescribed by the Department and based on a monthly schedule established by the Department. The type of information provided shall be consistent with the Department's written specifications.

2. Throughout the Contract term, these insurers and third party administrators shall also accept and properly process post-payment billings from the Department's fiscal agent for health care services and items received by Wisconsin BadgerCare Plus members.

If, at any time during the Contract term, any of the insurers or third party administrators fail, in whole or in part, to adhere to the requirements of this Contract, the Department may take remedial measures.

H. Medical Loss Ratio Reporting

1. MLR Requirement

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

2. MLR Reporting Requirements

a. Each PIHP expense must be included under only one type of expense category defined for MLR reporting, unless a proration between expense categories is required to reflect accuracy and a description of the allocation is provided.
b. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.
c. Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results.
d. Shared expenses, including the expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.
e. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.
f. The PIHP may add a credibility adjustment, which are published annually by CMS, to a calculated MLR if the MLR reporting year experience is partially credible.
g. The PIHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. Any PIHP with enrollment greater

than the minimum number of member months set by CMS will be determined to be fully credible.

h. If a PIHP's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.
i. The PIHP will aggregate data for all Medicaid eligibility groups covered under the contract with the Department.
j. The PIHP's MLR report must include the following:
    1. Total incurred claims
    2. Expenditures on quality improving activities
    3. Expenditures related to activities compliant with program integrity requirements
    4. Non-claims costs
    5. Premium/capitation revenue
    6. Taxes
    7. Licensing fees
    8. Regulatory fees
    9. Methodology(ies) for allocation of expenditures
    10. Any credibility adjustment applied
    11. The calculated MLR
    12. Any remittance owed to the state, if applicable
    13. A reconciliation of the information reported in the annual financial report
    14. A description of the aggregation method used to calculate total incurred claims
    15. The number of member months
    16. Additional description and guidelines for the MLR report are located in the MLR worksheet within the DHS PIHP Financial Reporting Template.

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

I. Supplier Diversity Reporting

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

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

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

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

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

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

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

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

ARTICLE VIII

VIII. MEMBER GRIEVANCES AND APPEALS

The County is required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F, as contained in the *Member Grievances and Appeals Guide*, Dated January 1, 2020, which is fully incorporated herein by reference.

ARTICLE IX

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

A. SUSPENSION OF NEW ENROLLMENT

Whenever the Department determines that the County is out of compliance with this Contract, the Department may suspend the County's right to enroll new members under this Contract. When exercising this option, the Department must notify the County in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension period 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.

B. WITHHOLDING OF CAPITATION PAYMENTS AND ORDERS TO PROVIDE SERVICES

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

1. Whenever the Department determines that the County has failed to provide one or more of the Medicaid covered Contract services under this Contract or failed to comply with the provisions contained in this Contract, the Department may either order the County to provide such service, or withhold a portion of the County'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. County shall be given at least seven days written notice prior to the County being required to comply with either: a) Department direction to the County to pay, or b) the withholding of any capitation payments, except that in case of an emergency, no such seven day notice is required.

   Whenever the Department determines that the County has failed to provide one or more of the Medicaid covered Contract services under this Contract or failed to comply with the provisions contained in this Contract, the Department may either order the County to provide such service, or withhold a portion of the County'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. County shall be given at least seven days written notice prior to the County being required to comply with either: a) Department direction to the County to pay, or b) the withholding of any capitation payments, except that in case of an emergency, no such seven day notice is required.

   When it withholds payments under this section, the Department must submit to the County a list of the members for whom payments are being withheld, the nature of the service(s) denied, and payments the Department must make to provide medically necessary services.

   If the Department acts under this section and subsequently determines that the services in question were not covered services:

   a. If the Department withheld payments it shall restore to the County the full capitation payment; or

b. If the Department ordered the County to provide services under this section it shall pay the County the actual documented cost of providing the services.

2. If the County 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 County 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 County's capitation payments.

3. Whenever the Department determines that the County has failed to perform an administrative function required under this Contract, the Department may withhold a portion of future capitation payments. For the purposes of this section, "Administrative Function" is defined as any Contract obligation other than the actual provision of Contract services. The amount withheld by the Department under this section will be an amount that the Department determines in the reasonable exercise of its discretion to approximate the cost to the Department to perform the function. The Department may increase these amounts by 50% for each subsequent non-compliance.

   Whenever the Department determines that the County 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 BadgerCare Plus program's costs of providing mental health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators.

4. 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.

5. Notwithstanding the provisions of this subsection, in any case where the Department deducts a portion of capitation payments under Section 2 above, the following procedures shall be used:

   a. The Department will notify the County Contract administrator no later than the second business day after the Department's deadline that the County has failed to submit the required data or the required data cannot be processed.

b. Beginning on the second business day after the Department's deadline, the County will be subject without further notification to liquidated damages per data file or report.
c. If the County submits any other required data or report but in the required format within five business days from the deadline, the Department will rescind liquidated damages and immediately process the data or report.

d. If the County repeatedly fails to submit required data or reports, or data that cannot be processed, the Department will require the County to develop an action plan to comply with the Contract requirements that must meet Department approval.

e. After a corrective action plan has been implemented, if the County continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under SUSPENSION OF NEW ENROLLMENT, or WITHHOLDING OF CAPITATION PAYMENTS AND ORDERS TO PROVIDE SERVICES sections, or both, in addition to liquidated damages that may have been imposed for a current violation.

f. If the County 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 County which will not be released to the County 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.

6. 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.

C. CONTRACTUAL REMEDIES

The remedies provided in this Contract are not intended to act as a waiver of any other contractual remedies existing in law or equity that the Department may have for breach of contract, including recovery of damages.

D. DEPARTMENT-INITIATED ENROLLMENT REDUCTIONS

The Department may reduce the maximum enrollment level and/or number of current members whenever it determines that the County has failed to provide one or more of the Contract services required, or that the County has failed to maintain or make available any records or reports required under this Contract, that the Department needs to determine whether County is providing Contract services. The County shall be given 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 the members' health or welfare is jeopardized.

E. INAPPROPRIATE PAYMENT DENIALS

Counties that inappropriately fail 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 on the nature of the services in question, whether the failure or denial was an isolated instance or a repeated pattern of practice, and whether the health of a member was injured, threatened or jeopardized by the failure or denial. This applies not only to cases where DHS has ordered payment after appeal, but also to cases where no appeal has been made (i.e., the Department is knowledgeable about the documented abuse from other sources).

F. SANCTIONS

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny BadgerCare Plus payments to the County for members who enroll after the date on which the County has been found to have committed one (1) of the violations identified in federal law. State payments for members of the contracting organization are 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 Department may impose sanctions if the County has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations. The following violations can trigger denial of payment pursuant to s.1903(m)(5) of the Social Security Act:

1. Substantial failure to provide required medically necessary items and services when the failure has adversely affected (or has substantial likelihood of adversely affecting) a member.

2. Imposition of premiums on BadgerCare Plus members in excess of permitted premiums.

3. Discrimination among BadgerCare Plus members with respect to enrollment, reenrollment, or disenrollment on the basis of their health status or requirements for health care services.

4. Misrepresentation or falsification of certain information.

G. REMEDIAL ACTIONS

The Department may pursue all sanctions and remedial actions with the County that are taken with BadgerCare Plus fee-for-service providers, including civil monetary in the following specified amounts penalties not to exceed the amounts specified in the Balanced Budget Amendment of 1997 P.L. 105-33 s. 4707(a) [42 U.S.C. 1396v(d)(2)].

1. 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.

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

3. 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).

4. 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 BadgerCare Plus program. The State must deduct from the penalty the amount of overcharge and return it to the affected member(s).

5. Appointment of temporary management for a County as provided in 42 CFR 438.706.

The Department will work with the County and their providers to change and correct problems and will recoup funds only if the County fails to correct a problem, unless otherwise allowed in this Contract.

H. TEMPORARY MANGEMENT

The state will impose temporary management when:

1. There is continued egregious behavior by the County, 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

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

3. The sanction is necessary to ensure the health of the County's members while improvements are made to remedy violations under 438.700 or until there is an orderly termination or reorganization of the County.

ARTICLE X

X. TERMINATION AND MODIFICATION OF CONTRACT

A. MUTUAL CONSENT

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

B. Automatic Termination by the Department

1. Foreign Entities
   a. Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with a PIHP located outside of the United States. In the event an PIHP moves outside of the United States, this contract will be terminated.
   b. Pursuant to 42 C.F.R. § 438.602(i), no claims paid by a PIHP to a network provider, out-of-network provider, subcontractor or

financial institution outside of the United States will be considered in the development of actuarially sound payments.

C. UNILATERAL TERMINATION

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

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

2. Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of this intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date will 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 County program. A "substantial failure to perform" for purposes of this paragraph includes any violation of any requirement of this Contract that is repeated or ongoing, that goes to the essentials or purpose of the Contract, or that injures, jeopardizes or threatens the health, safety, welfare, rights or other interests of members.

3. Either party may terminate this Contract if federal or state funding of contractual services rendered by the Contractor become or will become permanently unavailable. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the Contractor will be temporarily suspended or unavailable, the Department will 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 will attempt to give notice of suspension of performance of any or all of the Contractor's obligations by 60 calendar days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. In the event funding temporarily suspended or unavailable is reinstated, the Contractor may remove suspension hereunder by written notice to the Department, to be made within 30 calendar days from the date the funds are reinstated. In the event the Contractor elects not to reinstate services, the Contractor will give the Department written notice of its reasons for such decision, to be made within 30 calendar days from the date the funds are reinstated. The Contractor will 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 will terminate without termination costs to either party.

D. OBLIGATIONS OF CONTRACTING PARTIES UPON TERMINATION

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

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

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

    b. The County shall be responsible for all expenses related to said notification.

    c. The Department shall grant the County a hearing before termination by the Department occurs. The Department shall notify the members of the hearing and allow them to disenroll from the County managed care program without cause.

2. Where this Contract is terminated on any basis not given in 1 above including non-renewal of the contract for a given contract period:
    a. The Department shall be responsible for notifying all members of the date of termination and process by which the members will continue to receive Contract services.

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

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

    a. Any payments advanced to the County for coverage of members for periods after the date of termination shall be returned to the Department within within 90 days of Contract termination.

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

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

E. MODIFICATION

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

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

ARTICLE XI

XI. CONFIDENTIALITY OF RECORDS

The parties agree that all information, records, and data collected in connection with this Contract shall be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, V and VI Wis. Stats., DHS 108.01, Wis. Adm. Code, and 42 CFR 431 Subpart F. Except as otherwise required by laws, rules, or regulations, access to such information shall be limited by the County and the Department to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

A. DUTY OF NON-DISCLOSURE AND SECURITY PRECAUTIONS

Contractor shall not use Confidential Information for any purpose other than the limited purposes set forth in the Agreement. Contractor shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents *("Representatives")* who have a business-related need to have access to such Confidential Information in furtherance of the limited purposes of this Agreement and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Agreement. Contractor shall be responsible for the breach of this Agreement by any of its Representatives.

Contractor shall institute and/or maintain such procedures as are reasonably required to maintain the confidentiality of the Confidential Information, and shall apply the same level of care as it employs to protect its own confidential information of like nature.

Contractor shall ensure that all indications of confidentiality contained on or included in any item of Confidential Information shall be reproduced by Contractor on any reproduction, modification, or translation of such Confidential Information. If requested by the State, Contractor shall make a reasonable effort to add a proprietary notice or indication of confidentiality to any tangible materials within its possession that contain Confidential Information of the State, as directed.

If requested by the State, Contractor shall return or destroy all Individually Identifiable Health Information and Personally Identifiable Information it holds upon termination of this Agreement.

B. LIMITATIONS ON OBLIGATIONS

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

1. is part of the public domain without any breach of this Agreement by Contractor;
2. is or becomes generally known on a non-confidential basis, through no wrongful act of Contractor;
3. was known by Contractor prior to disclosure hereunder without any obligation to keep it confidential;
4. was disclosed to it by a third party which, to the best of Contractor's knowledge, is not required to maintain its confidentiality;
5. was independently developed by Contractor; or
6. is the subject of a written agreement whereby the State consents to the disclosure of such Confidential Information by Contractor on a non-confidential basis.

C. LEGAL DISCLOSURE

If Contractor or any of its Representatives shall be under a legal obligation in any administrative, regulatory or judicial circumstance to disclose any Confidential Information, Contractor shall give the State prompt notice thereof (unless it has a legal obligation to the contrary) so that the State may seek a protective order or other appropriate remedy. In the event that such protective order is not obtained, Contractor and its Representatives shall furnish only that portion of the information that is legally required and shall disclose the Confidential Information in a manner reasonably designed to preserve its confidential nature.

D. UNAUTHORIZED USE, DISCLOSURE, OR LOSS

If Contractor becomes aware of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or if any Confidential Information is lost or cannot be accounted for, Contractor shall notify the State's Contract Monitor within the same business day the Contractor becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the Contractor's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

The Contractor shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The Contractor shall reasonably cooperate with the State's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such threatened or actual breach, or to recover its Confidential Information, including complying with a reasonable Corrective Action Plan.

If the unauthorized use, disclosure, or loss is of Individually Identifiable Health Information, Contractor shall, at its own cost, notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice. In addition, the Contractor will take other reasonable corrective measures as are agreed to by the parties.

If the unauthorized use, disclosure, or loss is of Personally Identifiable Information, or reasonably could otherwise identify individuals, Contractor shall, at its own cost, take any or all of the following measures that are directed by the State as part of a Corrective Action Plan:

1. Notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice.

2. Notify consumer reporting agencies of the unauthorized release.

3. Offer credit monitoring and identity theft insurance to affected individuals from a company, and under terms, acceptable to the State for one year from the date the individual enrolls in credit monitoring.

4. Provide a customer service or hotline to receive telephone calls and provide assistance and information to affected individuals during hours that meet the needs of the affected individuals, as established by the State.

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

   If the unauthorized use, disclosure, or loss is of Individually Identifiable Health Information, Contractor shall, at its own cost, notify the affected individuals by mail or the method previously used by the State to communicate with the individual. If the Contractor cannot with reasonable diligence determine the mailing address of the affected individual and the State has not previously contacted that individual, the Contractor shall provide notice by a method reasonably calculated to provide actual notice. In addition, the Contractor will

take other measures as are directed by the State as part of a Corrective Action Plan.

E. TRADING PARTNER REQUIREMENTS UNDER HIPAA

For the purposes of this section Trading Partner means the County.

1. Trading Partner Obligations

    a. Trading Partner must not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915(a)).

    b. Trading Partner must not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915(b)).

    c. Trading Partner must not use any code or data elements that are either marked "not used" in the HHS Transaction Standard's implementation specifications or are not in the HHS Transaction Standard's implementation specifications (45 CFR Part 162.915(c)).

    d. Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications (45 CFR Part 162.915(d)).

    e. Trading Partner must submit a new Trading Partner profile form in writing if any of the information provided as part of the Trading Partner profile form is modified.

2. Trading Partner understands that there exists the possibility that the Department or others may request an exception from the uses of a standard in the HHS Transaction Standards. If this occurs, Trading Partner must participate in such test modification (45 CFR Part 162.940 (a) (4)).

3. Trading Partners or Trading Partner's Business Associates are responsible for adequately testing business rules appropriate to their types and specialties.

4. Trading Partner or their Business Associates agree to cure transaction errors or deficiencies identified by the Department.

5. Trading Partner or Trading Partner's Business Associates understand that from time-to-time HHS may modify and set compliance dates for

the HHS Transaction Standards. Trading Partner or Trading Partner's Business associates must incorporate by reference any such modifications or changes (45 CFR Part 160.104).

6. The Department and the Trading Partner agree to keep open code sets being processed or used for at least the current billing period or any appeal period, whichever is longer (45 CFR Part 162.925 (c)(2)).

7. Privacy

    a. The Trading Partner or the Trading Partner's Business Associates will comply with all applicable state and federal privacy statutes and regulations concerning the treatment of Protected Health Information (PHI).

    b. The Department and the Trading Partner or Trading Partner's Business Associates will promptly notify the other party of any unlawful or unauthorized use or disclosure of PHI that may have an impact on the other party that comes to the party's attention, and will cooperate with the other party in the event that any litigation arises concerning the unlawful or unauthorized disclosure of use of PHI.

    c. The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by the Trading Partner, Trading Partner's Business Associates, or any agent, contractor or third Party that received PHI from the Trading Partner.

    d. All information, records, and data collected in connection with this Contract shall be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, V, and VI Wis. Stats., DHS 108.01, Wis. Adm. Code, 42 CFR 431 Subpart F and 45 CFR 160, 162, and any other confidentiality law to the extent that these requirements apply.

8. Security

    a. The Department and the Trading Partner or Trading Partner's Business Associates must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's

operating system when the attempt may have an impact on the other party.

b. The Department and the Trading Partner or Trading Partner's Business Associates must develop, implement, and maintain appropriate security measures for its own operating system. The Department and the Trading Partner or Trading Partner's Business Associates must document and keep current its security measures. Each party's security measure will include, at a minimum, the requirements and implementation features set forth in 'site specific HIPAA rule' and all applicable HHS implementation guidelines.

F. LIQUIDATED DAMAGES; EQUITABLE RELIEF; INDEMNIFICATION

Indemnification: In the event of a breach of this Section by Contractor, Contractor shall indemnify and hold harmless the State of Wisconsin and any of its officers, employees, or agents from any claims arising from the acts or omissions of the Contractor, and its subcontractors, employees and agents, in violation of this Section, including but not limited to costs of monitoring the credit of all persons whose Confidential Information was disclosed, disallowances or penalties from federal oversight agencies, and any court costs, expenses, and reasonable attorney fees, incurred by the State in the enforcement of this Section. In addition, notwithstanding anything to the contrary herein, the Contractor shall compensate the State for its actual staff time and other costs associated with the State's response to the unauthorized use or disclosure constituting the breach.

Equitable Relief: The Contractor acknowledges and agrees that the unauthorized use, disclosure, or loss of Confidential Information may cause immediate and irreparable injury to the individuals whose information is disclosed and to the State, which injury will not be compensable by money damages and for which there is not an adequate remedy available at law. Accordingly, the parties specifically agree that the State, on its own behalf or on behalf of the affected individuals, shall be entitled to obtain injunctive or other equitable relief to prevent or curtail any such breach, threatened or actual, without posting security and without prejudice to such other rights as may be available under this Agreement or under applicable law.

Liquidated Damages: The Contractor agrees that an unauthorized use or disclosure of Confidential Information may result in damage to the State's ability to serve the public interest in its administration of programs affected by this Agreement. Such amounts of damages which will be sustained are not calculable with any degree of certainty and thus shall be the amounts set forth herein. Assessment under this provision is in addition to other remedies under this Agreement and as provided in law or equity. The State will assess

damages as appropriate and notify the Contractor in writing of the assessment. The Contractor shall automatically deduct the damage assessments from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice.

Liquidated Damages shall be as follows:

1. $100 for each individual whose Confidential Information was used or disclosed;

2. $100 per day for each day that the Contractor fails to substantially comply with the Corrective Action Plan under this Section.

3. Damages under this Section shall in no event exceed $50,000 per incident.

G. COMPLIANCE REVIEWS

The State may conduct a compliance review of the Contractor's security procedures to protect Confidential Information.

H. SURVIVAL

This Section shall survive the termination of the Agreement.

ARTICLE XII

XII. DOCUMENTS CONSTITUTING CONTRACT

The Contract between the parties to this Contract shall include, in addition to this document, ForwardHealth publications addressed to the County, and Contract Interpretation Bulletins issued pursuant to this Contract. In the event of any conflict in provisions among these documents, the terms of this Contract shall prevail. In addition, the Contract shall incorporate the following Addenda:

I. Subcontracts and Memoranda of Understanding
II. Utilization and Encounter Requirements
III. Performance Improvement Project Outline
IV. Coordination of Benefits
V. Compliance Agreement: Affirmative Action/Civil Rights
VI. Reporting Requirements and Due Dates
VII. Description of BadgerCare Plus-Covered Services Provided by County
VIII. Compliance Agreement On Evaluation
IX. Definition of "Serious Emotional Disturbance" and Eligibility Criteria
X. Member Grievance and Appeal Reporting
XI. School-based Services (SBS) MOU
XII. Attestation Form
XIII. Eligibility Criteria for Children Come First

The documents listed above constitute the entire Contract between the parties and no other expression, whether oral or written, constitutes any part of this Contract.

ARTICLE XIII

XIII. MISCELLANEOUS

A. INDEMNIFICATION

The County agrees to defend, indemnify and hold the Department harmless with respect to any and all claims, costs, damages, and expenses, including reasonable attorney's fees, which are related to or arise out of:

1. Any failure, inability or refusal of the County or any of its subcontractors to provide Contract services.

2. The negligent provision of Contract services by the County or any of its subcontractors; or

3. Any failure, inability or refusal of the County to pay any of its subcontractors for Contract services.

B. INDEPENDENT CAPACITY OF CONTRACTOR

The Department and the County agree that the County and any agents or employees of the County, in the performance of this Contract, shall act in an independent capacity, and not as officers or employees of the Department.

C. OMISSIONS

In the event that either party hereto discovers any material omission in the provisions of this Contract that is essential to the successful performance of this Contract, said party may so inform the other party in writing. The parties hereto shall thereafter promptly negotiate the issues in good faith in order to make all reasonable adjustments necessary to perform the objectives of this Contract.

D. CENTERS FOR MEDICAID/MEDICARE SERVICES REVIEW

This Contract shall be forwarded to the Centers for Medicaid/Medicare Services (CMS), Region V, for review and comment. The parties hereto agree to renegotiate this Contract, giving due consideration to the comments of CMS, and making such adjustments as deemed necessary by the parties.

E. CHOICE OF LAW

This Contract shall be governed by and construed in accordance with the laws of the State of Wisconsin. The County shall be required to bring all legal proceedings against Department in Wisconsin State courts.

F. WAIVER

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained.

G. CONFLICT OF INTEREST

The County covenants that its officers, members or employees presently have no interest and shall not acquire any interest, direct or indirect, which would conflict or compromise in any manner of degree with the performance of its services hereunder. The County further covenants that in the performance of this agreement, the County shall periodically inquire of its officers, members and employees concerning such interests. Any such interests discovered shall be promptly presented in detail to the Department.

The Department may, by written notice to the County, terminate the right of the County to proceed under this agreement, if it is found by the Department that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the County, any employee, agent, or representative of the County under this paragraph.

H. LOSS OF KEY PERSONNEL

The County agrees to notify the Department immediately of the loss of personnel responsible for administering this contact.

I. SEVERABILITY

If any provision of this Contract is declared or found to be illegal, unenforceable, invalid or void, then both parties shall be relieved of all obligations arising under such provision. If such provision does not relate to payments or services to BadgerCare Plus members and if the remainder of this Contract shall not be affected then each provision not so affected shall be enforced to the fullest extent permitted by law.

J. FORCE MAJEURE

Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a

catastrophic occurrence or natural disaster, including but not limited to an act of war, and excluding labor disputes.

K. HEADINGS

The article and section headings used herein are for reference and convenience only and shall not affect its interpretation.

L. ASSIGNABILITY

Except as allowed under subcontracting, the Contract is not assignable by the County either in whole or in part, without the prior written consent of the Department.

M. RIGHT TO PUBLISH

The County must obtain prior written approval from the Department before publishing any material on subjects addressed by this Contract.

N. INTERPRETATIONS

When disputes arise, the Department has the right to final interpretation of the Contract. The County will abide by the interpretation of the Department.

O. CONTRACT ADMINISTRATION

1. The Department designates the Administrator of the Division of Medicaid Services (DMS) as the Contract Administrator. The Contract Administrator shall exercise all of the Department's rights under this Contract. The Deputy or Associate Administrator of the DMS shall serve as Deputy Contract Administrator. In the absence or unavailability of the DMS Administrator, the DMS Deputy or Associate Administrator shall act as Contract Administrator and shall exercise the powers and duties of the DMS Administrator.

2. With respect to the scope of work under this Contract and the contractor's performance thereof, the Contract Administrator will issue, from time to time, such written specifications and instructions as may be necessary for the contractor to carry out its obligations. The Contract Administrator will periodically evaluate the Contractor's performance improvements under this Contract. The Contractor shall promptly undertake such corrections as may be reasonably necessary to correct the problems and/or deficiencies identified in the Contract Administrator's periodic evaluations.

3. The Contract Administrator shall designate a DMS staff person as contract monitor. For the purposes of daily communications and the informal discussion of questions and problems, this contract monitor will serve as the principal contact person for the Contractor. The Contract Administrator may change the contract monitor at any time and may designate a deputy contract monitor and/or separate contract monitors and/or deputy contract monitors for different aspects of the scope of work.

P. MEDIA CONTACTS

The County agrees to forward to the Department all media contacts regarding BadgerCare Plus programs or members.

ARTICLE XIV

XIV. COUNTY SPECIFIC CONTRACT TERMS

1. COUNTY IN WHICH ENROLLMENT IS ACCEPTED: Dane.

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

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

IN WITNESS WHEREOF, the State of Wisconsin and Dane County have executed this agreement:

Signature from County	Signature from State
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM I

I. SUBCONTRACTS AND MEMORANDA OF UNDERSTANDING

1. The Department will review and approve the County's Subcontract(s).

   The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract, as it deems appropriate. The Department may consider such factors, as it deems appropriate to protect the interests of the state and members, including but not limited to the proposed subcontractor's past performance. DHS will give the County: (1) 120 days to implement a change that requires the County to find a new subcontractor, and (2) 60 days to implement any other change required by DHS. The DHS will acknowledge the approval or disapproval of a subcontract within 14 days after its receipt from the County.

   The Department will review and approve or disapprove each subcontract before contract signing. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Contract. The Department's subcontract review will assure that County has inserted the following standard language in subcontracts:

   Subcontractor(s) agrees to abide by all applicable provisions of County's Contract with the Department of Health Services, hereafter referred to as the County Contract. Subcontractor(s) compliance with County Contract specifically includes but is not limited to the following requirements:

   a. Subcontractor uses only ForwardHealth-enrolled providers for services that are covered by the County Contract. For services not covered under the BadgerCare Plus state plan, the County must have written standards established by the County and available for review.

   b. No terms of this subcontract are valid which terminate legal liability of the County.

   c. Subcontractor agrees to participate in and contribute required data to the County QAPI programs.

   d. Subcontractor agrees to abide by the terms of the County Contract for the timely provision of emergency and urgent care. Where applicable, subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the County.

e. Subcontractor agrees to submit encounter data in the format specified by the County, so the County can meet the Department specifications. The County will evaluate the credibility of data obtained from subcontracted vendors' external databases to ensure that any patient-reported information has been adequately verified.

f. Subcontractor agrees to comply with all non-discrimination requirements.

g. Subcontractor agrees to comply with all record retention requirements.

h. Subcontractor agrees to provide representatives of the County, as well as duly authorized agents or representatives of DHS and the federal Department of Health and Human Services, access to its premises and its Contract and/or medical records. Subcontractor agrees otherwise to preserve the full confidentiality of medical records.

i. Subcontractor agrees to the requirements for maintenance and transfer of medical records.

j. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered BadgerCare Plus benefits (e.g., COB recovery procedures that delay or prevent care).

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

l. Subcontractor agrees not to bill a BadgerCare Plus member for medically necessary BadgerCare Plus covered services covered under the County Contract and provided during the member's period of County enrollment, other than the allowable co-payment (unless the County opts to waive co-payments). Subcontractor also agrees not to bill members for any missed appointments while a member is eligible under the BadgerCare Plus Program. This provision will continue to be in effect even if the County becomes insolvent. However, if a member agrees in writing to pay for a non-BadgerCare Plus covered service, then the County or County subcontractor can bill.

m. Subcontractors must forward to the County medical records pursuant to grievances and appeals, within 15 working days of County's request. If the subcontractor does not meet the 15-day requirement, the subcontractor must explain why and indicate when the medical records will be provided.

n. The subcontractor holds the Department harmless for failure of the County to pay for covered services performed by the subcontractor pursuant to the subcontract.

o. Subcontractor agrees to abide by the terms of this Contract regarding appeals to the County and to the Department for County non-payment of service providers.

p. Subcontractor agrees to abide by the County's marketing/informing requirements. Subcontractor will forward to the County, for prior approval, all flyers, brochures, letters, notices, and pamphlets the subcontractor intends to distribute to its BadgerCare Plus members concerning its County affiliation, changes in affiliation, or relate directly to the BadgerCare Plus population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the County and the Department.

2. Review and Approval of New Subcontracts and Changes in Approved Subcontracts during the Contract Period.

   New subcontracts and changes in approved subcontracts shall be reviewed and approved by the Department before taking effect. This requirement will be considered met if the Department has not responded within 15 consecutive days of the date of departmental receipt of request.

   a. This review requirement applies to changes, which affect the amount, duration, scope, location, or quality of services. In other words, technical changes do not have to be approved.

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

   c. County must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice to each member whose primary mental health provider or gatekeeper terminates their contract with the County. The Department must approve the notifications before they are sent to members.

3. The County shall notify the Department within seven (7) days of any notice by the County to a subcontractor, or any notice to the County from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce BadgerCare Plus members' access to care.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies provided for in this Contract. These remedies include Contract termination (notice to the County and opportunity to correct are provided for) and suspension of new enrollment.

4. The County shall submit MOUs referred to in this Contract to the Department upon the Department's request.

5. The County shall submit to the Department copies of new MOUs, or changes in existing MOUs within 15 days of signing.

   The County shall not pay non-subcontracted providers more than BadgerCare Plus rates for services provided, unless the Department approves a higher level of payment based on County's justification of a higher level of payment for a proportionately higher level of services.

6. A managed care entity may not knowingly have a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities as a director, officer, partner, or a person with beneficial ownership of more than 5% of the entity's equity, or have an employment, consulting or other agreement for the provision of items and services that are significant and material to the entity's obligations under its Contract with the state.

ADDENDUM II

II. UTILIZATION AND ENCOUNTER REQUIREMENTS

The County must submit utilization data requested on the Quarterly Utilization Report (attached) on an annual basis in a computer readable format. The County must provide utilization data on services delivered to all members. Reports must be submitted to the Department according to the schedule listed in this Contract.

All County subcontracts with providers must have provisions for assuring that the data required on the County Utilization Report is reported to County by the subcontractor(s).

The Department agrees to involve the County in the planning process prior to implementing any changes in format and will request the County review and comment on format changes before they take effect.

The County is subject to the remedies for violation, breach or non-performance of the Contract, outlined in the Contract, for non-compliance with these data reporting requirements. Conditions which constitute non-compliance with the reporting requirements include the following: Failure to submit the Quarterly Utilization Report identified by the Department or its subcontractor; failure to meet the Department's County Utilization Report production schedule; and failure to provide all data requested through the County Utilization Report.

The County must specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting County utilization data, and the staff person that should be contacted in the event that the primary contact person is not available.

All data should be reported by the unit specified in the Quarterly Utilization Report. For auditing purposes, the County should retain data which will allow the Department to verify for any given member that the units of service reported matches the units of service documented in the member's record(s).

Quarterly Utilization Report

The County must provide the following utilization data for services provided in a 12-month period (State calendar year). Data is due January 1 of each year, for services provided during the first 3 months of the previous State calendar year (January 1 – March 31); April 1st for the second quarter (April 1 – June 30); July 1 for the third quarter (July 1 – September 30) and October 1 for the fourth quarter (October 1 – December 31).
*ICD-10 changes are effective for dates of service on or after October 1, 2015. Use ICD-9 for services provided in CY 2014 through September 30, 2015. Begin submitting quarterly utilization reports July 1, 2015.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
1	CCF or WM BadgerCare Plus ID Number	NUMERIC	RIGHT	ZERO	1	8	8	This is the BadgerCare Plus provider number for the plan. This field is required for each record. A blank field will cause the record to error. The plan will resubmit the corrected record.
2	Record Identification Number	ALPHA NUMERIC	LEFT	SPACE	9	38	30	This is the unique record identification number assigned by each plan. This field is required for each record. This number is used for tracking purposes on error reports. A blank field will cause the record to error. The plan will resubmit the corrected record.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
3	Member Identification Number	NUMERIC	RIGHT	ZERO	39	48	10	This is the member's ten-digit BadgerCare Plus identification number. This field is required for each record. Member must be BadgerCare Plus eligible to receive services on date of service. A blank field will cause the record to error. The plan will resubmit the corrected record.
4	Last Name	ALPHA	LEFT	SPACE	49	83	34	This is the last name of the person receiving services and is required for each record. If member name is listed, it must match the eligibility file.
5	First Name	ALPHA	LEFT	SPACE	84	108	24	This is the first name of the person receiving services and is required for each record. If member name is listed, it must match the eligibility file.
6	Middle Initial	ALPHA	LEFT	SPACE	109	110	1	This is the middle initial of the person receiving services and is an optional field. If member name is listed, it must match the eligibility file. Zero fill if not used.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
7	Gender	ALPHA	LEFT	SPACE	111	112	1	This is the gender of the person receiving services and is a required field. M = male and F = female.
8	Date of Birth	NUMERIC	RIGHT	ZERO	113	121	8	This is the date of birth of the person receiving services and is a required field. Use the date format mmddyyyy.
9	Race Primary	ALPHA	RIGHT	ZERO	122	123	1	This is the race field for the person receiving services, as determined by the member. It is a required field. A = Asian or Pacific Islander. All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. B =Black. All persons having origins in any of the Black racial groups of Africa. H =Hispanic. All persons of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race. I = Native American or Alaska Native. All persons having origins in any of the original peoples of North

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
								America and who maintain cultural identification through tribal association or community recognition. W = All persons having origins in any of the original peoples of Europe, North Africa or the Middle East. 7 = Not provided. E = Other.
10	Race Secondary	ALPHA	RIGHT	ZERO	124	125	1	This is the secondary race field for the person receiving services and is a supplemental field. Zero fill when not used. Use coding scheme from above.
11	Ethnicity	ALPHA	RIGHT	ZERO	126	127	1	This is the ethnicity of the person receiving services and is a required field. Zero fill when not used. Use the coding scheme: 1 = Hispanic or Latino; N = Non Hispanic or Latino; M = Ethnicity missing.
12	Procedure Code	ALPHA NUMERIC	LEFT	ZERO	128	135	7	This is the HCPCS code used to identify the service provided. Must use the HCPCS code identified on the WM/CCF/BadgerCare Plus Service Code Crosswalk List. This is a required field.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
13	Procedure Code Modifier	NUMERIC	RIGHT	ZERO	136	139	3	This is the three-digit HCPCS modifier code used to identify the service provided. Must use the HCPCS modifier code identified on the WM/CCF/BadgerCare Plus Service Code Crosswalk List. This is a required field.
14	Service From Date	NUMERIC	RIGHT	ZERO	140	148	8	This is the 8-digit date field used to identify services such as a procedure or a hospital admission date. Zero fill when not used. Use the mmddyyyy format.
15	Service To Date	NUMERIC	RIGHT	ZERO	149	157	8	This is the 8-digit date field used to identify a hospital discharge date. Zero fill when not used. Use the mmddyyyy format.
16	Number of Service Units	NUMERIC	RIGHT	ZERO	158	161	3	This is the number of units (e.g., days, visits, time increments) associated with the procedure code.
17	ICD-10-CM Diagnosis*	ALPHA NUMERIC	LEFT	ZERO	162	169	7	This field holds the first ICD-10 diagnosis code for which the service is provided. Use a seven-digit diagnosis coding scheme. Zero fill unused

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
								portion of field. This is a required field.*
18	ICD-10-CM Diagnosis*	ALPHA NUMERIC	LEFT	ZERO	170	177	7	This field holds the second ICD-10 diagnosis code for which the service is provided. Use a seven-digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.*
19	ICD-10-CM*	ALPHA NUMERIC	LEFT	ZERO	178	185	7	This field holds the third ICD-10 diagnosis code for which the service is provided. Use a seven-digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.*
20	ICD-10-CM*	ALPHA NUMERIC	LEFT	ZERO	186	193	7	This field holds the fourth ICD-10 diagnosis code for which the service is provided. Use a seven-digit diagnosis coding scheme. Zero fill unused portion of field. This is a required field.*
21	Contractor Service Code	ALPHA NUMERIC	LEFT	ZERO	194	199	5	This is the internal CCF or WM service code used to identify the service provided. This is an optional field.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
22	Paid Amount	NUMERIC	RIGHT	ZERO	200	208	8	This is the charge amount by service code. This is a required field. No decimal point is required.
23	Unit Cost	NUMERIC	RIGHT	ZERO	209	217	8	This is the unit cost by service code. This is a required field. No decimal point is required.
24	Performing Provider ID Number	NUMERIC	RIGHT	ZERO	218	228	10	This is the BadgerCare Plus provider identification number of the performing provider, when the service provided is a BadgerCare Plus covered service. Zero fill unused portion of the field. This is a required field.
25	Performing Provider Last Name, First Name	NUMERIC	RIGHT	ZERO	229	258	30	This is the last name, first name of the performing provider. Do not use title. Zero fill unused portion of the field. This is a required field.
26	Encounter Data Submission Date	NUMERIC	RIGHT	ZERO	259	266	8	This is the date encounter data was submitted to the BadgerCare Plus program. Use the mmddyyyy format.
27	Program Enrollment Date	NUMERIC	RIGHT	ZERO	267	275	8	This is the program enrollment date. Use the mmddyyyy format.

FIELD #	FIELD NAME	FORMAT	JUSTIFY	ZERO OR SPACE FILL	STARTING POSITION	ENDING POSITION	FIELD LENGTH	EDITS
28	Program Disenrollment Date	NUMERIC	RIGHT	ZERO	276	283	8	This is the program disenrollment date. Use the mmddyyyy format.

ADDENDUM III

III. PERFORMANCE IMPROVEMENT PROJECT OUTLINE

The design, implementation and reporting format for each performance improvement project should include consideration of each of the ten criteria listed below in order for the Department to evaluate the reliability and validity of the data and the conclusions described in the study. The following is a recommended guideline for completing a performance improvement project:

1. Select a Study Topic

    a. Is the topic important to the enrolled population?
    b. Does the topic affect a significant portion of the members and reflect a high-volume or high-risk condition of the population served?
    c. Can it be affected by the actions of the County?
    d. Was the process of the topic selection described?

2. Define a Study Question

    a. Was the method and procedure used to study the topic clear?
    b. Was the study question clearly stated and consistent throughout the study?
    c. Is the study question specific and answerable?

3. Select Study Indicators

    a. Were the indicators objective, clear, and unambiguously defined?
    b. Are the indicators based on current clinical knowledge or health services research? (Healthcare guidelines)
    c. Do the indicators objectively measure either member outcomes such as health or functional status, member satisfaction, or valid proxies of these outcomes?

4. Identify the Study Population

    a. Is there a clear definition of who to include in the study?
    b. Did the study define an “at risk” population?
    c. Was the entire population included or was a sample used?
    d. If the entire population was included, were all members captured by the data collection process used?

5. Utilize Sampling Methods (if applicable)

    a. Was a valid sample size calculated?
    b. Were valid sampling techniques used?

6. Data Collection

    a. Were the data described in detail?
    b. Were the data appropriate to answer the study question?
    c. Was the data collection process clearly described?
    d. Was the data collection process appropriate to answer the study question?
    e. Was interrater reliability adequate?
    f. Did the loss of data or subjects affect validity?
    g. Was the study time clear?
    h. Was member confidentiality protected?

7. Improvement Strategies/Interventions (Not applicable if the project is to establish a baseline only.)

    a. Were interventions related to causes/barriers identified through data analysis?
    b. Was the intervention fully described?
    c. Can the intervention be widely implemented?
    d. Was the implementation of the intervention monitored for effectiveness?

8. Results and Interpretation

    a. Was the data collected fully reported?
    b. Did the study include comparisons to give meaning to the results?
    c. Is the norm or standard expressed in a specific numerical manner?
    d. Is the goal, norm or standard appropriate to this population and study?
    e. Did the study appropriately use statistical testing? (x^2 t-test, regression analysis, etc.)?
    f. Were the conclusions consistent with the results?
    g. Were data tables, figures and graphs consistent with the text?
    h. Did the study consider its limitations?
    i. Did the study conclude or imply causality when the supporting data is only correlational?
    j. Did the study include how to improve the study?
    k. Did the study present recommendations on the results?
    l. Did the report clearly state whether performance improvement goals were met (if an intervention was carried out)? If the goals were not met, was there an analysis of why not and a plan for future action?

9. Real Improvement Achieved

    a. Was statistically significant improvement achieved?
    b. Does the improvement in performance appear to be due to the planned intervention?
    c. What if any additional questions did the study raise? What are the next steps, if any, to study this question/topic?

d. What will you do differently as a result of your study?

10. Sustained Improvement

    a. Was sustained improvement demonstrated through repeated measurements over comparable time periods?

ADDENDUM IV

IV. COORDINATION OF BENEFITS

STATE OF WISCONSIN
WISCONSIN BADGERCARE PLUS
COUNTY REPORT ON COORDINATION OF BENEFITS

Name of County _____ Mailing Address_____

Office Telephone _____ _____

Provider Number _____ _____

Please designate below the annual period for which information is given in this report.

_____, 20____ through _____, 20_____

INSTRUCTIONS

For the purposes of this report, a member is any BadgerCare Plus member listed on the monthly enrollment reports coming from the fiscal agent, and who is an ADD or CONTINUE.

Subrogation may include collections from auto, homeowners, or malpractice insurance, as well as restitution payments from the Division of Corrections. In addition, subrogation should include collections from Workers' Compensation.

Birth costs are not a third party right, and consequently are not included in this report.

Coordination of Benefits Reports are to be completed on a calendar year basis.

The report is to be for the entire County, aggregating all separate service areas if the County has more than one service area.

Please complete and return this report by May 15th for the previous year to:

Bureau of Children's Services,
Room 418
Attn: Children Come First Contract Monitor
Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

Attn: COB Report from _____County

COB Report

The following information is **REQUIRED** in order to comply with CMS reporting requirements:

Cost Avoidance

Indicate the dollar amount of the claims you denied as a result of your knowledge of other insurance being available for the member. The provider did not indicate at the time of the claim submission (with an EOB, etc.) that the other insurance was billed prior to submitting the claim to you. Therefore, you denied the claim. Please indicate the dollar amount of these denials.

Amount Cost Avoided: _____

(Including claims denied for third party liability.)

Recovery (Post-Pay Billing/Pay and Chase)

Indicate the dollar amount you recovered as a result of billing members' other insurance.

_____

Subrogation/Worker's Compensation _____

Recovery (Dollars) This Year: _____

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the County, except as noted on the report.

Signed: _____

Original Signature of Director or Administrator

Printed Name:

_____

Title: _____

Date Signed: _____

ADDENDUM V

V. COMPLIANCE AGREEMENT

THE COUNTY HEREBY AGREES THAT it will comply with the following:

1. The County agrees to comply with Public Law 103-227, also known as the Pro-Children Act of 1994, which prohibits tobacco-smoke in any portion of a facility owned, leased, or contracted for by an entity which receives federal funds, either directly or through the state, for the purpose of providing services to children under the age of 18.

2. The County shall implement and adhere to rules and regulations prescribed by the United States, Department of Labor and in accordance with 41 Code of Federal Regulations, Chapter 60.

3. The County shall comply with regulations of the United States Department of Labor recited in 20 Code of Federal Regulations, Part 741 and the Federal Rehabilitation Act of 1973. The County shall ensure compliance by any and all subcontractors engaged by Contractor under the Contract with said regulations.

Affirmative Action Plan/Civil Rights

1. The County assures that they have submitted to the Department Affirmative Action/Civil Rights Compliance Office a current copy of an Affirmative Action Plan and Civil Rights Compliance Action Plan for Meeting Equal Opportunity Requirements under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title VI and XVI of the Public Service Health Act, the Age Discrimination Act of 1975, the Omnibus Budget Reconciliation Act of 1981 and the Americans with Disabilities Act (ADA) of 1990, the Wisconsin Fair Employment Act, and any or all applicable federal and state nondiscrimination statutes as may be in effect during the term of this Contract. If an approved plan has been reviewed during the previous calendar year, a plan update must be submitted during this Contract period. The plan may cover a two (2) year period.

    a. No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise subject to discrimination in any manner on the basis of race, color, national origin, sexual orientation, religion, sex, disability or age. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities.

    b. No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subject to discrimination in employment in any manner or term of employment on the basis of age, race, religion, color, sex, national origin, or ancestry, handicap [as defined in Section 504 and the American With Disabilities

Act (ADA)], physical condition, developmental disability [as defined in s. 51.05(5) Wis. Stats.], arrest or conviction record [in keeping with s. 111.32 Wis. Stats.], sexual orientation, marital status, or military participation. All employees are expected to support goals and programmatic activities relating to nondiscrimination in employment.

2. The County shall post the Equal Opportunity Policy, the name of the Equal Opportunity Coordinator and the discrimination complaint process in conspicuous places available to applicants and clients of services, and applicants for employment and employees. The complaint process will be according to Department standards and made available in languages and formats understandable to applicants, clients and employees. The County will continue to provide appropriate translated state procedures, mandated brochures and forms for local distribution.

3. The County agrees to comply with guidelines in the Civil Rights Compliance Standards and a Resource Manual for Equal Opportunity in Service Delivery and Employment for the Wisconsin Department of Health Services, its Service Providers and their Subcontractors (2018-2021 Edition).

4. Requirements herein stated apply to any subcontracts. The County has primary responsibility to take constructive steps, as per the CRC Standards and Resource Manual, to ensure compliance of subcontractors. However, where the Department has a direct Contract with another community agency or vendor, the County need not obtain a Subcontractor Affirmative Action Plan and Civil Rights Compliance Action Plan or monitor that agency or vendor.

5. The Department will monitor the Civil Rights Compliance of the County and will conduct reviews to ensure that the County is ensuring compliance of its subcontractors in compliance with guidelines in the CRC Standards and Resource Manual. The County agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the County, as well as interviews with staff, clients, applicants for services, subcontractors and referral agencies.

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

Access to Agency

1. The County agrees to hire staff, contract with, or identify community individuals with special translation or sign language skills and/or provide staff with special translation or sign language skills training or find persons who are available within reasonable time and who can communicate with non-English speaking or hearing impaired members; train staff in human relations techniques, sensitivity to

persons with disabilities and sensitivity to cultural characteristics; and make programs and facilities accessible, as appropriate, through outstations, authorized representatives, adjusted work hours, ramps, doorways, elevators or ground floor rooms, and Braille, large print or taped information for the visually impaired. Informational materials will be posted and/or available in languages and formats appropriate to the needs of the member population.

2. The County shall ensure the establishment of safeguards to prevent employees, consultants or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business, or other ties as specified in Wis. Stats. 946.10 and 946.13.

3. The applicant gives assurance that it will immediately take any measures necessary to effectuate this agreement.

4. The applicant shall comply with Conflict of Interest (Section 946.10 and 946.13, Wis. Stats., and DHS Employee Guidelines DMB-Pers. 102-7/1/71).

ADDENDUM VI

VI. REPORTING REQUIREMENTS AND DUE DATES

WEEKLY REPORTS		
Provider Network	List of all providers in the PIHP network. Submit via the SFTP. (See the File Submission Specification Guide)	Article IV, KK
MONTHLY REPORTS		
Supplier Diversity Report	Send monthly reports regarding the PIHPs subcontract with DOA certified MBEs and DVBs	Article VII(I)
QUARTERLY REPORTS		
1ST QUARTER: (Jan-March); 2ND QUARTER: (April – June); 3RD QUARTER: (July – Sept); 4TH QUARTER: (Oct – Dec)		
Attestation Form	Send quarterly attestation form to the BRS. Due date schedule is: 1st Quarter – April 30 2nd Quarter – July 30 3rd Quarter – Oct 30 4th Quarter – Jan 30	Article IV, FF; Addendum XII
Encounter Data Coordination of Benefit Report	Send quarterly Coordination of Benefit reports to your BCS contract monitor, by password protected attached email. Due date is 45 days within end of quarter.	Article VII, D Use form in contract
Grievance & HMO Appeal Summary Report	Send quarterly summary grievance and appeal reports to BCS by password protected attached email. Report includes PHI. Due date is within 30 days of end of quarter.	Article VIII Use form in Grievance and Appeal Guide.
Utilization Data Report	Due dates: January 1st (Jan of previous year, July, Dec. of previous year) Jan 1, 2021 for Dates of Service (DOS) in January of 2020, March 152020 for DOS in July 0 Dec of 2020. The schedule would repeat until encounters are able to be submitted through the 837 process.	Article VII, D
ANNUAL REPORTS		
Member Communication and Education / Outreach Plan	Send to your BCS contract monitor via password protected email attachment. Marketing Plan due on second Friday of January.	Article IV, V
Performance Improvement Project (PIP) Final Project	Send to your BCS contract monitor and EQRO contact by password protected email attachment. Report due on the 1st business day of July for the prior calendar year.	Article IV, X
Annual Financial Report	Financial report for the previous calendar year to BRS by SFTP. Report is due on May 30.	Article VII, C
Initial Performance Improvement Project (PIP) aka PIP Proposal	Send to your BCS contract monitor and EQRO contact by password protected email attachment. Topic Selection on first business day of December for the next calendar year.	Article IV, X
QA/ Plan, QA Staff, QA Committee, etc.	Submit to DHS annually by April 1st.	Article IV, X
OTHER REPORTS		
Affirmative Action Plan	AA/CRC Office in the format specified on Vendor Net. Send to dhscontractcompliance@dhs.wisconsin.gov	Article IV, S

Submit every 3 years		
Civil Rights Compliance Letter of Assurance and Plan	AA/CRC Office in the format specified in Article IV, S. Send to AA/CRC Coordinator dhscontractcompliance@dhs.wisconsin.gov	Article IV, S
Encounter Data File in (837I, 837P, 837D) format.	Send to Fiscal agent on SFTP.	Article VII, D
Fraud, Waste and Abuse Investigations.	The PIHP must report allegations of fraud, waste, and abuse (both provider and member) to the Department within 15 days of the suspected activity coming to the attention of the PIHP. Submit on an as needed basis.	Article IV, GG
MOUs for Emergency Services	Report to DHS within 30 days after the award of contract.	Article IV, J
New Subcontracts/Changes in Approved Subcontracts or MOUs	Report to DHS 15 days prior to effective date.	Addendum I
Outcome Indicator Data	Report to DHS the previous calendar year by June 15.	Addendum VIII
Privacy and Security Incidents	Send information to your BCS contract monitor the same day an incident occurs. Submit on an as needed basis.	Article XI, A
CMS Drug Utilization Reports	PIHPs are required to submit timely responses to report and survey requests as required by federal and/or state law or program policy.	County PIHP Guide to Covered Services, Coding, and Reporting Guide

MAIL REPORTS TO: Bureau of Children's Services
Room 418
Attn: Children Come First Contract Monitor
Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

OR FAX REPORTS TO: (608) 266-1096

Or **VIA EMAIL** to the DHS Children's Come First contract monitor

ADDENDUM VII

VII. BADGERCARE PLUS-COVERED SERVICES PROVIDED BY COUNTY

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

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

- Adult Mental Health Day Treatment
- Certified Peer Specialist Services
- Child/Adolescent Day Treatment
    - Hospital services, which includes coverage of: The facility component of all inpatient admissions and outpatient visits to a psychiatric hospital
    - The facility component of inpatient admissions to an acute care hospital for behavioral health, as identified by the Diagnosis-Related Group (DRG) code assigned to the inpatient admission
    - The facility component of outpatient visits to an acute care hospital for behavioral health, as identified by a primary diagnosis code indicating a behavioral health diagnosis
    - The professional component of inpatient hospital admissions and outpatient hospital visits for behavioral health, as identified by a primary diagnosis code indicating a behavioral health diagnosis
- Intensive In-Home Mental Health and Substance Abuse for Children
- Outpatient Mental Health
- Psychosocial Rehabilitation Services, which includes coverage of:
    - Employment-Related Skill Training Services
    - Individual Skill Development and Enhancement Services
    - Peer Support Services
    - Physical Health Monitoring Services
    - Psychoeducation
    - Wellness Management and Recovery Services
- Substance Abuse Day Treatment
- Targeted Case Management

All other ForwardHealth covered services will be reimbursed by ForwardHealth to the provider for CCF-enrolled members on a fee-for-service basis.

ADDENDUM VIII

VIII. COMPLIANCE AGREEMENT ON EVALUATION

For the purpose of evaluating County and program performance, DHS and the County will use outcome indicators as one measure of quality.

COUNTY AND ITS SUBCONTRACTOR(S) HEREBY AGREES they will comply with the following:

> The County and its subcontractor(s) agree to participate with the Department in the evaluation of Children Come First. The County and its subcontractor(s) agree to provide information relating to cost, quality, and any other information collected under the terms of this Contract necessary for quality improvement activities, program monitoring and/evaluation.

The following indicators will be collected and reviewed:

Outcome Indicators

1. The County agrees to complete the Child Behavior Checklist Score (CBCL) tool as specified in the 2015-2020 contract, with a minimum assessment frequency of member intake and discharge, until a new tool is determined. The County must continue to collect and report outcome indicator information until the new tool is implemented.
2. The Department and the participating County PIHPs will implement a new outcome indicator tool at a delivery and reporting frequency to be determined, in the initial contract year.

ADDENDUM IX

IX. DEFINITION OF "SERIOUS EMOTIONAL DISTURBANCE" – ELIGIBILITY CRITERIA FOR CHILDREN COME FIRST

For the purpose of this Contract, the following definition will be used for a "serious emotional disturbance," "severe emotional disturbance," "severely emotionally disturbed," or "SED." Severe emotional disturbance in an individual under the age of 21 requires acute treatment and may lead to institutional care. The disability must show evidence of 1, 2, 3 and 4.

1. The disability must have persisted for six (6) months and be expected to persist for a year or longer.

2. A condition of severe emotional disturbance as defined by: A mental or emotional disturbance listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

   Adult diagnostic categories appropriate for children and adolescents are substance related disorders, schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, dissociative disorders, sexual and gender identity disorders, impulse-control disorders, adjustment disorders and personality disorders. Disorders usually first evident in infancy, childhood and adolescence including pervasive developmental disorders, attention deficit and disruptive behavior disorders, tic disorders, stereotypic movement disorders, feeding and eating disorders, separation anxiety disorders, selective mutism and reactive attachment disorder.

3. The individual is receiving services from two (2) or more of the following service systems: Mental health, social services, child protective services, juvenile justice, or special education.

ADDENDUM X

X. MEMBER GRIEVANCE AND APPEAL REPORTING

The Member Grievance and Appeal report template can be found in Section 12.3 of the *Member Grievances and Appeals Guide*.

ADDENDUM XI

XI. SCHOOL-BASED SERVICES (SBS) MOU

The County must sign a MOU with all School-Based Services (SBS) providers in the County's service area who are ForwardHealth-enrolled. The MOU will be effective on the date when both the County and the SBS provider have signed it or when the SBS provider is ForwardHealth-enrolled, whichever is later.

Refer to the sample SBS MOU following this page**.**

MODEL MEMORANDUM OF UNDERSTANDING
BETWEEN COUNTY
AND
SCHOOL DISTRICT OR CESA BADGERCARE PLUS
CERTIFIED FOR THE SCHOOL BASED SERVICES BENEFIT

School-based services (SBS) are a benefit paid FFS by Wisconsin BadgerCare Plus for all school-enrolled members, including those enrolled in the County. The SBS provider is responsible for services provided in the schools such as occupational/physical/speech therapies, private duty or home care individualized nursing services, mental health services, testing services, school Individual Education Plan (IEP) services, and Individualized Family Service Program (IFSP) services. The County is responsible for providing and managing medically necessary services outside of school settings. However, the schools cannot provide services in some situations, such as after school hours, during school vacations, and during the summer. Therefore, avoidance of duplication of services and promotion of continuity of care for BadgerCare Plus County members requires cooperation, coordination and communication between the County and the SBS provider.

The County and the SBS provider agree to facilitate effective communication between agencies, work to resolve inter-agency coordination and communication problems, and inform staff from both the County and the SBS provider about the policies and procedures for this cooperation, coordination and communication. Recognizing that these "members-in-common" could receive duplicate services and could suffer from problems in continuity of care (e.g., when the school year ends in the middle of a series of treatments), the County and the SBS provider agree to cooperate in communicating information about the provision of services and in coordinating care.

This agreement becomes effective on the date when the SBS provider is certified by Wisconsin BadgerCare Plus or when both the County and the SBS provider have signed it, whichever is later. It may be terminated in writing with two weeks' notice by either signer. The SBS provider is the School District.

County	SBS Provider
Name of County	Name of SBS Provider
Authorizing Signature	Authorizing Signature
Printed Name	Printed Name
Title	Title

Date	Date

ADDENDUM XII

XII. ATTESTATION FORM

I, _____, have reviewed the following data:
(Name and Title)

☐ Encounter Data for (quarter)___(year) 20___.

☐ PIHP Network Submission (submitted monthly) for (quarter)___(year) 20___.

___

☐ Other _____ (Specify Report)

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Print Date)

ADDENDUM XIII

ELIGIBILITY CRITERIA FOR CHILDREN COME FIRST

The following information is completed by the County on each child referred to CCF and submitted to the service provider agency.

Child's Name:_____ D.O.B.:_____ Date of Referral:_____

BC+ Eligible: ___ Yes ___ No MA #_____ Member Number_____

Referral Source: (circle one)

1. Agency 2. County 3. Crisis 4. Parent 5. Court

Referral Type: (circle one)

1. Hospital Diversion
2. Return from CCI
3. Corrections Diversion
4. CCI Diversion

The child/youth must meet all five (5) of the following conditions:

1. Under 19 years of age.

2. DSM-IV diagnosis (from diagnostic categories identified in DHS 107.32, Wis. Adm. Code) by a psychiatrist or psychologist. Condition has persisted for six (6) months and expected to persist for a year or longer.

   Diagnosis:_____

   Given by Whom:_____

3. Current emotional/behavioral problems putting child at imminent risk of a residential treatment, hospital, institutional, or corrections placement as determined by the enrollment process or the Emergency Services Unit at the Mental Health Center of Dane County. (Circle all that apply.)

   a. Recent suicide attempt.
   b. Report from reliable source of suicidal thinking, threatening or planning.
   c. Acts of self-destructive behavior.
   d. Use of and apparent lack of response to outpatient therapy.
   e. Documented assaultive behavior not connected with criminal intent.
   f. Expected assaultive behavior with or without criminal intent due to emotional disturbance as reported by a reliable source.
   g. Destructive acts without criminal intent.

h. Destructive thoughts with history of acts and/or evidence of diminished capacity for self-restraint.
i. Judgment is markedly impaired and not showing signs of improvement.
j. Other specific mental health-related symptoms requiring intensive, skilled observation for evaluation, diagnosis or treatment, high behavioral control or comprehensive evaluation for accurate diagnosis or worsening of symptoms despite compliance with other forms of mental health treatment. Specify:_____
_____

For all items circled above document the following:

Item	Date(s)	Source	Severity (describe)

4. Involvement with two (2) or more of the following systems. Check all systems involved and give from and to dates of involvement.

System	Period of Involvement	Services from this System
___Mental health services	_____	_____
___Social services	_____	_____
___Special education	_____	_____
___Child protective services	_____	_____
___Juvenile justice system (court)	_____	_____

5. The child/youth must have functional impairment in two (2) of the following capacities (compared with expected developmental level). Please specify.

Functioning in self-care:

Functioning in community:

Functioning in social relationships:

Functioning in the family:

Functioning in school/work:

Other comments:

_____

Name of person initiating this form for referral to CCF Date