435500-G23-ChildrenCC-00

SFY23

CONTRACT FOR SERVICES

Between

Department of Health Services

and

Dane County

July 1, 2022 – June 30, 2023

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Between Department of Health Services and Dane County

THIS CONTRACT is made and entered into for the period of July 1, 2022, through June 30, 2023, 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 Medicaid members enrolled in the County's Prepaid Inpatient Health Plan (PIHP) also known as Children Come First and here on out referred to as the County PIHP.

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:

ARTICLE I

I. Definitions

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to Medicaid, in reimbursement for services that 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 PIHP 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 PIHP to act within the standard resolution timeframes for grievances and appeals as detailed in the *Member Grievances and Appeals Guide*.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

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

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

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

Capitation Payment: A payment the State agency makes periodically to a contractor on behalf of each member enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State Plan. The State agency makes the payment regardless of whether the particular member receives services during the period covered by the payment.

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 PIHP, with the purpose of marketing.

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

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

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

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 PIHP 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.

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

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 PIHP to make an authorization decision. The member or authorized representative may file a grievance either orally or in writing.

Grievance and Appeal System: The processes the 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 their 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 PIHP to a Medicaid member who is not enrolled, that can reasonably be interpreted as intended to influence that member to enroll in the County PIHP.

Marketing Materials: Materials that are produced in any medium, by or on behalf of the County PIHP, 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.

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

Member: An individual who has been verified as Medicaid eligible, is enrolled in Medicaid, and 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 PIHP 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 PIHP 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 PIHP does not have a contract with to provide services to a member of the plan.

Other Sector Staff: Other Sector Staff references various workers from other sectors (e.g., county child welfare agencies, primary care providers, etc.) who are invested in the member's care.

Participating Provider: Facility or provider the County PIHP 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 PIHP 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.

Prepaid Inpatient Health Plan (PIHP): A managed care entity that provides services to members under contract with the State, and on the basis of capitation payments.

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 PIHP has contracted with to provide medical care to its members. These providers are “network providers,” “in-network providers” or “participating providers”. A provider that has not contracted with the plan is called an “out-of-network provider” or “non-participating provider.”

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

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 PIHP 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 PIHP.

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 PIHP'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 an adverse benefit determination.

Subcontract: Any written agreement between the County PIHP 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.

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

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

MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MY	Measurement Year
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limits
NTS	Narcotic Treatment Services
OBMH	Obstetric Medical Home
OCI	Office of the Commissioner of Insurance
OIG	Office of the Inspector General
ONC	Office of National Coordinator
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PE	Pulmonary Embolism
PHI	Protected Health Information
PIHP	PrePaid Inpatient Health Plan
PIP	Performance Improvement Project
PNCC	Prenatal Care Coordination
PPACA	Patient Protection Affordable Care Act
PPR	Potentially Preventable Readmissions
P4P	Pay for Performance
QAPI	Quality Assessment Performance Improvement
RHC	Rural Health Center
SBS	School Based Services
SCHIP	State Children’s Health Insurance Program
SFTP	Secure File Transfer Protocol
SIU	Special Investigations Unit
SMV	Specialized Medical Vehicles
SSA	Social Security Administration
SSI	Supplemental Security Income
TCM	Targeted Case Management
TCOC	Total Cost of Care
TMSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
UM	Utilization Management
URAC	Utilization Review Accreditation Commission

VFC	Vaccines for Children
WCAG	Web Content Accessibility Guidelines
WIC	Women, Infant, and Children
WICT	Wisconsin Interdisciplinary Care Team
WIR	Wisconsin Immunization Registry
WISHIN	Wisconsin Statewide Health Information Network

Article II

II. Enrollment and Disenrollment

A. Covered Population

1. RESIDENCY----The child/adolescent is a legal resident of Dane County.

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

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

4. IMMINENT RISK OF PLACEMENT----Eligible children and youth 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.

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

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

7. NON-RESIDENTIAL CARE CENTER---Eligible children and youth shall not be residing in a Residential Care Center at the time of enrollment.

B. Eligibility Determination

1. Referral

A referral can originate from County social workers, parents, other agency staff or Emergency Services Unit staff, schools or community-based providers.

2. Eligibility Determination

a. Within 5 business days of receiving the referral, the County shall:

i. Confirm key eligibility criteria are met:

1. Age;
2. Residency;
3. Involvement in at least 2 systems of care; and
4. WI Medicaid eligible.

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

iii. Determine the child/youth has a severe emotional disturbance (SED) either through previous documentation or a screen (see Addendum VII).

iv. Refer for a comprehensive assessment and possible County PIHP enrollment.

b. The County PIHP makes final determination of the most appropriate service delivery, including County PIHP enrollment, to send to the Department's Medicaid Fiscal Agent.

c. The County PIHP faxes enrollment forms to the State Medicaid Fiscal Agent.

C. Enrollment

1. Enrollment Process

a. Once the Department's Medicaid Fiscal Agent receives the enrollment form from the County PIHP, they will verify that youth identified on the enrollment requests are:

i. Medicaid eligible, if all other enrollment eligibility requirements are met.

ii. Under 19 years of age.

iii. Not currently residing in a psychiatric hospital, nursing facility, or residential care center.

iv. Residents of Dane County.

v. Verified during on-site medical record review conducted by the Department, that the individuals enrolled in the County PIHP meet the definition of severely emotionally disturbed.

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

b. The Department's Medicaid Fiscal Agent will have 5 working days to process County PIHP enrollment to final disposition. Final disposition means that:

i. County PIHP enrollment is approved and updates are applied to the member eligibility segment; or

ii. County PIHP enrollment is denied and the County PIHP is notified, who then notifies the family and informs them of their right to appeal.

c. If determined eligible, the Medicaid Fiscal Agent enrolls the Member effective on the date the enrollment form is received.

d. The County PIHP shall accept as enrolled all person who appear as members on the County PIHP Enrollment Reports.

e. Services can begin immediately.

2. Enrollment Rosters

The Department will promptly notify the County PIHP of all members enrolled in the County PIHP under this contract. Notification will be effected through the County PIHP Enrollment Rosters. These rosters shall available through electronic file transfer capability and will include medical status codes.

For each month of coverage through the term of the contract, the Department will transmit "County PIHP Enrollment Rosters" to the County PIHP. These rosters will provide the County PIHP with ongoing information about its members and disenrollees and will be used as the basis for the monthly capitation claim payments to the County PIHP.

a. The County PIHP Rosters will be generated in the following sequence:

i. The Initial County PIHP Enrollment Rosters will list all of the County PIHP's members and disenrollees for the enrollment month that are known on the date of roster generation. The Initial County PIHP Enrollment Rosters will be available to the County PIHP on or about the twenty first of each month. A capitation claim shall be generated for each member listed as an ADD or CONTINUE on this roster. Members who appear as PENDING on the Initial Roster and are reinstated into the PIHP by the last business day of the month will appear as a CONTINUE on the Final Roster and a capitation claim will be generated at that time.

ii. The final County PIHP Enrollment Roster will list all of the County PIHP's members for the enrollment month, who were not included in the Initial County PIHP Enrollment Roster. The Final County PIHP Enrollment Roster will be available to the County PIHP by the first day of the capitation month. A capitation claim will be generated for every member listed as an ADD or CONTINUE on this roster. Members in PENDING STATUS will not be included on the final roster.

b. The Department will provide the County PIHP with effective dates for medical status code changes, county changes and other address changes in each enrollment roster to the extent that the income maintenance agency report these to the Department.

3. Enrollment Policy

a. Enrollment can be any day of the month. If the member is enrolled in a BadgerCare Plus HMO, the Medicaid Fiscal Agent will enroll the member with start date effective the date the enrollment request was received.

b. If the member is enrolled in BadgerCare Plus HMO, the Medicaid Fiscal Agent will automatically disenroll the member from the BadgerCare Plus HMO. The member will receive all non-County PIHP provided Medicaid services on a fee-for-service basis.

c. The County PIHP must permit the Department to monitor its enrollment and disenrollment practices under this Contract. The County PIHP will not discriminate in enrollment/disenrollment activities between individuals on the basis of health status or requirements for health care services

d. Enrollment in the County PIHP shall be voluntary by the member.

e. The County PIHP shall accept referrals of eligible children and adolescents at any time during the time this agreement is in effect.

f. The County PIHP will accept members in the order in which they apply without restriction, except as otherwise noted herein. The County PIHP will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability. [42 CFR 438.3(d)(4)]

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h. The County PIHP shall not obtain enrollment through the offer of any compensation, 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.

4. Enrollment Errors

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

5. Enrollment Levels

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

6. Pre-Existing Conditions

The County PIHP 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.

7. Hospitalization at the time of Enrollment or Disenrollment

a. The County PIHP 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 Medicaid covered services on a fee-for-service basis.

The County PIHP 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.

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

c. 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.

D. Disenrollment

1. Process

The County PIHP 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 PIHP enrollment are appropriately disenrolled according to Department policy.

2. Voluntary Disenrollment

All members shall have the right to disenroll from the County PIHP pursuant to 42 CFR §438.56(b)(1), if the member feels they can no longer abide by the service plan and they have exhausted all available options provided by the County PIHP. 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 PIHP shall promptly forward to the Department or its designee all oral or written requests from members for disenrollment.

3. System Based Disenrollments

Disenrollments happen automatically based on changes to the member's eligibility.

a. Loss of Medicaid Eligibility

If a member loses Medicaid eligibility or dies, the member shall be disenrolled. The date of disenrollment shall be the date of Medicaid eligibility or the date of death.

No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

b. Out-of-Service Area Disenrollment

The member moved to a location that is outside the County PIHP's service area. The date of disenrollment shall be the date the move occurred, even if this requires retroactive disenrollment. No recoupments will be made to the capitation payment to reflect a mid-month disenrollment, but any capitation payment(s) made for months subsequent to the disenrollment month will be recouped.

c. Inmates of a Public Institution

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

d. Member is 19 years old or older.

e. Member enrolls in another Medicaid program.

4. Involuntary Disenrollments

The County PIHP 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 PIHP 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 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 the County PIHP 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.

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

5. Change in Member Circumstances

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

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

b. The death of an enrollee.

E. Appeal of Denial of Enrollment in the County PIHP

The County PIHP will maintain and operate an appeal procedure that includes the right to a fair hearing when the County PIHP denies enrollment. 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 their right to request first an appeal to the County PIHP, 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 in the DMS with the name, email 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 PIHP requires to consider the appeal and that are consistent with County PIHP's appeal procedure. The procedure must comply with the required timeframes in the *Member Grievances and Appeals Guide*.

6. Notification of the County PIHP decision to the DMS.

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

Article III

III. County PIHP Care Management

A. General Requirements

The County PIHP must have systems in place to ensure well-managed member care that promotes coordination and collaboration across multiple sectors and between the individuals instrumental to the member's success in the community.

1. Information Sharing for New Members

   County PIHPs 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, and upcoming non-emergency medical transportation trips. (Pursuant to 42 CFR § 438.208(b)(4)).

2. Screening Requirements

   Pursuant to 42 CFR § 438.208(b)(3), the County PIHP must make a best effort to conduct an initial screening of each member's needs, within 90 days of County PIHP enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. New members include those that were previously enrolled in the County PIHP but re-enroll in the County PIHP at least six months after their last disenrollment.

3. The County PIHP must assign a lead to:

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

   b. Establish effective lines of communication between the County PIHP, health care providers, and other sector staff.

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

      2) Communication plans must be shared with providers and other staff as indicated.

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

d. Provide psychoeducation to service providers and other sector staff, parents/legal guardians, and other relevant care team members on issues relevant to the services members receive through the County PIHP.

e. Assist other sector staff in providing ongoing training for providers on children with severe emotional disturbances.

f. Address access issues and concerns related to the County PIHP.

4. The County PIHP must have a process to assign a care coordinator to each member at the time of their enrollment, including a defined method to notify the member of their care coordinator and how to contact the provider. The care coordinator serves within a larger care coordination team, who oversees the member's care. The County PIHP must ensure that:

    a. Care coordinators have trauma-informed care training and experience working with children with significant behavioral health challenges.

    b. Care coordinators are allowed adequate time to effectively coordinate the delivery of integrated care.

        The County PIHP must have strategies in place to monitor workload. The care coordinator must be allowed adequate time to effectively coordinate the care of each member on their caseload. In developing case load standards, the PIHP should consider the following:

            1) Workload—the complexity of cases.

            2) The need for care coordinators to coordinate and collaborate with other sector staff.

            3) The need for face-to-face contacts with the child and family treatment team.

            4) Management duties, which include,

                a. Time to gather and ensure all relevant history and ongoing issues is given to service providers in a timely manner.

b. The need to provide necessary documentation timely to other sectors for time sensitive proceedings, such as court or other related meetings.

c. Time to adequately document case management activities.

5. The County PIHP must establish a process that maximizes the ability for the care coordinator to be informed of the results of assessments, evaluations, screenings, etc. that would necessitate an update or review of the member's care plan.

6. The County PIHP must have procedures to ensure that each member has an individualized care plan in place with 30 days of enrollment.

7. The County PIHP must assure a crisis plan is included in the plan of care for emergency situations, including a review of the document and directives within the plan to help assure that members and providers know where and how to obtain necessary care in emergency situations.

8. The County PIHP must have a process for prioritizing the care management needs of each member.

9. The County PIHP must establish protocols to assess each member's care management needs both at initial enrollment and as the member's needs change over time.

10. The County PIHP must have policies and procedures in place to ensure that, to the extent feasible, transitional care planning is included in the care planning.

11. The County PIHP must information technology to improve communication within and across sectors and to reduce fragmentation in the delivery of services to the member.

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

B. Duties of Care Coordinators

1. The primary goal of the care coordinator is to collaborate with the member's care team to develop and implement a comprehensive service plan of care that ensures integration of needs across sectors.

   The role of the care coordinator can be characterized as a problem-solving process

that involves four essential steps:

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

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

a. Assessing the member and family's strengths and needs for the purpose of informing the development of the comprehensive care plan. Other sector team members will be essential partners in this activity.

b. Establishing a plan for ongoing and timely communication with the member's service providers.

c. Collaborating and coordinating across the member's treatment team (workers from other sectors, family and other supportive adults. Etc.) to schedule, as necessary and appropriate, face-to-face visits to introduce care team members, review program benefits, and obtain current behavioral health information using a validated screening tool.

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

e. Ensuring that information is transferred to a new primary care provider when a member is transferred to a new service provider, care setting, or any other changes that may potentially interrupt the member's services.

f. Arranging and facilitating the provision of all County PIHP services and coordination with services provided through Medicaid Fee-for-Service, community and social support providers, as well as by any other systems and programs.

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

h. Holding meetings as needed with the member's care team and others involved in the delivery of services to the member to monitor and evaluate progress/success.

i. Maintaining documentation of all County PIHP services delivered to each member.

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

k. Making members aware of written information.

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

C. Information Gathering (Assessment)

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

    a. The need for immediate appointment scheduling and referrals.

    b. The need for medication management.

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

    d. The need for stabilization services.

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

    a. Obtain information related to member's behavioral health history.

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

    c. Review the recommendations from relevant assessments across sectors. This includes, but is not limited to:
        1. Individualized Educational Plans, when appropriate.
        2. Child welfare assessments.

d. Obtain input from providers across sectors and determine if there are specific, court-ordered services that need to be identified in the member's comprehensive care plan.

e. Obtain input from providers across sectors to determine the need for additional referrals, diagnostic, or treatment services.

D. Comprehensive Care Plan—Requirements

The Care coordinator must ensure that each member has a comprehensive care plan that is based on information collected during the information gathering process. The initial care plan must be developed within the first 30 days of the member's enrollment in the County PIHP.

In developing the comprehensive care plan, the member's care coordinator will do the following:

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

   A member-centric plan addresses the unique needs and suppots of the member, recognizing the need for an enhanced schedule for County PIHP covered care, as necessary; assuring continuity of care; and flexibility on location of services, prioritizing those provided in the community.

   A comprehensive care plan include the following, at a minimum:

   a. Relevant diagnoses.

   b. Current and relevant medications.

   c. The names and contacts of all individuals who are instrumental to the child's care and treatment, including, but not limited to, the member's legal guardians and care providers and workers from other sectors (educational, child welfare, justice system, etc.).

   d. Intended providers and treatment actions.

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

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

g. The tracking and timely follow up on referrals.

h. Short and long-term treatment goals identified in collaboration with the member.

i. Self-identified, measurable program completion criteria.

j. Barriers to care.

k. An individualized crisis/action.

l. Transitions between inpatient and outpatient settings, including home care. The transition plan must address the need for the warm handoff between settings, especially after an inpatient for behavioral stay.

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

2. Identify primary participants in the development and periodic reviews of the comprehensive care plan, including the child and family treatment team.

   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. Treatment team members should be chosen by the child and parent (or guardian or primary care giver, whichever is applicable). The members of the treatment team shall be documented in the case record and any change of a treatment team member shall be recorded. Child and/or family can request a change of any treatment team member, including the care coordinator, without negative consequences. Following the request for change of a treatment team member the County PIHP must notify the child and family of their rights to file a grievance. The ability for a family to request a change of treatment team members without reproach should be detailed in the grievances and appeals procedures written in the family handbook.

   Participation of all the sectors that are involved in the member's welfare will be key in eliminating duplication; mitigating caregiver confusion regarding the member's treatment plan; and paramount to ensuring full coordination and integration of the member's needs.

3. Obtain input from the following:

   a. The member;

b. The member's parent/legal guardian;

c. The member's care giver, if different from the parent/legal guardian; and

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

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

4. Collaborate with the broader care team to prioritize the services necessary to address or further assess the child's needs across sectors.

5. Collaborate with the broader care team to establish specific communication plans for each child.

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

7. Assure that each plan of care will be reviewed and signed by a licensed psychiatrist or psychologist, parent or guardian, member and other team members, to the best of the County PIHP's ability. 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. 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.

8. The County PIHP should not prioritize contracted providers over appropriate services for the member. 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.

E. Ongoing Monitoring

Ongoing monitoring includes all activities related to implementing and maintaining the member's care plan. The member's assigned care coordinator is responsible for all ongoing monitoring activities.

1. Ongoing monitoring includes:

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

comprehensive care plan.

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

   The care plan must be reviewed and updated after a change in placement setting.

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

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

e. Communicating with individuals instrumental to the member's care and support across sectors.

f. The care coordinator must periodically review the member's care plan in collaboration with members of the treatment team, across sectors, and the member's parent/legal guardian/caregiver. The case record will be updated to document the issues discussed, actions to be taken or conclusion reached, and members attending of these meetings.

g. Plan must be reviewed and updated as indicated, but at least every three months.

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

F. Transitional Care Planning

The Care coordinator must engage in transitional health care planning prior to the child leaving the County PIHP. The transitional planning must be developed with input from the child, primary caregiver/legal guardian, service providers, and all other treatment team members across the sectors as appropriate.

G. 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 PIHP.

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

Article IV

IV. Services

A. County PIHP Covered Services

The County PIHP must provide covered services to the extent outlined below, but is not restricted to only providing covered services. Sometimes the County PIHP may find that other treatment methods may be more appropriate than the County PIHP covered services, or result in better outcomes. A County PIHP may cover services for a member that are in addition to those services covered under the state plan and Behavioral Health in nature. In lieu of services can be covered by County PIHPs on a voluntary basis as follows: The Department determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan; the member is not required by the County PIHP to use the alternative service or setting; the approved in lieu of services are identified in the County PIHP contract and will be provided at the option of the County PIHP; and the utilization and cost of in lieu of services is taken into account in developing the component of the capitation rates that represent the covered state plan services.

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

The County PIHP 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.

The County 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. Covered Services

The County PIHP provides coverage of certain Medicaid services related to mental health and substance use disorder.

1. Medicaid Services that are in scope for the County PIHP must:

    a. Be determined by the child and family treatment team through the process of evaluation and case planning to be necessary for the treatment and rehabilitation of the member to facilitate the maximum reduction of the member’s disability and to restore the member to his or her best possible functional level.

b. Be identified on the member's treatment plan, which must indicate the measurable goal to be achieved through provision of the service and the provider(s) who will administer the service.

c. Be provided by Medicaid-enrolled providers. The provider must be enrolled under a provider type that is allowable for the provided service per ForwardHealth policy.

d. Meet the requirements for Medicaid covered services as described in the Medicaid State Plan, the applicable service areas of the ForwardHealth Online Handbooks, ForwardHealth publications, and Wisconsin Administrative Code. Note: Any limitations or requirements described in these sources regarding place of service, amounts of service, collateral contacts, or prior authorization are not applicable to the County PIHP.

e. Meet the terms and conditions of the Contract for Services between the Wisconsin Department of Health Services and the County for the operation of the County PIHP.

2. Covered Services

a. **Adult Mental Health Day Treatment.** The specific billing codes that represent this service area are listed on the Service Code Table. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service area titled "Adult Mental Health Day Treatment".

b. **Child/Adolescent Day Treatment.** The specific billing codes that represent this service area are listed on the Service Code Table. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service area titled "Child/Adolescent Day Treatment, HealthCheck 'Other Services'".

c. **Hospital Services**. This service area includes coverage of:

i. The facility component of all inpatient admissions and outpatient visits to a psychiatric hospital. Billing codes that represent the facility component of inpatient admissions and outpatient visits to a psychiatric hospital are not listed on the Service Code Table because all such services are in scope of County PIHP.

ii. 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 specific DRG codes that represent the facility component of behavioral health admissions are listed on the Service Code Table.

iii. 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. Billing codes that represent the facility component of outpatient visits to an acute care hospital for behavioral health are not listed on the Service Code Table because all such services are in scope of the County PIHP.

iv. 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. The specific billing codes that represent these services are listed on the Service Code Table.

d. **Intensive In-Home Mental Health and Substance Abuse for Children.** The specific billing codes that represent this service area are listed on the Service Code Table. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service area titled "In-Home Mental Health/Substance Abuse Treatment Services for Children, HealthCheck 'Other Services'".

e. **Narcotic Treatment Services (NTS).** The specific billing codes that represent this service area are listed on the Service Code Table. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service area titled "Narcotic Treatment".

f. **Outpatient Mental Health and Substance Abuse.** The specific billing codes that represent this service area are listed on the Service Code Table. For purposes of the County PIHP, this service area also includes Evaluation and Management (E/M) procedure codes, as identified on the Service Code Table, that may be billed by certain providers in conjunction with certain psychotherapy procedure codes per national coding guidelines. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service areas titled "Outpatient Mental Health" and "Outpatient Substance Abuse".

g. **Psychosocial Rehabilitation Services.** This service area includes coverage of:

i. Employment-Related Skill Training Services
ii. Individual Skill Development and Enhancement Services
iii. Peer Support Services
iv. Physical Health Monitoring Services
v. Psychoeducation
vi. Wellness Management and Recovery Services

The specific billing codes that represent this service area are listed on the Service Code Table. The descriptions of the above psychosocial rehabilitation services and the allowable provider types for each service are listed in Topic #17137 of the ForwardHealth Online Handbook.

h. **Substance Abuse Day Treatment.** The specific billing codes that represent this service area are listed on the Service Code Table. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service area titled "Substance Abuse Day Treatment".

i. **Targeted Case Management.** The specific billing codes that represent this service area are listed on the Service Code Table. Additional policy information for this service area can be found in the ForwardHealth Online Handbook under the service area titled "Case Management, Targeted".

3. Provider travel time and documentation time are typically not separately billable under the Wisconsin Medicaid program. The County PIHP should refer to the ForwardHealth Online Handbook for the applicable service area to determine specific Medicaid policy for provider travel time and documentation time. If the applicable ForwardHealth Online Handbook does not address provider travel time and/or documentation, time, the County PIHP should refer to national coding standards for the applicable service code.

4. Medical Necessity

   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 PIHP must provide assessment and evaluation services ordered by a court. The County PIHP 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 PIHP and members about medical necessity and appropriateness can be appealed through the County PIHP 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*.

5. Telehealth

   The PIHP must develop policies and procedures that are consistent with ForwardHealth policies and Wisconsin Statute (Wis. Stat. § 49.45(61)). The PIHP may not impose additional restrictions for telehealth services that are not similarly required for in person services and must offer members like services in physical locations in addition to telehealth services.

C. Medicaid Services Covered on a Fee-for-Service Basis

   All other Medicaid services will be reimbursed by ForwardHealth to the provider for County PIHP members on a fee-for-service basis, including, but not limited:

   1. **Non-Emergency Medical Transportation (NEMT):** Member travel to and from in-scope services, even if provided by PIHP staff, is not in scope for the County PIHP but is rather available through the non-emergency medical transportation manager.

   2. **Behavioral Treatment (BT):** The definition of BT services, and the specific billing codes that represent BT services, are included in the ForwardHealth Online Handbook under the service area titled “Behavioral Treatment Services”. Any service that meets the definition of BT, as defined in the ForwardHealth Online Handbook, is not in scope of County PIHP and is instead covered for County PIHP members on a fee-for-service basis.

3. **Crisis Intervention (CI):** The definition of CI services, and the specific billing codes that represent CI services, are included in the ForwardHealth Online Handbook under the service area titled "Crisis Intervention". Any service that meets the definition of CI services, as defined in the ForwardHealth Online Handbook, is not in scope of County PIHP and is instead covered for County PIHP members on a fee-for-service basis.

4. **Pharmacy:** Pharmacy services, including provider-administered drugs as listed in the ForwardHealth Online Handbook, are not in scope of County PIHP and are instead covered for County PIHP members on a fee-for-service basis.

5. **Residential Substance Use Disorder (RSUD) Treatment:** The definition of RSUD Treatment, and the specific billing codes that represent RSUD Treatment, are included in the ForwardHealth Online Handbook under the service area titled "Residential Substance Use Disorder Treatment". Any service that meets the definition of RSUD Treatment, as defined in the ForwardHealth Online Handbook, is not in scope of County PIHP and is instead covered for County PIHP members on a fee-for-service basis.

D. Emergency and Post Stabilization Services

1. Definition of Emergency Services

For the entirety of this section, emergency, stabilization, and/or post-stabilization services only pertain to those that are related to behavioral health (i.e., the encounter submissions have a primary diagnosis code indicating a behavioral health diagnosis). See Article IV, section B(2)(c) for more details.

2. 24-Hour Coverage

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 PIHP's own facilities or through arrangements approved by the Department with other providers. The County PIHP 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 PIHP 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 PIHP must be able to communicate with a caller in the language spoken by the caller or the County PIHP 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 PIHP shall notify the Department of any changes of this one telephone number for emergency calls within seven (7) working days of change.

3. Coverage of Payment of Emergency Services

The County 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 County 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 County PIHP of the member's screening and treatment within ten (10) days of presentation for emergency mental health services. The County 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 County 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.

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

b. Emergency service encounters must be submitted with a primary diagnosis code indicating a behavioral health diagnosis. All other ailments and related services (e.g., x-rays for a broken arm) will be covered by the member's medical insurance.

    i. In-Scope Services include, but not limited to:
        i. Presenting at the Emergency Department in a mental health crisis;
        ii. Emergency screening for behavioral health services;
        iii. Admission to inpatient setting for mental health reasons.

    ii. Out-of-Scope Services include, but are not limited to:
        i. Medical treatment required simultaneously during an Emergency screening for behavioral health services;
        ii. Any services that are listed as carved out (e.g., pharmacy; see Article IV for complete list);
        iii. Any services that should be covered by the member's FFS Medicaid required during an Emergency visit, even if the primary diagnosis code for the overall visit is for a behavioral health diagnosis.

c. The County PIHP may not deny payment for emergency behavioral health services for a member with an emergency mental health condition or for a member who had County PIHP approval to seek emergency services.

d. The member may not be held liable for payment of screening and treatment needed to diagnose or stabilize the patient accessing emergency services for a behavioral health diagnosis code.

e. Treating providers is responsible for determining when the member is sufficiently stabilized for transfer or discharge and that determination is legally binding the County PIHP.

4. Coverage and Treatment of Post-Stabilization Care Services

    a. The PIHP is financially responsible for:

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

        2) Behavioral health post-stabilization service obtained within or outside the County PIHP's network that are not pre-approved by the County PIHP, but administered to maintain, improve or resolve the member's stabilized behavioral health condition if:

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

iii. The member is discharged.

b. The County PIHP's financial responsibility for post-stabilization care behavioral health 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 County PIHP reach agreement or when the member is discharged.

c. The County PIHP must limit charges to members for post-stabilization behavioral health care services to an amount no greater than what the organization would charge the member if they had obtained the services through the County 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.

5. Additional Provisions

a. Payments for qualifying emergencies (including services with a primary diagnosis code indicating a behavioral health diagnosis provided at hospitals or urgent care centers within the County 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 d addressing the initial emergency. Liability for emergency services continues until the patient is stabilized and can be safely discharged or transferred.

b. When emergency services are provided by non-affiliated providers, the County 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 County PIHP be required to pay more than billed charges.

This condition does not apply to:

i. Cases when prior payment arrangements were established; and
ii. Specific subcontract agreements.

E. Additional Services

1. The County PIHP may cover services for a member that are in addition to those services covered under the state plan; however, those encounters will not be used for determining payment rates, per 42 CFR §438.3(e).

2. In lieu of services can be covered by the County PIHP on a voluntary basis as follows: the Department determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan; the member is not required by the County PIHP to use the alternative service or setting; the approved in lieu of services are identified in the County PIHP contract and will be provided at the option of the County PIHP; and the utilization and cost of in lieu of services is taken into account in developing the component of the capitation rates that represent the covered state plan services.

   Currently, there are no in lieu of services in the County PIHP contract.

F. 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 PIHP provider extends until the County PIHP issues a written denial of referral. This requirement does not apply if the County PIHP issues a written denial of referral within seven (7) days of receiving the request for referral.

G. Moral Objection

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

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

8. Member will be informed of their right to disenroll if services are unavailable due to an objection on religious or moral grounds.

H. Hospital Payments

The County PIHP is exempt from making hospital access payments.

Article V

V. Provider Network and Access Requirements

The County PIHP must provide services covered by this Contract to itsmembers that are accessible to them, in terms of timeliness, amount, duration, and scope, as those services to non-enrolled Medicaid members within the area served by the County PIHP.

A. Use of Medicaid Enrolled Providers

Except in emergency situations, the County PIHP must use only Medicaid enrolled providers for the provision of covered services. The Department reserves the right to withhold from the capitation development the costs related to services provided by non-enrolled providers, at the FFS rate for those services, unless the County PIHP can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was Medicaid enrolled at the time the County PIHP reimbursed the provider for service provision. The Wis. Adm. Code, Ch. DHS 105 and the ForwardHealth Handbook, contains information regarding provider certification requirements. The County PIHP must require every physician providing services to members to have a Provider Number or National Provider Identifier (NPI). The Department requires that Medicaid-enrolled providers undergo periodic revalidation. During revalidation, providers update their enrollment information with ForwardHealth, and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Terms of Participation. Providers who fail to revalidate are terminated from Wisconsin Medicaid.

B. Protocols/Standards to Ensure Access

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

The County PIHP’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 PIHP must have mechanisms in place to allow members to directly access a specialist, as appropriate, for the member’s condition and identified needs.

C. Written Standards for Accessibility of Care

1. The County PIHP must have written standards for the accessibility of care and services. These standards must be communicated to providers and monitored by the County PIHP. 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 members;
    d. Accessibility of facilities and reasonable accommodations (e.g., ramps, elevators, etc.); and
    e. Whether or not provider(s) speak the member's language.

2. The County PIHP 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 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 PIHP from the requirement to provide or arrange for the provision of any medically necessary covered service required by its members.

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

D. Monitoring Compliance

The County PIHP must develop policies and procedures regarding wait times for appointments and care. The County PIHP 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 PIHP or by the Department, the County PIHP must take corrective action so that providers meet the County PIHP's standards and improve access for members. The Department will investigate complaints received that covered services exceed standards for waiting times for care and waiting time for appointments.

E. Access to Selected Medicaid Providers and Covered Services

Per 42 CFR § 438.207, Counties must provide assurances to the State that demonstrates that the County PIHP has the capacity to serve the expected enrollment in its service area per the State standards for access to care provided below. All County PIHP 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**	Dane	The County PIHP 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 PIHP	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	A mental health and substance abuse provider must be within a 30 minute drive time of any member residing in the county.

740 – Mental Health		service area. At least one mental health and substance abuse provider must be in each County PIHP's 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.		prescribing and dispensing provider for medication-assisted treatment (MAT) for members presenting with opioid use disorder (OUD); including providers authorized to prescribe and dispense methadone, buprenorphine, and naltrexone for OUD. Type of medication must be based on an assessment of the individual member and choice of clinically-indicated medication (i.e. 72-hour requirement cannot be met by directing all members to naltrexone providers). To ensure adherence to MAT wait time standards, 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 PIHP, 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 PIHP 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 PIHP 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 PIHP Referrals to Out of-Network Providers for Services

   The County PIHP must provide adequate and timely coverage of services provided out-of-network, when the required medical service is not available within the County PIHP network. The County PIHP 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 PIHP 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 PIHP must reimburse for emergency services provided to members in Canada or Mexico; however, payment for such services must be made to a financial institution or entity located within the United States. 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 PIHP per the County PIHP's prior authorization policies, provided the financial institution receiving payment is located within the United States.

4. Second Medical Opinions

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

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

The County PIHP 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 PIHP 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. Federally Qualified Health Centers

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

7. Telehealth Services

County PIHPs must develop policies and procedures for internal monitoring and/or telehealth utilization (Wis. Stat. § 49.45(61)). County PIHPs will submit these policies and any applicable monitoring information to the Department as requested. Telehealth services will be considered during the annual network adequacy review only secondary to physical provider location requirements

F. Network Adequacy Requirements

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

1. The anticipated 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 PIHP 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 PIHP 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 PIHP 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 Provider Network File Submission Specification Guide. The County PIHP 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 PIHP's operations that would affect adequate capacity and services, including modifications to County PIHP 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 PIHP must notify the Department of any geographical service area reductions 120 days before the intended decertification date unless DHS agrees to a shorter time period based on extraordinary circumstances beyond the control of the County PIHP. The County PIHP must submit a member communication/transition plan for all service area reductions.

G. Provider Network Adequacy Standard Exceptions and Conditional Approvals

1. Exception Process

   The County PIHP 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 PIHP may be granted an exception to the network adequacy standard, at the Department's discretion. The County PIHP 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 PIHP may be placed on a conditional provider network approval. It is the Department's expectation that the County PIHP 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 PIHP on a corrective action plan if deficiencies persist.

H. Online Provider Directory

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

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

The County PIHP is required to implement and enforce all of the requirements regarding member outreach and marketing processes, including Title 42 Code of Federal Regulations Part 38.10 and 42 CFR 438.104, as contained in the *Communication Outreach and Marketing Guide*.

Article VI

VI. Marketing and Member Materials

HMOs are 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 *Communication Outreach and Marketing Guide*, Dated December, 2021, which is fully incorporated herein by reference.

Article VII

VII. Member Rights and Responsibility

A. General Member Rights

The County PIHP must have written policies regarding member rights, including free exercise of rights without adverse action by the County PIHP or the providers. The County PIHP must notify members of their rights in the member handbook upon enrollment and annually. The County PIHP 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. As cited in 42 CFR § 438.100, enrollees of the County PIHP have the following rights:

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

B. Advance Directives

The County PIHP must maintain written policies and procedures related to advance directives that comply with Chapter 154, Wisconsin Statutes. If there is a change in state law related to advance directives, the County PIHP must provide members written information reflecting changes in state law no later than 90 days after the effective date of any change.) An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. The County PIHP must:

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

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

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

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

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

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

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

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

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

C. Choice of Health Professional

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

D. Cultural Competency

1. Mission, vision, and goals

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

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

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

e. Culturally competent grievance and appeal protocols.

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

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

Article VIII

VIII. Provider Appeals

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

A. County PIHP Responsibility

1. The County PIHP must notify providers in writing of the County PIHP'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 PIHP.

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

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

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

        2) Include the provider's name, date of service, date of billing, day of payment and/or nonpayment, member's name and Medicaid 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 PIHP 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 the Department if the County PIHP fails to respond to the appeal within 45 days or if the provider is not satisfied with the County PIHP's response to the request for reconsideration.

2. The County PIHP must accept written appeals from providers submitted within 60 days of the County PIHP's initial payment and/or nonpayment notice. The County PIHP must respond in writing within 45 days from the date of receipt of the request for reconsideration. If the County PIHP fails to respond within 45 days, or if the

provider is not satisfied with the County PIHP's response, the provider may seek a final determination from the Department.

B. Provider Responsibility

1. Appeals to the Department must be submitted in writing within 60 days of the County PIHP's final decision or, in the case of no response, within 60 days from the 45-day timeline allotted the county respond.

2. Appeals regarding the County PIHP to the Department can be faxed or mailed to:

   BadgerCare Plus and Medicaid SSI
   Managed Care Unit—Provider Appeal
   PO Box 6470
   Madison, WI 53716-0470

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

Article IX

IX. Member Grievances and Appeals

The County PIHP is required to implement and enforce all of the requirements regarding member grievance and appeals processes, including Title 42 Code of Federal Regulations Part 438 Subpart F, as contained in the Member Grievances and Appeals Guide, dated December 2021, which is fully incorporated herein by reference.

Article X

X. Quality Assessment Performance Improvement (QAPI)

The County PIHP 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 PIHP must have a QAPI system that:

i. Conduct performance improvement projects designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time in clinical care areas.
ii. Collect and submit performance measurement data.
iii. Have in effect mechanisms to detect both underutilization and overutilization of services.
iv. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

A. Quality Assessment/Performance Improvement Program

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

2. The County PIHP must have documentation of all aspects of the QAPI program available for Department review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the County PIHP 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.

3. The County PIHP must have a written QAPI work plan that is ratified by the County PIHP 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.

4. The County PIHP is ultimately accountable to the Department for the quality of mental health care provided to County PIHP members. Oversight responsibilities of

the governing body shall include, at a minimum:

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

5. QAPI committee shall be in an organizational location within the County PIHP such that it can be responsible for all aspects of the QAPI program. The Committee membership must be interdisciplinary and be made up of both providers and administrative staff of the County PIHP, including:

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

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

    c. County PIHP management or governing body.

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

    e. Members of the County PIHP must be able to contribute input to the QAPI committee. The County PIHP must have a system to receive member input on quality improvement, document the input received, document the County PIHP'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 PIHP response must be timely.

6. 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 County PIHP Commission.

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

8. QAPI activities of County PIHP providers and subcontractors, if separate from County PIHP QAPI activities, shall be integrated into the overall County PIHP 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 PIHP QAPI Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts.

9. 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 PIHP's quality activities.

10. The County PIHP 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.

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

12. The County PIHP 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 PIHP's own providers, as well as the County PIHP's subcontracted providers.

13. The qualifications, staffing level and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of important aspects of 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.

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

B. Monitoring and Evaluation

1. The 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 PIHP must be supported by appropriate data collection and analysis methods to improve clinical care and services.

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

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

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

6. The State will arrange for an independent, external review of the quality of services delivered under each County PIHP's contract with the State. The review will be conducted for each County PIHP contractor on an annual basis in accordance with Federal requirements described in 42 CFR Part 438, Subpart D, Quality Measurement and Improvement; External Quality Review. The entity which will provide the annual external quality reviews shall not be a part of the State government, the County PIHP, or an association of the County PIHP.

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

1. The County PIHP must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the County PIHP'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 PIHP's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

   The County PIHP must complete the credentialing process within 180 days after receipt of all necessary documents required by providers.

   The County PIHP shall not credential or recredential individual providers employed by a Narcotic Treatment Service (NTS) certified under DHS 75.15. These providers must be enrolled in the Wisconsin Medicaid Program in order to be reimbursed for services provided to Wisconsin Medicaid members per DHS 105. HMOs can rely upon NTS providers' status as Medicaid-enrolled in lieu of credentialing at the provider level. HMOs may have credentialing and recredentialing policies for facilities certified under DHS 75.15.

   The County PIHP may not employ or contract with providers debarred or excluded in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

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

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

4. The selection process must not discriminate against providers such as those serving high-risk populations or specialize in conditions that require costly treatment. The HMO must have a process for receiving advice on the selection criteria for credentialing and recredentialing practitioners in the HMO's network.

   If the HMO declines to include groups of providers in its network, the HMO must give the affected providers written notice of the reason for its decision.

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

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

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

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

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

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

D. Accreditation

Per 42 CFR § 438.332, the County PIHP must report to the Department if it is accredited by a private independent accrediting agency. CMS has recognized the following entities as private independent accrediting agencies: The National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC). 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 PIHP certification application process. This copy must contain:

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

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

E. Utilization Management

1. The County PIHP 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 PIHP 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.

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

3. 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 PIHP 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 PIHP must give the member or their authorized representative and the requesting provider written notice of:

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

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

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

      i. 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:

         a. Within 14 days of the receipt of the request, or;

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

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

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

4. 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.

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

F. Performance Improvement Project

The County PIHP must develop and ensure implementation of program initiatives to address the specific clinical and non-clinical needs of the County- PIHP's enrolled population served under this agreement. The Department strongly advocates the development of collaborative relationships among the County PIHP, 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 PIHP must monitor and evaluate the quality of care and services through at least one performance improvement project. The County PIHP 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 PIHP will have the full calendar year as the intervention year, with the final report due by July 1 of the following year. The County PIHP 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 V 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:

i. Identification
ii. Stratification
iii. Outreach
iv. Intervention
v. Rapid Cycle Improvement
vi. Measurement and Evaluation
vii. Sustainability and Diffusion

1. The County PIHP will be required to complete one, abbreviated PIP for MY23 pertaining to the transition of youth from CCF developed in close collaboration with the Department.

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

3. Clinical and Non-Clinical Priority Areas

a. Clinical Priority Area

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

b. Non-Clinical Priority Areas

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

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

4. The Department's Approved Performance Measures

The Department will evaluate the County PIHP's performance using the Department's approved performance measures, based on County PIHP-supplied encounter data and other relevant data (for selected measures). Evaluation of County PIHP 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 PIHP of its performance on each measure, whether the County PIHP's performance satisfied the goal requirements set by the Department, and whether a performance improvement initiative by the County PIHP is required. The County PIHP will have 60 business days to review and respond to the Department's performance report. When a performance improvement initiative is required due to sub-goal performance on the measure, the County PIHP may request recalculation of the performance level based on new or additional data the County PIHP may supply, or if the County PIHP can demonstrate material error in the calculation of the performance level. The Department will provide a tentative schedule of measure calculation dates to the County PIHP 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 PIHP 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 PIHP of its intent to change any of measures, technical specifications or goals. The County PIHP shall have the opportunity to comment on the measure specifications, goals and implementation plan within the 90-day notice period. The Department reserves the right to require the County PIHP to report such performance measure data as may be deemed necessary to monitor and improve County PIHP quality performance.

G. Indicator Reporting

The County PIHP is required to report on quality measures and operational details to support program operation.
The following Indicators will be collected and reviewed:

1. Time Frame

   The Department will use the Measurement Year (MY) starting on July 1 and ending on June 30 of the contract year to explore applicable measures for mental health services.

2. Measures and Targets

   a. Initial Measures

      Initial measures represent activities happening when children are enrolled in County PIHP. These include:

      i. Childhood Behavior Checklist

         The Child Behavior Checklist tool, 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 indicated.

3. 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.

Article XI

XI. PIHP Administration

A. Statutory Requirement

In consideration of the functions and duties of the department contained in this Contract the County PIHP shall retain at all times during the period of this Contract a valid Certificate of Authority issued by the State of Wisconsin Office of the Commissioner of Insurance. A separate Certificate of Authority must be submitted for each contract the County PIHP intends to enter into with the Medicaid program (if, for example, a County PIHP offers multiple product lines, does business under another name, etc.).

B. Compliance with Applicable Law

In the provision of services under this contract, the Contractor and its subcontractors shall comply with all applicable federal and state statutes and rules and regulations, 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.

Changes to Medicaid-covered services mandated by federal or state law subsequent to the signing of this Contract will not affect the Contract services for the term of this Contract, until agreed to by mutual consent, or 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 PIHP at least 30 days' notice before the intended effective date of any such change that reflects service increases and the County PIHP may elect to accept or reject the service increases for the remainder of that Contract year.

The Department will give the County PIHP 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 PIHP has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in 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.

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.

C. Organizational Responsibilities and Duties

1. Ineligible Organizations

   Upon obtaining information or receiving information from the Department or from another verifiable source the County PIHP must exclude from participation in the County PIHP'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):

   a. 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:

      1) Been convicted of the following crimes:

         a) 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));

         b) 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));

         c) 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));

         d) 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

         e) 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)).

2) Been excluded, debarred, suspended, otherwise excluded, or is an affiliate (as defined in such Act) of a person C(1)(a) above from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

3) Been assessed a civil monetary penalty under section 1128A of the Act. Civil monetary penalties can be imposed on individual providers, as well as on provider organizations, agencies, or other entities by the DHHS Office of Inspector General. Section 1128A authorizes their use in case of false or fraudulent submittal of claims for payment, and certain other violations of payment practice standards (see Section 1128(b)(8)(B)(ii) of the Act).

b. Entities that have a direct or indirect substantial contractual relationship with an individual or entity listed in [insert citation]. A substantial ,contractual relationship is defined as any contractual relationship which provides for one or more of the following services:

1) The administration, management, or provision of medical services;

2) The establishment of policies pertaining to the administration, management, or provision of medical services; or

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

c. Entities that employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A, for the Provision (directly or indirectly) of health care, Utilization Review, medical social work or administrative services. For the services listed, County PIHP 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.

d. Foreign Entities

1) Pursuant to 42 C.F.R. § 438.602(i), the State is prohibited from contracting with a PIHP located outside of the United States. In the event an PIHP moves outside of the United States, this contract will be terminated.

2) Pursuant to 42 C.F.R. § 438.602(i), no claims paid by a PIHP to a network provider, out-of-network provider, subcontractor or financial institution outside of the United States will be considered in the development of actuarially sound payments.

2. Contract Representative

The County PIHP is required to designate a staff person to act as liaison to the Department on all issues that relate to the Contract between the Department and the County PIHP. The contract representative will be authorized to represent the County PIHP regarding inquiries pertaining to the Contract will be available during normal business hours and will have decision making authority in regard to urgent situations that arise. The Contract representatives will be responsible for follow-up on contract inquiries initiated by the Department.

3. Attestation

The County PIHP's designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department. This includes encounter data, provider and facility network submissions, comprehensive exam reports and health data indicators and any other data regarding claims the County PIHP paid. The County PIHP must use the Department's attestation form in Addendum IV. The attestation form must be submitted quarterly to the County PIHP's Managed Care Analyst in DHS.

4. Affirmative Action (AA) and Equal Opportunity, and Civil Rights Compliance (CRC)

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

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

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

a. Affirmative Action Plan

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

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

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

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

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

b. Civil Rights Compliance (CRC) Plan

1) The County PIHP receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA) for the compliance period of 2022-2023. The County PIHP 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 7250
Madison, WI 53703-7850
Telephone: (608) 267-4955 (Voice)
711 or 1-800-947-3529 (TTY)
Fax: (608) 267-1434
Email: DHSCRC@dhs.wisconsin.gov

2) The County PIHP 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 PIHP conducts on an on-site monitoring visit.

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

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

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

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

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

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

The County PIHP 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 PIHP 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.

6. Provision of Services to County PIHP Members

The County PIHP must provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under Medicaid fee for services and BadgerCare Plus members as set forth in 42 CFR § 438.210(a)(2) and 42 CFR § 440.230.

Per 42 CFR § 438.210(a)(3), the County PIHP:

a. 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 to members in Medicaid fee for service.

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

7. County PIHP Staffing Level to Support Providers

At the time of contract renewal, the County PIHP must have appropriate staffing levels for the entire service area to support contracted provider participation and timely claim payment.

The County PIHP must:

a. Have adequate customer service and help desk staff to answer inquiries from providers (via phone or email); adequate home office or regional provider representatives to provide training to new and ongoing providers on County PIHP policy, communication methods, correct claim submission, and appeal process.

b. Clearly communicate to providers the availability of support resources provided through the County PIHP website or Provider Manual, including but not limited to the methods used by the County PIHP to communicate policy changes, electronic claim submission, claim reconsideration, internal appeal process, and how to appeal to the Department.

The Department reserves the right to request a staffing plan from the County PIHP at the time of contract renewal to demonstrate the County PIHP has appropriate staffing levels for its entire service area to support provider participation and timely claim payment.

8. Access to Premises

The County PIHP must allow duly authorized agents or representatives of the state or federal government access to the County PIHP or County PIHP subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the County PIHP'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 PIHP or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the

performance of County PIHP's or subcontractor's activities. The County PIHP will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

9. Subcontracts

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

10. Coordination with Community-Based Health Organizations, Local Health Departments, Dane County Child Welfare Agency, School-Based Service Providers, Targeted Case Management Agencies, School-Based Mental Health Services, and Healthy Wisconsin

    The County PIHP must have a system in place too coordinate the services it provides to member with services a member receives through community and social support providers.

    a. Community-Based Health Organizations

       The Department encourages the County PIHP to contract with community-based health organizations to ensure continuity and culturally appropriate care and services. Community-based health organization can provide contracted services as well as have the potential to serve as a nexus for other services the PIHP member might have (e.g., WIC services, HealthCheck screening and outreach, immunizations, etc.).

    b. Local Health Departments

       The Department encourages the County PIHP to work closely with local health departments. Local health departments have a wide variety of resources that could be coordinated with the County PIHP to produce more efficient and cost-effective care for the County PIHP members. Examples of such resources are ongoing medical services programs, materials on health education, prevention, and disease states, expertise on outreach to specific populations, communication networks, and social service agencies and access to ongoing studies of health status and disease

trends and patterns.

c. Child Welfare Coordination

County PIHP must designate at least one staff member to serve as a contact with the county child welfare agency in the Wisconsin Department of Children and Families. The Department encourages the County PIHP to designate a staff member with at least two years of experience working in a child welfare agency, or who has attended child welfare training through the WI Child Welfare Training Partnership.

County PIHPs shall coordinate with the appropriate county human services agency for the provision of services to members involved with the county.

d. School-Based Services (SBS) Providers

The County PIHP must use its best effort and document attempts to sign a MOU with all SBS providers in the County PIHP to ensure continuity of care and to avoid duplications of services. School based services are paid FFS when provided by a County PIHP enrolled 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 PIHP is responsible for providing and paying for all covered services. The County PIHP must not consider SBS (e.g., physical, occupational, and speech and language therapy services) as automatically duplicative when it is considering the necessity of a requested community based service.

MOUs must be signed every three years as part of certification. If no changes have occurred, the both the school and the County PIHP must sign off that no changes have occurred and documentation to this effect may be submitted to DHS upon request. County PIHPs must conduct outreach to schools that do not have a MOU with the health plan, at a minimum, every two years. The County PIHP must submit evidence that it attempted to obtain a MOU or contract in good faith.

e. School-based Mental Health Services

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

11. County PIHP in the Event of a Federal or State Declared Emergency

County PIHPs are required to submit an annual plan to maintain business operations in the event of a state or federal declaration of disaster or State of emergency. The County PIHP must cooperate with DHS' efforts to ensure minimal disruption to the ForwardHealth program and the members served.

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.

The health plan must follow all relevant ForwardHealth Updates or other DHS communications issued during a federal or state disaster to ensure members continue to receive all medically necessary services.

b. Continuity of Operations

1) Business Continuity Plan

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

1. A description of how the health plan will organize and assign the urgency with which activities and processes will need to be resumed in the event of a disruption including:
    i. Member's Access to services. The health plan must:
        1) 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.

2) 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.
3) 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 that means by which the health plan will identify the location of members who have been displaced.
4) Report status of members and issues regarding member access to covered services as directed by DHS.

ii. Claim Payments

1) The health plan must ensure timely provider claims processing and payment consistent with DHS contract requirements and health plan-provider contract policies.
2) 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.
3) The health plan must honor unauthorized provider claims consistent with ongoing treatment due to demonstrated patient need or urent patient need occurring during Federal or State declared disaster or emergency period where health plan authorization communications and processes were delayed or failed.
4) 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.

iii. 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 what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.

iv. 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.

v. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.
    1) Health plans must ensure that proper training is provided for each role under this provision.

vi. Criteria for executing the business continuity plan, including escalation procedures.
    1) 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:
        a) 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 POC.
        b) Designating a POC to support members residing in Tribal Lands where applicable.
        c) Participating in meetings with DHS or other agencies.

d) Assisting with impacted member or provider communications.
e) Facilitate effective communication with members, providers, and staff regarding the impact of the disaster as well as a process by which inquiries maybe submitted and addressed.
f) Implementing policy, process, or system changes at the direction of DHS, keeping DHS informed on the progress of the implementation
g) Additional communication and/or reporting requirements through the duration of the emergency
h) 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.
i) 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 County PIHP resources or contact information, and instructions on how to opt into text messaging.

vii. 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 theCounty PIHP.

viii. Recovery time for each major business function, based on priority.
ix. Business workflow and workaround procedures, including alternate processing methods and performance metrics.
x. Recording and updating business events information, files, and data, once business processes have been restored.
xi. Documentation of security procedures for protection of data through web-based cloud application.
xii. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
xiii. A description of an annual testing and evaluation plan.
xiv. 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.
    1) 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.
xv. A description of the steps that will be taken to ensure and preserve member safety and well being in the event of a disruption or disaster.
    1) Care Coordination

       The health plan must ensure that care coordination for all members is 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 services are disrupted or interrupted.

xvi. Emergency Recovery Plan

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:

1) Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.
2) Communication plan for critical personnel, key stakeholders and business partners involved in the health plan's management information system, 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.
3) 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).
4) Full and complete back-up copies of all data and software.
5) Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
6) Policies and procedures for purging outdated backup data.
7) 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, County PIHP 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.

12. Interoperability and Access to Health Information – Patient Access Application Programming Interface (API, Provider Directory API, and Payer-to-Payer Data Exchange)

The County PIHP shall implement requirements from the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the

Federally-facilitated Exchanges, and Health Care Providers" final rule (85 FR 25510). The PIHP shall implement these interoperability requirements in accordance with the applicable specifications of the Office of the National Coordinator's (ONC's) "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" companion final rule (85 FR 25642).

The PIHP shall implement:

a. Patient Access Application Programming Interface (API):

   The County PIHP shall provide members with the ability to access their own personal health information, including unstructured claims and encounter information, costs, and a defined sub-set of their clinical information as outlined at 42 CFR § 422.119, 42 CFR § 431.60, 42 CFR § 457.730, and 45 CFR § 156.221, specifically for the Patient Access API, and current version of the United States Core Data for Interoperability (USCDI) dataset. The County PIHP will be responsible for the Patient Access API, including all applicable technology standards, supporting technology infrastructure, and security protocols required to conform with the CMS final rule. This information shall be provided via an HL7 FHIR compliant standards-based API available to third-party applications of the member's choice.

b. Provider Directory API:

   The County PIHP shall make their Member-enrolled provider directory information publicly available via an HL7 FHIR complaint standards-based API per the requirements outlined at 42 CFR § 438.242(b)(6) and 42 CFR § 457.1233(d). At a minimum, the County PIHP must make the provider names, addresses, phone numbers, and specialties available.

c. Payer-to-Payer Data Exchange:

   The County PIHP shall provide members with the ability to exchange certain patient clinical data (specifically the current version of the U.S. Core Data for Interoperability (USCDI) data set). Members shall have the ability to request the transfer of all clinical and claims-related data from an assigned payer to a future payer to enable health data portability. The PIHP is required to conform with 42 CFR §438.62(b)(1)(vi) & (vii) for Medicaid managed care plans (and by extension under 42 CFR § 457.1216 CHIP managed care entities).

d. County PIHP shall review the ONC 21st Century Cures Act Final Rule to determine its obligation to comply with the final rule. Specifically, County PIHP shall review the terms "Health Information Exchange" (HIE) and "Health Information Network" (HIN) which are defined in 45 CFR § 171.102, and the exceptions to information blocking as amended by Section 4004 of the Cures Act and as found in 42 USC § 300jj-52, in relation to their contractual and financial relationships. If the County PIHP meets the definition for an HIE/HIN as it pertains to information blocking, County PIHP shall comply with all the requirements set forth in the rule.

e. Access to Educational Materials:

Pursuant to 42 CFR § 431.60(f) and 42 CFR § 457.730(f), County PIHP shall develop educational resources regarding privacy and security, including information regarding the possible risk of sharing their data with third-party app and how members can protect the privacy and security of their health information in non-technical, simple and easy-to-understand language. The County PIHP shall publish these resources on its publicly accessible website.

f. Pursuant to CMS notice that it will not exercise enforcement action with respect to certain payer-to-payer data exchange provisions, DHS will not be taking action to enforce these standards at this time, with the understanding that the County PIHP is in the process of implementing these standards. County PIHP is expected to provide routine updates on the implementation process.

D. Confidentiality of Records and HIPAA Requirements

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 PIHP and the Department to persons who, or agencies which, require the information in order to perform their duties related to this Contract, including the U.S. Department of Health and Human Services and such others as may be required by the Department.

1. Duty of Non-Disclosure and Security Precautions

Contractor shall not use Confidential Information for any purpose other than the limited purposes set forth in the Agreement. Contractor shall hold the Confidential Information in confidence, and shall not disclose such Confidential Information to any persons other than those directors, officers, employees, and agents ("Representatives") who have a business related need to have access to such

Confidential Information in furtherance of the limited purposes of this Agreement and who have been apprised of, and agree to maintain, the confidential nature of such information in accordance with the terms of this Agreement. Contractor shall be responsible for the breach of this Agreement by any of its Representatives.

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

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

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

a. Limitation on Obligations

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

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

b. 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.

c. 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.

6) 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.

d. Trading partner requirements under HIPAA

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

a. Trading Partner Obligations

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

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

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

4) Trading Partner must not change the meaning or intent of any of the HHS Transaction Standard’s implementation

specifications (45 CFR Part 162.915(d)).

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

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

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

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

e. 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).

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

g. Privacy

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

2) The Department and the Trading Partner or Trading Partner's Business 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.

3) The Department retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by

the Trading Partner, Trading Partner's Business Associates, or any agent, contractor or third Party that received PHI from the Trading Partner.

4) 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.

h. Security

1) 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.

2) 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.

2. 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.

a) 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.

2) 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:

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

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

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

3) Compliance Reviews

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

4) Survival

This Section shall survive the termination of the Agreement.

5) Party in Interest

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

a. Any sale or exchange, or leasing of any property between the County PIHP and such a party.

b. Any furnishing for consideration of goods, services (including management services), or facilities between the County PIHP and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

c. Any lending of money or other extension of credit between the County PIHP and such a party.

Article XII

XII. Reports and Data

A. Access to and/or Disclosure of Financial Records

The County PIHP 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 PIHP or subcontractors that relate to the County PIHP'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 PIHP shall comply with applicable recordkeeping requirements specified in DHS 105.02(1)-(7) Wisconsin Administrative Code, as amended.

B. Periodic Reports

The County PIHP 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 bymembers processed by the County PIHP 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. 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 PIHP 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.

D. Encounter Data and Reporting Requirements

The County PIHP is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. County 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 County PIHP. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual County PIHP meetings with the Department to address changes in requirements, local applications or databases. The County 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 County PIHP no less frequently than once every three years.

1. Data Management and Maintenance: The County 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 County PIHP must:

a. Participate in the County 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 County 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 County 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 County 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 County 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.
l. The County PIHP must submit adjudicated clean claims as encounters no later than 180 days after the date the County PIHP adjudicates the claim. If a County PIHP paid encounter is denied within the Department's Medicaid Management Information System (MMIS), the County PIHP has 90 days to resolve the encounter to priced status within the system.

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

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

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

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

a. The County 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 County PIHP must test the encounter data set until the Department is satisfied that the County PIHP is capable of submitting valid, accurate, and timely encounter data according to the schedule and timetable. A new County PIHP must become certified to submit compliant encounters within six months of their start date.
c. The County 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 PIHP must follow the data specifications defined in the Encounter User Guide and must submit encounters tat conform to national standards as well as specific Department requirements.

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

c. The County PIHP must process all the County PIHP 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:

a. The County PIHP must submit accurate and complete encounter data that the Department can use for rate-setting, Federal Reporting, special programs and any other purpose deemed necessary by the Department. The County PIHP must track metrics used by the Department to confirm that data is accurate and complete. Any deficiencies in the metrics must be reported to the Department within 15 days of the County PIHP identifying the problem.

b. County PIHPs must submit a consistent volume of encounters each month based on a calendar year average.

6. The Chief Operating Officer or their designated authority must attest to the following metrics included on the report:

a. Encounter Volume—The County PIHP must submit encounters with a consistent volume from month to month. County PIHPs provide expected average monthly volume on the quarterly progress report. An inconsistency as defined as a volume that is sustained for more than three months that is greater than 10 percent lower than the expected volume.

b. Pricing Percentage—The County PIHP must achieve and maintain a consistent Pricing Percentage of 95 percent for a 12-month period over all Institutional and Professional claim types. The PIHP must report a deficiency in pricing percent that lasts greater than three months.

c. Encounter Completeness for Rate Base Period—The County PIHP must provide an estimate of completeness of their encounter data for the base period. Completeness is defined in the Progress Report and Template. The Department expects the PIHP to achieve a level of completeness that the Department and the Department's actuaries agree are credible for rate-setting purposes.

d. The County PIHP must identify any gaps or defects in the data using the Data Exclusions section of the quarterly progress report. The County PIHP must identify data exclusions in enough detail to allow the Department's actuaries to preserve as much data as possible for rate-setting purposes and exclude only the time period or category or data that is problematic. For example, if there is missing data for a time period, the County PIHP should provide exact dates of service that should be excluded.

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

E. Records Retention

The County PIHP 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, unless otherwise directed by court order.

F. Reporting of Corporate and Other Changes

The County PIHP must report to the Department through their Managed Care Analyst any change in corporate structure or any other change in information previously reported, whether reported through the application for certification process or through other means.

1. Any change in information relevant to ineligible organizations.

2. Any change in information relevant to ownership and business transactions of the County PIHP or contracted administrator.

G. Provider and Facility Network Data Submission

1. The County PIHP that contracts with the Department to provide services must submit a detailed provider network and facility file monthly and when the County PIHP experiences significant change with respect to network adequacy (as defined in Art. V, F.), to the State's SFTP. The file must be submitted using the format specified in the ForwardHealth Encounters and Reporting Provider Network Universe.

2. The provider network and facility file shall include only Medicaid-enrolled providers who are contracted with the County PIHP to provide contract services to members.

3. County PIHP must submit complete and accurate provider network and facility data. The Department will provide the County PIHP with the required file format layout and data fields. The Department retains the right to conduct audits of provider and facility data for completeness and accuracy during the contract period. Incomplete or inaccurate provider and/or facility data may subject the County PIHP to administrative sanctions outlined in Article XIV, section C.

H. Financial Report

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

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

Additionally, the County PIHP 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 PIHP's auditor is unable to verify the accuracy of the financial template the County PIHP 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 PIHP 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 PIHP must provide an alternative due date as part of the request.

The County PIHP 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 PIHP no less frequently than once every three years.

The County PIHP 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:

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

2) Unallowable costs must be segregated and excluded from allowable administrative costs in the County 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.

I. Reporting Requirements and Due Dates

MONTHLY REPORTS		
Provider Network	List of all providers in the County PIHP network. Submit via the SFTP. (See the File Submission Specification Guide)	Article V

Supplier Diversity Report	Send monthly reports regarding the County PIHPs subcontract with DOA certified MBEs and DVBs	Article XII, section J
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	Addendum IV, section C
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.	Addendum IV, section A
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.	Addendum IV, section B See *Member Grievances and Appeals Guide*
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 VI See Communications, Outreach, and Marketing guide
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 X, section F
Annual Financial Report	Financial report for the previous calendar year to BRS by SFTP. Report is due on April 1.	Article XII, section H
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 X, section F
QA/ Plan, QA Staff, QA	Submit to DHS annually by April 1st.	Article X, section A

Committee, etc.		
OTHER REPORTS		
Affirmative Action Plan Submit every 3 years	AA/CRC Office in the format specified on Vendor Net. Send to dhscontractcompliance@dhs.wisconsin.gov	Article XI, section C(4)
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 XI, section C(4)
Encounter Data File in (837I, 837P, 837D) format.	Send to Fiscal agent on SFTP.	Article XII, section D
Fraud, Waste and Abuse Investigations.	The County 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 County PIHP. Submit on an as needed basis.	Article XII, section J
MOUs for Emergency Services	Report to DHS within 30 days after the award of contract.	Addendum I, section B
New Subcontracts/ Changes in Approved Subcontracts or MOUs	Report to DHS 15 days prior to effective date.	Article XIV, section B(2)(b)
Outcome Indicator Data	Report to DHS the previous calendar year by June 15.	Article X, section G
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, section D
CMS Drug Utilization Reports	County PIHPs are required to submit timely responses to report and survey requests as required by federal and/or state law or program policy.	Article XI, section B

MAIL REPORTS TO: Bureau of Children's Services
Room 418
Attn: County PIHP 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 contract monitor

J. Program Integrity

1. Administrative Management Arrangements

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

a. Written policies, procedures, and standards of conduct that articulate the County PIHP's commitment to comply with all applicable federal and state laws and rules.

b. An organizational chart depicting the designation of a compliance officer and a compliance committee that is accountable to senior management.

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

d. A schedule of training and education for the Compliance Officer, the County PIHP's senior management, and the County PIHP's employees for the federal and state laws, rules and requirements, including program integrity under the contract.

e. Documented lines of communication between the compliance officer, senior management and the County PIHP's employees.

f. Enforcement of program integrity standards through well-publicized disciplinary guidelines.

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

1) Routine internal monitoring and auditing of compliance risks related to provider network, including both prepayment and post-payment program integrity strategies;
2) Prompt response to compliance issues, both internal and related to the provider network, as they are raised;
3) Timely investigation of potential compliance problems, both internal and related to the provider network, identified in the course of self-evaluation and audits;
4) Correction of such problems promptly and thoroughly to reduce the potential for recurrence;

5) Ongoing compliance with the requirements under the contract

h. The identification of dedicated staff responsible for identifying, mitigating and preventing fraud, waste and abuse.

1) The Activities and performance of the identified staff are subject to audit/review by the DHS Office of the Inspector General (DHS OIG).
2) The PIHP is required to respond to any corrective action or performance improvement activities in the written report to the PIHP within the timeframes specified.

i. A documented process to ensure a prompt response to detected offenses, and for development of corrective action initiatives relating to the PIHP's contract.

j. A method for verifying, on a quarterly basis, whether services that have been reported for payment have been delivered by network providers and received by the appropriate Medicaid member.

1) The PIHP must ensure all network providers are enrolled with the State as Medicaid providers
2) The PIHP must verify the provision of services with members for a least 100 paid encounters each quarter.
3) The PIHP must maintain appropriate records of these verifications.
4) DHS will verify compliance with this requirement.

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

1) Whistleblowers should report program integrity concerns to the DHS Office of Inspector General. Whistleblowers may make a report through the hotline (877-865-3432) or through the online portal: (http://www/reprtfraud.wisconsin.gov/rptfrd/default.aspx). The PIHP is responsible for ensuring employees have access to this information.

2) Whistleblower information should be included in employee, provider, and contractor hadnbooks and include this information on its website.

2. Fraud, Waste and Abuse Investigations

The County PIHP must cooperate with the Department on fraud, waste and abuse investigations. The County PIHP must report all potential fraud, waste, and abuse, including any credible allegation of fraud, directly to the DHS OIG within 15 business days of the County PIHP's identification of the issue. The County PIHP may make a report through the hotline (877-865-3432) or through the online portal (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx).

a. Reports of fraud, waste or abuse from a County PIHP must not be made anonymously, and these reports may be subject to open records laws.

b. The County PIHP must collect preliminary information including available data, statements from appropriate parties, and other materials supporting the allegations. The DHS OIG SharePoint site can be utilized as a secure method to upload preliminary information and documentation along with the original referral that was submitted to the online portal or hotline. Following the report of the alleged fraud, waste or abuse, the County PIHP must continue to investigate the allegations of fraud unless otherwise directed by DHS OIG, Department of Justice Medicaid Fraud Control and Elder Abuse Unit, or other law enforcement or regulatory entity.

c. If the County PIHP's investigation finds evidence of fraud, the County PIHP must collaborate with DHS OIG to complete the credible allegation of fraud referral form (F-02296) and compile appropriate exhibits to the form.

d. The County PIHP must report allegations of only Medicaid fraud, waste and abuse to DHS OIG. It is unnecessary to report violations that occurred in the County PIHP's commercial line of business, or otherwise did not result in the loss of Medicaid funds.

e. Failure on the part of the County PIHP to cooperate with these directives or report fraud, waste, or abuse may result in the DHS taking any applicable sanctions under Article XIV, Section D.

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

    1) If a County PIHP forwards a report of potential Medicaid fraud to any additional state or federal agency, the County PIHP shall notify the DHS OIG of that referral.

3. Suspension of Provider Payments

a. The County PIHP agrees to cooperate with the Affordable Care Act (ACA) suspension of payment requirements. The County PIHP is prohibited from paying for an item or service furnished by an individual or entity to whom the state has suspended payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments. The DHS Inspector General must review and authorize any request for a good cause exception.

b. The County PIHP must have a documented process outlining how it will respond to a credible allegation of fraud notification. The provider file sent by the Department to the County PIHP will have a field that will indicate the outcome of the credible allegation of fraud investigation. They are:

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

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

d. The County PIHPs must have clearly defined criteria, policies, and procedures in place for suspending providers within their network independent of payment suspensions issued by the DHS OIG. These policies and procedures must include notification of DHS within 24 hours of the suspension of payments using the DHSOIGManagedCare@wisconsin.gov email address. The County PIHPs must also record these payment suspensions on the terminations/sanctions/suspensions tab of the Quarterly Program Integrity Report (F-02250).

4. Termination or Exclusion of Provider

The County PIHP must report providers terminated for cause by the County PIHP, as well as providers the County PIHP identifies as excluded, to DHS OIG. The County PIHP must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of the email should include the name of the provider, NPI and MA ID numbers, date of termination/exclusion, and reason for termination/exclusion. This information must also be captured on the Termination/Sanctions/Suspension tab in the Quarterly Program Integrity Report (F-02250). DHS OIG may follow up for additional information depending on the reason for termination.

5. Treatment of Recoveries Made by the County PIHP of Overpayments to Providers*

a. Pursuant to 42 CFR § 438.608(d), the County PIHP must attempt to recover all overpayments made to network providers, including those overpayments attributed to fraud, waste, and abuse, identified by the County PIHP. The County PIHP recovers the payments and retains the funds for all overpayments identified by the County PIHP, provider or DHS OIG. Any overpayment identified by DHS OIG would be an estimated overpayment based on the max fee schedules. The County PIHPs would be responsible for determining the actual overpayment amount.

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

* This provision does not apply to any amount of recovery retained under the False Claim Act cases or other investigations.

6. County PIHPs must submit a monthly report of any capitation payments or other payments in excess of amounts specified in the contract within sixty (60) calendar days of identification as required by 42 CFR § 438.608(c)(3). County PIHPs must submit the report via DHS OIG's SharePoint site. The report must contain the following information:

a. The County PIHP's name;
b. The member's Medicaid number;
c. The member's name;
d. The month or number of days if partial month;
e. The rate paid;
f. The correct rate;
g. The reason for the overpayment, if known;
h. The original date the overpayment report to DHS; and
i. The action taken by the County PIHP, if any.

7. Network Provider Audits

DHS OIG and DHS OIG's contracted program integrity (PI) vendors will conduct audits of the PIHP's network providers. DHS OIG will utilize the fee-for-service max fee tables when assigning value to services provided in the audit. The County PIHP must collaborate with DHS OIG and DHS OIG's contracted PI vendors on all matters related to these audits including, but not limited to:

a. Coordinating relative to scope and sample to prevent a duplication of audit efforts between DHS OIG and the County PIHP;

b. Sharing claims-level data for program integrity purposes;

c. Receiving copies of audit related communications between DHS OIG and contract PI vendors and the network providers;

d. Engaging in audit resolution which may include technical assistance to both the plan and provider, corrective action plans administered by DHS, referrals to MFCEAU or DSPS, termination of a network provider's Medicaid certification, financial sanctions administered by DMS, under Article XIV, Section D, or other means by which the audit findings can be addressed;

e. Ensuring audit findings are addressed across the County PIHP'S entire network of providers, not just the provider(s) included in DHS OIG's audit;

f. Communicating recovery of any overpayments based on DHS OIG's audit findings:

1) DHS OIG will not collect any overpayments based upon its audit but the County PIHP may choose to use DHS OIG's estimated value of the audit findings and seek recovery of the overpayment from the audited network provider. The County PIHP is entitled to keep the overpayment. Provider agreement language should be updated to reflect this activity if the County PIHP elects to identify and pursue overpayments based on DHS OIG's audit findings.

2) The County PIHP must document the recovery of any overpayments associated with network provider audits conducted by DHS OIG or DHS OIG's contracted PI vendors on Tab 3 of the Quarterly Program Integrity Report by entering "OIG Audit (OIG case number)" in Column F "Reason for Recovery."

3) Network providers may appeal overpayments through the process identified in the County PIHP's provider agreement first, and subsequently follow the process outlined in Article VIII of this contract, if needed.

g. Ensuring that provider agreements require the County PIHP's network providers to collaborate with DHS OIG and DHS OIG's contracted PI vendors in the following ways:

1) Network providers must respond to requests for all records in a timely manner as specified in the record request letter.

2) If a network provider would like to submit rebuttal to initial findings for consideration by DHS OIG or DHS OIG's contracted PI vendors, the network provider must submit the rebuttal documentation to DHS OIG or DHS OIG's contracted PI vendors by the date specified in the preliminary findings letter or amended preliminary findings letter.

8. Corrective Action Plans and Sanctions

DHS will issue any formal corrective action plans or sanctions related to non-compliance with this Article in accordance with Article XIV, Section D.

9. Quarterly Program Integrity Reporting Log

a. The County PIHP must submit the Quarterly Program Integrity Reporting Log (F-02250) to DHS OIG on a quarterly basis. The log must be completed thoroughly and accurately and is due no later than the last business day of the month following the end of the calendar year quarter (April, July, October, and January). The Quarterly Program Integrity Reporting Log consists of the following four separate reporting categories:

1) Program Integrity Log: Captures complaints regarding fraud, waste, and abuse received by the County PIHP warranting preliminary investigation.

2) Provider Education Log: Captures education given to network providers related to billing practices, billing errors, or fraud, waste, and abuse. The County PIHP's should differentiate between education that originates from a complaint, training requested by the provider and regular scheduled training opportunities. It is unnecessary to capture education regarding subject matter unrelated to program integrity.

3) Overpayment Recovery Log: Captures pertinent information regarding all overpayment recoveries, not just those recovered due to fraud, waste, and abuse, regardless of which entity identified the overpayment.

4) Termination/Sanctions/Suspension Log: Captures all terminations, sanctions, and payment suspension actions taken by the County PIHP that impact Medicaid network providers.

b. The Quarterly Program Integrity report must be submitted to the Department via DHS OIG's SharePoint site. DHS OIG will evaluate the submitted reports and may follow up with the County PIHP to obtain additional information, provide technical assistance, or request further action. DHS may impose a corrective action plan or a financial sanction for non-compliance with reporting requirements and deadlines.

10. Records Retention

The County PIHP must retain records pertaining to all program integrity activities, including but not limited to audits, investigations, review, Quarterly Program Integrity Reports, and complaints as required in Article XII: Reports and Data, Section G: Records Retention in this contract. Article XII: Reports and Data, Section G: Records Retention requires documentation to be retained for a period of not less than ten years from the date of termination of this contract.

K. Medical Loss Ratio Reporting

1. MLR Requirement

   The County 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 County PIHP must submit the MLR on April 1 of the following year with the annual financial reporting submission in the designated worksheet within the County PIHP Financial Reporting Template. The County 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 County 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 County PIHP Financial Reporting Template in the next scheduled financial reporting submission based on the DHS reporting due dates.

2. MLR Reporting Requirements

   a. Each County 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 County 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 County PIHP may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. Any County PIHP with enrollment greater than the minimum number of member months set by CMS will be determined to be fully credible.
   h. If a County PIHP’s experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.
   i. The County PIHP will aggregate data for all Medicaid eligibility groups covered under the contract with the Department.

j. The County 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

k. Additional description and guidelines for the MLR report are located in the MLR worksheet within the DHS PIHP Financial Reporting Template.

L. The County PIHP must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the County PIHP within 180 days of the end of the MLR reporting year or within 30 days of being requested by the County 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

M. Program Integrity

1. Fraud, Waste, and Abuse Investigations

The County PIHP 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 PIHP's compliance structure, activities, and performance are subject to audit/review by the Office of Inspector General (OIG). The County PIHP is required to respond to any corrective action or performance improvement activities specified in the written report to the County PIHP within the timeframes specified.

The arrangements or procedures must include the following:

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

b. 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.

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

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

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

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

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

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

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

i. The County PIHP 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:

1) Program Integrity Log; Captures complaints regarding fraud, waste, and abuse received by the County PIHP warranting preliminary investigation.
2) Provider Education Log; Captures education given to network providers related to billing practices, billing errors, or fraud, waste, and abuse. The County PIHP 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.
3) Overpayment Recovery Log; Captures pertinent information regarding all overpayment recoveries, not just those recovered due to fraud, waste, and abuse, regardless of which entity identified the overpayment.

The County PIHP 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 PIHP 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 PIHP 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 PIHP must report providers terminated for cause by the County PIHP, as well as providers the County PIHP identifies as excluded, to County PIHP. The County PIHP must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of the email should include the name of the provider, NPI and MA ID numbers, date of termination/exclusion, and reason for termination or exclusion.

Pursuant to 42 CFR 455.20, the County PIHP 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 PIHP must verify the provision of services with members for 100 paid encounters each quarter.

b. The County PIHP must maintain appropriate records of these verifications.
c. DHS will verify Compliance with this requirement.

1) If the County PIHP 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 PIHP 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.

2) The County PIHP 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 PIHP's identification of the issue. The County PIHP 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 a County PIHP should not be made anonymously, and these reports may be subject to open records laws.
b. The County PIHP 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 PIHP 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 PIHP collaborates with OIG to complete the credible allegation of fraud referral (F-02296) and compile appropriate exhibits.
d. The County PIHP 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 PIHP 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 PIHP must have a documented process outlining the County PIHP's response to information in the provider file from the Department notifying the County PIHP of suspension of payment. The provider file sent by the Department to the County PIHP will have an added field that will indicate the outcome of the credible allegation of fraud investigation. The values are:

a. A—ACA suspension of payment s currently active. The County PIHP must suspend payment based on the effective date for the start of the investigation.

b. C—The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.

c. 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 PIHP must have a written process documenting its response to email notification of provider payment suspensions from

the DHS OIG resulting from credible allegations of fraud, including but not limited to how the payments are suspended in the County PIHP's claims processing system and any required internal communications.

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

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

Pursuant to 42 CFR s. 438.608, the County PIHP must recover all overpayments made to network providers, including those overpayments attributed to fraud, waste, and abuse, identified by the County PIHP. The County PIHP 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 PIHP recovers the payments and retains the funds for all overpayments identified by the County PIHP.

The County PIHP must have a documented process requiring the network providers to return any overpayments they received. The County PIHP must share the documented process with all providers in the County PIHP's network. The County PIHP must require the network providers to return overpayments within 60 days of the provider receiving written notification of the overpayment. The County PIHP must appropriately reflect the recovery of all overpayments in the County PIHP'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.

N. Supplier Diversity Reporting

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

The State of Wisconsin is committed to the promotion of MBEs and DVBs in the State's purchasing program. The 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.

O. Utilization and Encounter Requirements

The County PIHP is required to implement and maintain all of the requirements regarding utilization and encounter reporting, as contained in Article IV.

Article XIII

XIII. Functions and Duties of the Department

A. County PIHP Review

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

B. County PIHP Review of Study or Audit Results

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

C. Fraud, Waste, and Abuse Training

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

Article XIV

XIV: Contractual Relationship

A. Delegations of Authority

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

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

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

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

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

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

B. Subcontracts

The County PIHP 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 PIHP under this Contract. The County PIHP may subcontract for any function covered by this Contract PIHP, subject to the requirements of this Contract.

1. Subcontract Standard Language

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

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

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

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

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

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

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

g. Per 42 CFR 438.3(k), subcontractor agrees to comply with all audit and record retention and inspection requirements of 42 CFR 438.230(c)(3)(i-iv) and, where applicable, the special compliance requirements on abortions, sterilizations, hysterectomies, and HealthCheck reporting requirements. Specifically, the State (including the 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 PIHP'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 PIHP, 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 PIHP for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

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

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

l. Subcontractor agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered 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 members for medically necessary services covered under this Contract and provided during the members' period of County PIHP enrollment. Subcontractor also agrees not to bill members for any missed appointments while the members are. This provision will remain in effect even if the County PIHP becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the County PIHP, County PIHP provider or County PIHP subcontractor can bill.

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

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

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

r. Subcontractor agrees to abide by the County PIHP 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 PIHP affiliation(s), or changes in affiliation, or relating directly to the County PIHP population. Subcontractor will not distribute any "marketing" or member informing materials without the consent of the County PIHP and the Department.

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

2. Subcontract Submission Requirements

a. Changes in Established Subcontracts

1) The County PIHP must submit changes in previously approved subcontracts to the Department for review and approval before they take effect. This review requirement applies to changes that affect the amount, duration, scope, location, or quality of services.

a) Technical changes do not have to be approved.

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

2) The Department will review the subcontract changes and respond to the County PIHP within 15 business days.

b. New Subcontracts

The County PIHP must submit new subcontracts to the Department for review and approval before they take effect.

3. Review and Approval of Subcontracts

   The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract, as it deems appropriate. The Department may consider such factors, as it deems appropriate to protect the interests of the state and members, including but not limited to the proposed subcontractor's past performance. DHS will give the County PIHP: (1) 120 days to implement a change that requires the County PIHP 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.

4. Notification Requirements Regarding Subcontract Additions or Terminations

   The County PIHP must:

   a. Notify the Department of Additions or Terminations

   The County PIHP must notify the Department within 10 days of subcontract additions or terminations when those changes are substantial and impact member access. Those notifications could involve:

   1) A clinic or group of mental health providers,
   2) An individual mental health provider and/or clinic.

   This department notification must be through the submission of an updated provider network to the SFTP server.

b. Notify the Department of a Termination or Modification that Involve Reducing Access to Care

The County PIHP shall notify the Department within seven (7) days of any notice by the County PIHP to a subcontractor, or any notice to the County PIHP from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could reduce 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 PIHP and opportunity to correct are provided for) and suspension of new enrollment.

c. Notify Members of Provider Terminations

Not less than 15 days prior to the effective date of the in-network provider or gatekeeper termination, the County PIHP must send written notification to the provider or gatekeeper's members. The County PIHP must use a template letter for this notification and obtain Department approval of the template before it is sent to members. Any subsequent proposed changes ot the template must be approved by the Department.

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

Section 1903(m)(5)(B)(ii) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny payments to the County PIHP for members who enroll after the date on which the County PIHP 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 PIHP 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:

i. 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.

ii. Imposition of premiums on members in excess of permitted premiums.

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

iv. Misrepresentation or falsification of certain information

1. Financial Penalties

The Department may pursue all sanctions and remedial actions with the County PIHP that are taken with 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)]

a. A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to members, potential members or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.

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

c. A maximum of $15,000 for each member the State determines was not enrolled because of a discriminatory practice (subject to the $100,000 overall limit above).

d. A maximum of $25,000 or double the amount of the excess charges, (whichever is greater) for charging premiums or charges in excess of the amounts permitted under the BadgerCare Plus program. The State must deduct from the penalty the amount of overcharge and return it to the affected member(s).

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

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

2. Withholding of Capitation Payments and Orders to Provide Services

a. Procedures for Withholding Capitation Payments

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

1) Whenever the Department determines that the County PIHP 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 PIHP to provide such service, or withhold a portion of the County PIHP'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 PIHP shall be given at least seven days written notice prior to the County PIHP being required to comply with either: a) Department direction to the County PIHP 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 PIHP 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 PIHP to provide such service, or withhold a portion of the County PIHP'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 PIHP 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 PIHP 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 PIHP 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:

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

ii. If the Department ordered the County PIHP to provide services under this section tit shall pay the County the actual documented cost of providing the services.

2) If the County PIHP fails to submit required data and/or information to the Department or the Department's authorized agents or fails to submit such data or information in the required form or format, by the deadline specified by the Department, the Department may immediately impose liquidated damages in the amount of $1,500 per day for each day beyond the deadline that the 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 PIHP's capitation payments.

3) Whenever the Department determines that the County PIHP 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 PIHP 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 County PIHP'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 PIHP Contract administrator no later than the second business day after the Department's deadline that the County PIHP has failed to submit the required data or the required data cannot be processed.

   b. Beginning on the second business day after the Department's deadline, the County PIHP will be subject without further notification to liquidated damages per data file or report.

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

d. If the County PIHP repeatedly fails to submit required data or reports, or data that cannot be processed, the Department will require the County PIHP 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 PIHP 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 PIHP notifies the Department that it will discontinue contracting with the Department at the end of a Contract period but reports or data are due for a Contract period, the Department retains the right to withhold up to two months of capitation payments otherwise due the County which will not be released to the County PIHP until all required reports or data are submitted and accepted after expiration of the Contract. Upon determination by the Department that the reports and data are accepted, the Department will release the monies withheld.

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.

b. 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).

c. Required Reports and Data Submissions

1) Encounter Data-

a) If the County PIHP fails to submit required data and/or information to the Department or the Department's authorized agents, or fails to submit such as data or information in the required form or format, as outlined in Article (Xii)(D)(1), by the deadline specified by the Department, the Department may place the County PIHP under a 3-month Corrective Action Plan (CAP). The start of the 3-month CAP is the date the DHS requests the CAP from the County PIHP in writing. If after the 3 months the PIHP has not come into contract compliance, DHS may immediately impose liquidated damages in an amount not to exceed the equivalent of $1,500 per day for each day beyond the deadline that the County PIHP fails to submit the data or fails to submit the data in the required for or format, such liquidated damaged to be deducted from the County PIHP's capitation payments.

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

c) The County PIHP must meet the Department's aggregate standards for submitting encounter data as outlined in Article XII(D)(1) or liquidated damages may apply based on "erred" data. The term "erred encounter record" means an encounter record that failed an edit when a correction is expected by the Department unless the record is otherwise priced and included in the County PIHP encounter data. This does not apply to records for out-of-state emergency services that are not moved from the erred table due to the inability to match to the provider file. If the PIHP fails to correct an error to the encounter record within the time frame specified, the Department may assess liquidated damages in an amount not to exceed the equivalent of $5 per erred encounter record per month until the error has been corrected or the issue has been resolved to the Department's satisfaction. The liquidated damage amount will be deducted from the PIHP's capitation payment. When applied, these liquidated damages will be calculated and assessed on a monthly basis. If upon audit or review, the Department finds that the PIHP has removed an erred encounter record without the Department's approval, the Department may assess liquidated damages for each day from the date of original error notification until the date of correction.

i. The Department may assess up to $5 per record per month until the encounter record has been fixed for each encounter record found to be different from the provider claim for the procedure code, units of service, diagnosis code, modifier code, charge field, and TPL paid amount.

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

iii. Failure to successfully report usable data using the ASC X12 837 HIPAA Compliant Transaction or the Financial Report information may result in up to a 1% withhold to the PIHP's administration rate. The amount will be withheld from the capitation payment until the County PIHP is able to submit usable data. If the County PIHP is unable to submit usable data by the period of time defined by the Department when withholding the payment, the amount withheld will be forfeited. If either party terminates the contract during the period that payment is withheld, the amount will be automatically forfeited.

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

v. Whenever the Department determines that the County PIHP has failed to perform the administrative functions, the Department may withhold a portion of future capitation payments sufficient to directly compensate the Department for the program's costs of providing health care services and items to individuals insured by said insurers and/or the insurers/employers represented by said third party administrators. "Administrative Function" is defined as any Contract obligation other than the actual provision of Contract services.

d. Temporary Management

The state will impose temporary management when:

1) There is continued egregious behavior by the County PIHP, including but not limited to behavioral 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 PIHP's members while improvements are made to remedy violations under 438.700 or until there is an orderly determination or reorganization of the County PIHP.

3. Suspension and Reduction of Enrollment

    a. Suspension of New Enrollment

    Whenever the Department determines that the County PIHP is out of compliance with this Contract, the Department may suspend the County PIHP's right to enroll new members under this Contract. When exercising this option, the Department must notify the County PIHP 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. Department-Initiated Enrollment Reductions

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

4. 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. Modification and Termniation of Contract

1. Modification

a. Mutual Consent

This contract may be modified at any time by mutual written agreement of both the County PIHP and the Department.

b. Unilateral Modification by the Department:

This contract will be modified by the Department if changes in federal or state laws, rules, regulations, or amendments to Wisconsin's CMS approved waivers or the state plan require modification to the contract. In the event of such change, the Department will notify the HMO in writing. If the change materially affects the HMO's rights or responsibilities under the contract and the HMO does not agree to the modification, the HMO may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination.

2. Termination

a. Mutual Consent

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

b. Unilateral Termination by the Department

1) Authority to Terminate Contract: The Department has the authority to terminate the County PIHP's contract and enroll that entity's members in other health plans of the member's choosing, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the County PIHP has failed to do either of the following:

a) Carry out the substantive terms of this Contract; or

b) Meet applicable requirements in sections 1932, 1903(m), and 1905(t) of the Social Security Act.

2) Notice and Pre-Termination Hearing:

Before the Department terminates the County PIHP contract for failing to carry out substantive terms of the contract or to meet applicable requirements in sections 1932, 1903(m), or 1905(t) of the Social Security Act, the Department must provide the PIHP a pre-termination hearing. The Department will give the PIHP written notice of its intent to terminate, the reason for termination, and the time and place of the hearing.

3) Member Disenrollment During Termination Hearing Process:

Per 42 CFR §438.722, the Department may provide the County PIHP's members with written notice of its intent to terminate the contract and allow members to disenroll from the HMO immediately without cause.

a) The HMO shall provide assistance to any member electing to terminate his or her enrollment, by making appropriate referrals and providing the individual's member record to new providers and/or a member's new HMO.

b) The Department shall ensure that a member who is disenrolled receives appropriate choice counseling and is permitted to enroll in a new HMO of the member's choosing

4) Post-Hearing Notice:

After the hearing, the state will give the County PIHP written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination. For an affirming decision, the Department will give members of the County PIHP notice f the termination and information, consistent with 42 CFR § 438.10, on their options for receiving Medicaid Services following the effective date of termination,

c. Automatic Termination by the Department

1) Foreign 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 a 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 County 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.

d. Unilateral Termination by the County PIHP

1) Changes to Capitation Rates:

This contract may be terminated by the County PIHP due to dissatisfaction with the final capitation rates, which will be effective based on negotiations with County PIHPs. The County PIHP must notify the Department within 30 days of the notice of the final rates if the County PIHP intends to terminate its contract with the Department. The County PIHP must also notify the Department within 30 days if it intends to decrease its service area due to the final capitation rates. In the event of termination under this paragraph. To assure the smooth transition of members, the termination of the Contract or the decrease in service area will be effective no less than 90 days, and no more than 120 days, after PIHP notification to DHS of the intent to terminate the Contract or decrease the County PIHP's service area.

2) changes in Reporting Requirements:

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

e. Termination by either party:

1) Changes Mandated by Federal or State Law:

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) For Cause:

Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of 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 PIHP 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) Loss of Feeral or State Funding:

a) Permanent Loss of Funding

Either party may terminate this Contract if federal or state funding of contractual services rendered by the County PIHP become or will become permanently unavailable and such lack of funding would preclude reimbursement for the performance of the County PIHP's obligations. In the event it becomes evident state or federal funding of claims payments or contractual services rendered by the County PIHP will become unavailable, the Department will immediately notify the County PIHP, in writing, identifying the basis for the anticipated unavailability of funding and the date on which the funding will end.

b) Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department or County PIHP suspend performance of any or all of the County PIHP's obligations under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or County PIHP will attempt to give notice of suspension of performance of any or all of the County PIHP'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. Once the funding is reinstated, the County PIHP will resume the suspended 30 calendar days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

f. Obligations of Contracting Parties Upon Non-Renewal or Termination

When non-renewal or termination of the Contract occurs, the following obligations shall be met by the parties:

1) Transition Plan:

The County PIHP shall submit a written plan that receives the Department's approval, to ensure uninterrupted delivery of services to County PIHP members and their successful transition to other applicable programs (e.g., Medicaid fee-for-service). The plan will include provisions for the transfer of all member related information held by the County PIHP or its providers and not also held by the Department. Additional elements of the transition plan may include, but are not limited to, a communication plan; additional data-sharing reports for transitioning members; and timelines for outstanding financial reconciliation.

a) Submission of the Transition Plan

The County PIHP shall submit the plan at one of the following times, depending on which applies: no less than ninety (90) calendar days prior to the contract's expiration when the County PIHP decides to not renew the contract; within ten (10) business days of notice of termination by the Department; or along with the County PIHP's notice of termination.

b) Management of the Transition

The County PIHP shall designate a person responsible for coordinating the transition plan and will assign staff as the Department determines is necessary to assist in the transition. Status meetings including staff from all parties involved in the transition will be held as frequently as the Department determines is necessary.

c) Continuation of Services

If the County PIHP has been unable to successfully transition all members to applicable programs by the time specified in the approved transition plan, the County PIHP shall continue operating as a PIHP under this contract until all members are successfully transitioned. The Department will determine when all members have been successfully transitioned to applicable programs.

If the Department determines it necessary to do so, the County PIHP will agree to extend this contract, in order to continue providing services to members until they are successfully transitioned to applicable programs. During this period the County PIHP remains responsible, and shall provide, the services in the benefit package, and all terms and conditions of the contract will apply during this period.

d) Costs of Transition Plan

The County PIHP will be responsible for all expenses related to the transition plan, including but not limited to costs associated with the Department's enrollment of the County PIHP's members into other County PIHPs or the provision of MA benefits to the County PIHP's members through other options in the event of a unilateral termination by the Department.

2) Notice to Members and Providers:

a) The Department shall be responsible for developing the format for notifying all members of the date of non-renewal or termination and process by which the members will continue to receive Contract services.

b) The Department will be responsible for the provision of any other necessary notifications to impacted members and providers. Such notifications may include, but are not limited to, mailed notices, ForwardHealth Member and/or Provider Updates and/or phone outreach.

c) Costs of Notice to Members and Providers

The County PIHP shall be responsible for all expenses related to said notification under a) and b).

3) Return of Advanced Payments:

a) Any payments advanced to the County PIHP 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) Transfer of Information: The County PIHP shall supply all information necessary for the reimbursement of any outstanding claims within the period of time specified by the Department.

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

E. Interpretation of Contract Language

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

Article XV

XV. Fiscal Components/Provisions

A. Billing Members

For the County PIHP, any provider who knowingly and willfully bills a member directly for a service covered by the County PIHP shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B.(d)(1), 42 U.S.C. 1320a-7b(d) of the Social Security Act and Wis. Stats. s. 49.49(3p), see also Wis. Admin Code § 106.04(3). This provision shall continue to be in effect even if the County PIHP becomes insolvent.

If a member agrees in advance in writing to pay for a service not covered by the County PIHP or a prior authorization request is denied and the member is advised of the fact before receiving the service, the County PIHP, provider, or subcontractor may bill the member only for provision of the non-covered service. The standard release form signed by the member at the time of services does not relieve the County PIHP and its providers and subcontractors from the prohibition against billing a member in the absence of a knowing assumption of liability for a non- covered service. The form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services, or procedures that are not covered.

The County PIHP and its providers and subcontractors must not bill a member for services provided to the member, for which the State does not pay the County PIHP; or the State or the County PIHP does not pay the individual or health care provider that furnished the services under contract, referral, or other arrangement; during the member's period of enrollment, except for allowable copayments and premiums established by the Department for covered services provided during the member's period of enrollment in the County PIHP. In addition, the County PIHP must ensure that its members are not held liable for payments for necessary covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the County PIHP covered the services directly. This contract limits a member's liability for cost sharing to the amounts listed in the ForwardHealth online handbook.

County PIHPs 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 PIHP 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.

B. Physician Incentive Plan

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

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

C. Responsibility to Provide Services

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

D. Payment Requirement and Procedures

The County PIHP is responsible for the provision and payment of all Contract services provided to all members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Reports generated for the month of coverage.

Additionally, the County PIHP agrees to provide, or authorize provision of, services to all members with valid ForwardHealth ID cards indicating County PIHP 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 PIHP 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 PIHP enrollment but did not appear as a CONTINUE on the Final Report.

1. County PIHP Claim Retrieval System

   The County PIHP 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 PIHP shall date stamp all provider claims upon receipt. In addition, the County PIHP 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.

2. Thirty-Day Payment Requirement

   The County PIHP 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 PIHP agrees not to delay payment to subcontractors pending subcontractor collection of third party liability unless the County PIHP has an agreement with their subcontractor to collect third party liability.

3. 2022 American Rescue Plan Rate Increase

   The Department will make payments to the County PIHP for American Rescue Plan Act (ARPA) eligible services, which the County PIHP shall distribute to ARPA eligible service providers, under the following terms and conditions:

   a. For purposes of this section, “ARPA eligible service provider” are providers of:
      i. Alcohol and Other Drug Abuse (AODA) services
      ii. AODA Day Treatment
      iii. Mental Health Day Treatment
      iv. Mental Health Services

   b. Providers of services not listed, including but not limited to common carrier transportation providers are not eligible service providers under this section.

c. County PIHPs are required to provide a unit rate increase to all eligible providers equal to 5% of each eligible provider's rates for the services identified in a. For sub-capitated arrangements, increases can be based on unit rates or made in a lump sum. Additionally, County PIHPs are to include a provision stating the sub-capitated vendors required to pass the 5% increase to al eligible providers. These increases are effective for dates of service beginning January 1, 2022.

d.

E. Payment Schedule

Capitation payments to the County PIHP 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 PIHP receives 'Initial' and 'Final' enrollment reports each month showing members as ADD, CONTINUE, DISENROLLED, or PEND ('Initial' report only).

Article XVI

XVI. PAYMENTS TO COUNTY PIHP

A. 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).

B. Renegotiation

The monthly capitation rates set forth in this article are recalculated on an annual basis. The County PIHP 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.

C. Capitation Rates

In consideration of full compliance by the County PIHP with Contract requirements, the Department agrees to pay the County PIHP 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 PIHP 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 PIHP 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 County PIHP 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 County PIHP when the payment will process and provide a file listing the encounters included in the payment through the SFTP.

D. Recoupments

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

1. The Department will recoup the County PIHP capitation payments for the following situations where a member's County PIHP 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 PIHP's service area; or
   b. Member enters a public institution; or
   c. Member dies.

2. The Department will recoup the County PIHP capitation payments for the following situations where the Department initiates a change in a member's County PIHP enrollment status on a retroactive basis, reflecting the fact that the County PIHP 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 for 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 County PIHP 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 PIHP 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 PIHP 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 PIHP unless the member moves out of the extended service area or the County PIHP's service area. Any capitation payment made for periods of time after disenrollment will be recouped.

E. Reinsurance

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

F. Coordination of Benefits (COB), Third Party Liability (TPL and Subrogation

The County PIHP 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 PIHP 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 PIHP shall use cost avoidance when possible, except as otherwise permitted herein. Specifically, the County PIHP 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 PIHP 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 PIHP determines seeking reimbursement would not be cost effective, upon request of the Department. COB activities include pursuit of the County PIHP's subrogation rights under Chapter 49 of the Wisconsin Statutes.

2. To assure compliance, records shall be maintained by the County PIHP of all COB collections and reports shall be made annually on the form designated by the Department. The County PIHP 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 PIHP 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 PIHP, as a health plan, under s. 49.89(9), After attorneys' fees and expenses have been paid, the County PIHP shall collect the full amount paid on behalf of the member.

3. Where the County PIHP 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 PIHP or its subcontractors. Subcontractors must report COB information to the County PIHP. County PIHP 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 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.

G. 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 County 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 County PIHP works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the County PIHP will not be paid for that work. If the state paid the County 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 County 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 County PIHP, the County 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 XVII

XVII. COUNTY PIHP SPECIFIC CONTRACT TERMS

A. Documents Constituting Contracts

1. Current Documents

In addition to this base agreement, the contract between the Department and County PIHP includes, existing provider publications addressed to the PIHP, the terms of the most recent County PIHP Certification issued by this Department prior to the contracts starting SFY23, any questions and answers released pursuant to said County PIHP certification application by the Department, DHS issued guides and the County PIHP's signed application. In the event of any conflict in the provisions among these documents, terms of this base agreement will prevail. The provisions in any question and answer document will prevail over the County PIHP certification applications. The County PIHP certification application terms shall prevail over any conflict with the County PIHP's actual signed application.

2. Future Documents

The County PIHP is required by this contract to comply with all future Wisconsin Health Care Programs Online Handbooks and Contract Interpretation Bulletins issued pursuant to this Contract. The documents listed in this section constitute the entire Contract between the parties. No other oral or written expression constitutes any part of this contract.

B. Disclosure Statement(s) of Ownership or Controlling interest in a County PIHP and Business transactions

1. Ownership or Controlling Interest Disclosure Statement(s)

a. Pursuant to 42 CFR § 455.104 County PIHP's and subcontracted disclosing entities and fiscal agents must provide the following disclosures to the Department:
   1) The name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box.
   2) Date of birth and Social Security number (in the case of an individual).

3) Other tax identification number (in the case of a corporation) with ownership or control interest in the disclosing entity (or fiscal or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5% or more interest.

   Calculation of 5% ownership or control is as follows:

   a) The percentage of direct ownership or control is the percentage interest in the capital, stock, or profits.
   b) The percent of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock ina corporation that owns 80% of the stock the County PIHP, the person owns 8% of the County PIHP.
   c) The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the County PIHP's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the County PIHP's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the County PIHP's assets, the person owns 6% of the County PIHP.

4) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity is a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
5) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclsing entity (or fiscal agent or managed care entity) has an ownership or control interest.
6) The name, address, date of birth, and Social Security number of any managing employing of the disclosing entity (or fiscal agent or managed care entity).

b. Disclosure from any provider or disclosing entity is due at any of the following times:

1) Upon the provider or disclosing entity submitting the provider application.
2) Upon the provider or disclosing entity executing the provider agreement.
3) Upon request of the department during the re-validation of the enrollment process.
4) Within 35 days after any changes in ownership of the disclosing entity.

c. Disclosure from fiscal agents are due at any of the following times:
   1) Upon the fiscal agent executing the contract with the Department.
   2) Upon renewal or extension of the contract.
   3) Within 35 days after any changes in ownership of the fiscal agent.
d. Disclosure from the County PIHP's are due at any of the following times:
   1) Upon the County PIHP executing the contract with the Department.
   2) Upon renewal or extension of the contract.
   3) Within 35 dafter any change in ownership of the managed care entity.

   4) County PIHPs must disclose all ownership and controlling interest to the Department upon request or as federally required. The County PIHP may supply this information on a separate report or submit reports filed with the state's insurance or health regulators as long as these reports provide the necessary information for the prior 12 month period.

      As directed by the CMS Regional Office (RO), the Department must provide documentation of this disclosure information as part of the prior approval process for contracts. The Documentation must be submitted to the Department and the RO prior to each contract period. If the County PIHP has not supplied this information, contract with the County PIHP is not considered approved for this period of time and no FFP is available for the period of time preceding the disclosure.

      A managed care entity may not knowingly have as a director, officer, partner, or person with beneficial ownership of more than 5% of the entity's a person who is debarred, suspended, or otherwise excluding from participating in procurement or non-procurement activities under the Federal Acquisition Regulation or who has an employment, consulting, or other agreement for the provision of items and services that are significant and material to the entity's obligations under its contract with the state.

      If the Department finds that the County PIHP has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:
      a. Must notify the Secretary of noncompliance.
      b. May continue an existing agreement with the County PIHP unless the Secretary directs otherwise.
      c. May not renew or otherwise extend the duration of an existing agreement the County PIHP unless the Secretary provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

2. Business Transaction Disclosures

   The County PIHP must report to the Department information related to business transactions in accordance with 42 CFR § 455.105. The County PIHP must be able to submit this information within 35 days of the date written request from the Department.

   a. The ownership of any subcontractors with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the requestion; and

   b. Any significant transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of request.

      1) If the County PIHP contract is being renewed or extended, the County PIHP must disclose information those business transactions that occurred during the prior contract period. If the contract is an initial contract, but the County PIHP has operated previously, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving County PIHP enrollment. All of these County PIHP business transactions must be reported.

3. Disclosure by providers: information on persons convicted of crimes

   In accordance with 42 CFR § 455.106:

   a. The County PIHP must disclose to the Department the identity of any person who:
      2) Has ownership or control interest in the provider, or is an agent or managing employee of the provider, and
      3) Has been convicted of a criminal

   b. The County PIHP shall report to the Department within 20 working days of the receipt of the following:
      1) Any information regarding excluded or convicted individual or entities, including those in paragraph (C)(a) above;
      2) Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a provider.

   c. Denial or termination or provider participation

1) The Department may refuse to enter into or renew an agreement with a provider if any person who has ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX service program.
2) The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurate make any disclosure required.

C. Miscellaneous

1. Indemnification

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

a. Any failure, inability, or refusal of the County PIHP or any of its subcontractors to provide contract services,
b. The negligent provision of contract services by the County PIHP or any of its subcontractors.
c. Any failure, inability or refusal of the County PIHP to pay any of its subcontractors for contract services.

2. Independent Capacity of Contractor

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

3. Omissions

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

4. Contract Administration

a. 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.

b. 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.

c. 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

5. Choice of Law

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

6. Waiver

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

7. Severability

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

8. Survival

   The terms and conditions in this Contract that by their sense and context are intended to survive the completion of performance shall so survive the completion, expiration or termination of the Contract. This specifically includes, but is not limited to recoupments and confidentiality provisions.

9. 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.

10. Headings

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

11. Assignability

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

12. Right to Publish

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

    12. Media Contacts

    The County PIHP agrees to forward to the Department all media contacts regarding the program or its members.

13. 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.

14. Loss of Key Personnel

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

15. Media Contacts

    The County PIHP agrees to forward to the Department all media contacts regarding the County PIHP or members.

D. County PIHP Specific Contract Terms

1. Initial Contract Period

   The respective rights and obligations of the parties as set forth in this Contract shall commence on July 1, 2022 and, unless earlier terminated, shall remain in full force effective June 30, 2023. The specific terms for enrollment and rates are as specified in the Contract.

2. Renewals

   By mutual written agreement of the parties, there may be one one-year renewal of the term of the Contract. An agreement to renew must be effected at least 30 days prior to the expiration of any contract term. The terms and conditions of the Contract shall remain in full force and effect throughout any renewal period, unless modified under the provision of the Contract.

3. Specific Terms of the Contract

   a. The specific terms in the County PIHP's completed application for certification are incorporated into this Contract.
   b. For each rate period in this Contract, the County PIHP agrees at minimum, to maintain the service area that was in effect at the time the County PIHP accepted the rates. This provision does not prevent the County PIHP from expanding to new service areas as approved by the Department.
   c. The County PIHP's service area and maximum enrollment are specified in its certification application.
   d. Rates are determined for the County PIHP in which enrollment is accepted.
   e. Adjusted rates-Rates may be changed to reflect legislative changes in reimbursement or changes in approved services. Rate changes may occur during the rate year or in rare instances retroactively.
   f. The Department shall calculate chronicity or risk adjustment scores as part of the rate development methodology depending on the availability of data. The risk adjustment scores will be applied prospectively to the rate schedule in the rate exhibits provided by the Department. The Department may adjust the risk adjustment score that was used to adjust the base rates. Any such adjustment will take effect no sooner than 45 days after calculating the variance. Any risk score changes applied to a given County PIHP will also impact other County PIHP risk scores due to budget neutrality requirements.
   g. An annual risk adjustment reconciliation will be calculated based on actual enrollment. This may result in additional payments to or recoupments from the County PIHP. The adjustments will be budget neutral to the Department.

E. Noncompliance

The Department shall have the right to audit any records of the County PIHP and to request any information to determine if the County PIHP has complied with the requirements in this section. If at any time the Department determines that the County PIHP has not complied with any requirement in this article, the Department will issue an order to the County PIHP to comply. The County PIHP shall comply within 15 calendar days after receipt of the order. If the PIHP fails to comply after an order, the Department may pursue action against the PIHP as provided under Article XIV. Additionally, the County PIHP may be required to forfeit the reimbursement.

F. Payment Disputes

The Department shall have the right to adjust the reimbursement outside the information provided by the County PIHP in the guide or template.

The PIHP may dispute the reimbursement amount by sending a letter to the Department no later than 30 days after receipt of payment. After 30 days, the County PIHP waives the right to dispute the reimbursement amount.

G. Resolution of Reporting Errors

If the County PIHP discovers a reporting error, the Department's Bureau of Rate Setting in the Division of Medicaid Services in writing within 15 days of discovery.

Errors discovered after the retroactive capitation rate amendment is issued will be applied to the following year's reimbursement.

H. County PIHP Specific Contract Terms

1. COUNTY IN WHICH ENROLLMENT IS ACCEPTED: Dane.

2. CAPITATION RATE: The monthly capitation rate for each member is $1,839.42 for the period from July 1, 2022-June 30, 2023. DHS pays a pro-rated capitation rate for individuals enrolled for a partial month, calculated as the monthly rate *12/365* days number of enrolled days.

3. The Contract shall become effective on July 1, 2022 and shall terminate on June 30, 2024.

4) IN WITNESS WHERE OF, the State of Wisconsin and Dane County have executed this agreement:

DocuSigned by: Astra Iheukumere 01C29C1D3[illegible] Signature from County PIHP	DocuSigned by: Lisa A. Olson AFFC3C5B099D4AE... Signature from State
Astra Iheukumere Printed Name	Lisa A. Olson Printed Name
Interim Director Title	Medicaid Director Title
12/27/2022 Date	12/27/2022 Date

Addendum I: Memoranda of Understanding

A. MOU Submission Requirements

The County PIHP shall submit to the Department copies of new MOUs, or changes in existing MOUs within 15 days of signing.

The County PIHP shall submit MOUs referred to in this Contract to the Department upon the Department's request.

The County PIHP 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 PIHP's justification of a higher level of payment for a proportionately higher level of services.

B. Emergency Services MOU or Contract

The County PIHP will negotiate in good faith MOUs with emergency care providers to ensure prompt and appropriate delivery of and payment for emergency services.

1. The MOU shall provide for:

    a. The process for determining whether an emergency exists.

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

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

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

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

2. Unless a Contract or MOU specifies otherwise, the County PIHP 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 PIHP, hospitals and urgent care centers regarding emergency situations based on fee-for-service criteria.

Addendum II: Standard Member Handbook

The Standard Member Handbook is located in the HMO and PIHP Communication, Outreach and Marketing Guide, Updated December 2021.

Addendum III: Cross Sector Coordination of Services

Coordination of cross sector services is critical to ensure appropriate and timely service delivery and to communicate service specific information with the various individuals (other county agencies, families, providers, etc.) invested in the member's treatment. The care coordinator, who is responsible for monitoring and updating the treatment plan, is responsible for ensuring frequent, effective communication and collaboration with providers and other sector staff.

A. Coordination Goals

1. Review results of all relevant screens and evaluations that relate to the member's treatment plan, including any prior evaluations or evaluations completed by another sector (e.g., school or child welfare).

2. Coordinate and arrange all assessments and/or treatment services recommended.

3. Ensure all periodic reassessments and reviews are done according to protocol (see Article III), including any additional services needed as a change in member/member's family circumstances.

4. Ensure that all family and caregivers are educated regarding the child's specific needs.

5. Facilitate coordination and communication among providers involved in an individual child's care.

6. Assure that identification and ongoing oversight of children who are prescribed psychotropic medications is occurring regularly, including recommended metabolic testing for children on antipsychotic medication.

B. Other Sector Staff

Staff in other sectors includes, but is not limited to:

1. County child welfare agencies
2. Medical sector staff (e.g., primary care provider, antipsychotic prescriber)
3. Justice System workers
4. Education specialists
5. Housing assistance

Addendum IV: Report Forms and Worksheets

A. Coordination of Benefits Quarterly Report Form and Instructions for Completing the Form

In order to comply with CMS reporting requirements, the County PIHP must submit a Coordination of Benefits (COB) report regarding the County PIHP members. For the purposes of this report, the County PIHP member is any member listed as an ADD or CONTINUE on the monthly County PIHP enrollment report(s).

THIRD PARTY LIABILITY (TPL)

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

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

1. In Medicaid, there are two primary functions related to detecting TPL obligations:

    a. Cost-avoidance—Determining the presence of TPL obligations before the claim is paid
    b. Pay-and-chase—Identifying TPL obligations after the claim is pain.

2. The following definitions apply to TPL:

    a. Coinsurance—A portion or percentage of the cost for a specific service or item is delivered.
    b. Cost Avoidance—A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists the Medicaid agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).
    c. Deductible—A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.

d. Estate—Property (real or personal) in which one has a right or interest at time of death.
e. Health Insurer—Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)
f. Insurer—Any private insurer or public insurer.
g. Post Payment Recovery (Pay and Chase)—A method used where Medicaid pays the member's bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.
h. Third Party—Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan.

The report is to be for the County PIHP's entire service area. The report must be completed on a calendar quarterly basis and submitted to the Department's fiscal agent within 45 calendar days of the end of the quarter being reported.

STATE OF WISCONSIN
WISCONSIN Medicaid
COUNTY PIHP REPORT ON COORDINATION OF BENEFITS

Name of County PIHP_____Mailing Address_____

Office Telephone _____ _____

Provider Number _____ _____

Please designate below the quarter period for which information is given in this report.

_____, 20____ through _____, 20_____

INSTRUCTIONS

For the purposes of this report, a member is any 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 PIHP, aggregating all separate service areas if the County PIHP 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: County PIHP Contract Monitor
Division of Medicaid Services
P.O. Box 309
Madison, WI 53701-0309

Attn: COB Report from _____County PIHP

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 PIHP, except as noted on the report.

Signed: _____

Original Signature of Director or Administrator

Printed Name: _____

Title: _____

Date Signed: _____

B. Member Grievance and Appeal Reporting Template

The member Grievance and Appeal report template can be found in section 12.3 of the *Member Grievances and Appeals Guide*.

C. Attestation Form

I, _____, have reviewed the following data:
(Name and Title)

☐ Encounter Data for (quarter)___(year) 20___.

☐ County 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)

D. SBS MOU Sample

MODEL MEMORANDUM OF UNDERSTANDING
BETWEEN COUNTY PIHP

AND

SCHOOL DISTRICT OR CESA Medicaid

CERTIFIED FOR THE SCHOOL BASED SERVICES BENEFIT

School-based services (SBS) are a benefit paid FFS by Wisconsin Medicaid for all school-enrolled members, including those enrolled in the County PIHP. 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 PIHP 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 County PIHP members requires cooperation, coordination and communication between the County PIHP and the SBS provider.

The County PIHP 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 PIHP 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 PIHP 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 Medicaid or when both the County PIHP 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 PIHP	SBS Provider
Name of County PIHP	Name of SBS Provider
Authorizing Signature	Authorizing Signature

Printed Name	Printed Name
Title	Title
Date	Date

E. Eligibility Criteria for Dane County PIHP

ELIGIBILITY CRITERIA Dane County PIHP

The following information is completed by the County PIHP on each child referred to the County PIHP 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. Not currently residing in a Nursing Home, Psychiatric Hospital, or Residential Care Center.
3. 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:_____
4. 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)
_____			
_____			
_____			

5. 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)	_____ _____

6. 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:

Addendum V: 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 recommendation guideline for completing a performance improvement project.

A. Select a Study Topic

1. Is the topic important to the enrolled population?
2. Does the topic affect a significant portion of the members and reflect a high-volume or high-risk condition of the population served?
3. Can it be affected by the actions of the County PIHP?
4. Was the process of the topic selection described?

B. Define a Study Question

1. Was the method and procedure used to study the topic clear?
2. Was the study question clearly stated and consistent throughout the study?
3. Is the study question specific and answerable?

C. Select Study Indicators

1. Were the indicators objective, clear, and unambiguously defined?
2. Are the indicators based on current clinical knowledge or health services research? (Healthcare guidelines)
3. Do the indicators objectively measure either member outcomes such as health or functional status, member satisfaction, or valid proxies of these outcomes?

D. Identify the Study Population

1. Is there a clear definition of who to include in the study?
2. Did the study define an “at risk” population?
3. Was the entire population included or was a sample used?
4. If the entire population was included, were all members captured by the data collection process used?

E. Utilizing Sampling Methods (if applicable)

1. Was a valid sample size calculated?

2. Were valid sampling techniques used?

F. Data Collection

1. Were the data described in detail?
2. Were the data appropriate to answer the study question?
3. Was the data collection process clearly described?
4. Was the data collection process appropriate to answer the study question?
5. Was the interrater reliability adequate?
6. Did the loss of data or subjects affect validity?
7. Was the study time clear?
8. Was member confidentiality protected?

G. Improvement Strategy/Interventions (Not applicable if the project is to establish a baseline only.)

1. Were interventions related to causes/barriers identified through data analysis?
2. Was the intervention fully described?
3. Can the intervention be widely implemented?
4. Was the implementation of the intervention monitored for effectiveness?

H. Results and Interpretation

1. Was the data collected fully reported?
2. Did the study include comparisons to give meaning to the results?
3. Is the norm or standard expressed in a specific numerical manner?
4. Is the goal, norm or standard appropriate to this population and study?
5. Did the study appropriately use statistical testing? (x2 t-test, regression analysis, etc.)?
6. Were the conclusions consistent with the results?
7. Were data tables, figures and graphs consistent with the text?
8. Did the study consider its limitations?
9. Did the study conclude or imply causality when the supporting data is only correlational?
10. Did the study include how to improve the study?
11. Did the study present recommendations on the results?

12. 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?

I. Real Improvement Achieved

1. Was statistically significant improvement achieved?
2. Does the improvement in performance appear to be due to the planned intervention?
3. What if any additional questions did the study raise? What are the next steps, if any, to study this question/topic?
4. What will you do differently as a result of your study?

J. Sustained Improvement

1. Was sustained improvement demonstrated through repeated measurements over comparable time periods?

Addendum VI: Compliance Agreement

A. THE COUNTY PIHP HEREBY AGREES THAT it will comply with the following:

1. The County PIHP 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 PIHP 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 PIHP 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 PIHP shall ensure compliance by any and all subcontractors engaged by Contractor under the Contract with said regulations.

B. Affirmative Action Plan/Civil Rights

1. The County PIHP 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 PIHP 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 PIHP will continue to provide appropriate translated state procedures, mandated brochures and forms for local distribution.

3. The County PIHP 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 PIHP 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 PIHP 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 PIHP and will conduct reviews to ensure that the County PIHP is ensuring compliance of its subcontractors in compliance with guidelines in the CRC Standards and Resource Manual. The County PIHP agrees to comply with Civil Rights monitoring reviews, including the examination of records and relevant files maintained by the County PIHP, as well as interviews with staff, clients, applicants for services, subcontractors and referral agencies.

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

C. Access to Agency

1. The County PIHP 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 PIHP 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 VII: Definition of "Serious Emotional Disturbance"—Eligibility Criteria

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).

3. 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.

4. 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