CONTRACT FOR SERVICES

Between

State of Wisconsin Department of Health Services (DHS)

and

Children's Hospital and Health System, Inc.

For

Foster Care Medical Home

This Contract is between the State of Wisconsin Department of Health Services (DHS), at 1 West Wilson Street, Madison, Wisconsin 53703, and Children's Hospital and Health System, Inc. at 8915 W Connell Ct, Milwaukee, WI 53226. With the exception of the terms being modified by this Contract modification, all other terms and conditions of the existing contract, including funding, remain in full force and effect. This Modification, including any and all attachments herein and the existing contract, collectively, are the complete contract of the parties and supersede any prior contracts or representations. DHS and the Contractor acknowledge that they have read the Modification and understand and agree to be bound by the terms and conditions of the existing contract as modified by this action. This Modification becomes null and void if the time between the earlier dated signature and the later dated signature exceeds sixty (60) days, unless waived by DHS.

Contract ID Number: 435400-O23-FosterCare-01 M1
Contract Amount: See rate exhibits included in this amendment
Contract Term: January 1, 2022 to December 31, 2023
Optional Renewal Terms: One (1) optional renewal of one year can be mutually agreed by the Parties

DHS Division: Division of Medicaid Services
DHS Contract Administrator: David Sorenson
DHS Contract Manager: Isabelle Leventhal

Contractor Contract Administrator: Heather Swider
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Modification Description:
The following changes are made to the contract through this amendment

Article I: Definitions

Amend the following definitions and acronym grid to read:

Out-of-Home Caregiver: The individual(s) responsible for the temporary care of the child/youth while they are placed in out-of-home care. These individuals include the child's relative or like-kin, foster parents, or agency managing the group home, shelter care, or assessment center the youth is placed at.

Remove the following definitions and acronyms:

- Health Needs Assessment (HNA)
- Preauthorization

Article II: Enrollment and Eligibility

Article II, section A: Enrollment

Remove maximum enrollment language in Article II, Section A(6) and update section title to now read:

6. Enrollment Policy

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

Article III: FCMH Care Management

Article III, section E: Comprehensive Care Planning Requirements

Add list items p and q to Article III, section E(1) to read:

p. Last date of contact with different team members (child/youth, parents, out-of-home care givers, child welfare professionals, and key treatment providers).

q. Transition plan should be created at the same time as the initial comprehensive plan and then updated on the same schedule. See Article III, section G for more details on the transition planning.

Article III, section G: Transitional Health Care Planning

Amend Article III, section G to read:

G. Transitional Health Care Planning

The HCC must engage in transitional health care planning prior to the child leaving the medical home. Transitions can be both expected and unexpected and HCCs must be prepared regardless of the forewarning.

1. Transitional Plan Policy
    a. The transitional planning must be developed with input from the child, their parents and out-of-home caregivers (as applicable) the child's health care providers, and the child welfare professional as appropriate.
    b. Transition planning begins at enrollment.
    c. Identifies all individuals critical to the planning and execution of all transitions, including but not limited to:
        i. Providers,
        ii. Caregivers,
        iii. Parents, and
        iv. Child welfare professionals.

2. Elements of the transitional plan include, but are not limited to:
    a. Medical summary of treatment provided including:
        i. Current medications and last prescription refill date;
        ii. Treatments provided throughout enrollment in WI FCMH;
        iii. List of significant health incidents during FCMH enrollment;
        iv. Inventory of relevant treatment plans (e.g., crisis plan, rescue inhaler plan, etc.); and
        v. List of maintenance needs.
    b. Compile a full medication history from all available sources and a prescription renewal, when appropriate;
        i. Include all indicators for beginning or ending medication, changing dosage amounts, etc.,
        ii. List of prescribers for each medication,
        iii. Refill prescriptions either provided to the member and their caregivers OR called in to a pharmacy.
    c. Upcoming appointments that have been scheduled or need to be scheduled;
    d. Documentation of referrals and linkages to resources and services;
    e. Medical education materials for new providers, caregivers, and parents with a summary of all relevant information for their child (e.g., new medication schedule or when to use a rescue inhaler), and
    f. List of specialists involved in member's care.
3. Transition Activities
    a. Care Management Case Closing

        A care management review is completed, when possible, and includes all members of the care team, including caregivers and legal guardians, to review treatments, services that will need to be scheduled, and any other final information that the care team needs to share among relevant individuals.

    b. Transfer of records

        A case is considered officially closed when all records are transferred to the member's new providers.

Article IV: Services

Article IV, section A: Foster Care Medical Home Services

Retitle section A from Foster Care Medical Home Services to Provision of Contract Services.

Remove section A introductory paragraphs.

Amend section A to read:

A. Provision of Contract Services

1. The FCMH must promptly provide or arrange for the provision of all services required under Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23) and Wis. Adm. Code DHS 107 and the Online ForwardHealth Handbook.

2. The FCMH Contract Administrator or their designee, is responsible for subscribing to ForwardHealth Updates and Alerts, and disseminating them to FCMH staff for analysis and implementation.

   The FCMH 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 the member under fee for service Medicaid, as set forth in 42 CFR § 438.210(a)(2), 42 CFR § 440.230, and 42 CFR part 441, subpart B.

   The amount, duration, and scope of services furnished to members under fee for service Medicaid are included in the Online Handbook and updated periodically and at the Department's discretion as ForwardHealth updates.

3. Pursuant to 42 CFR §438.210(a)(3), the FCMH:

   a. Must ensure that the services furnished to the member are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

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

4. Medical Necessity

   a. The actual provision of any service is subject to the professional judgment of the FCMH providers as to the medical necessity of the service, except that the FCMH must provide assessment, evaluation, and treatment services ordered by a court.

   b. Per 42 CFR §438.210(a)(4), the FCMH can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and DHS 101.03(96m) or place appropriate limits on a service for the purpose of utilization control provided that:

      i. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);

      ii. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services and supports; and

      iii. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

   c. The FCMH must specify what constitutes "medically necessary" in a manner that is no more restrictive than that used in the Medicaid program as indicated in Wis. Admin Code §DHS 101.03(96m), the State Plan, Wis. Stats., s. 49.46(2), s.

49.471(11), s. 49.45(23) and Wis. Adm. Code ch. DHS 107, Wisconsin Health Care Programs Online Handbook and FCMH Contract Interpretation Bulletins, and the ForwardHealth Provider Updates.

d. The FCMH is responsible for covering services related to:

   i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that result in health impairments and/or disability.

   ii. The ability for a member to achieve age-appropriate growth and development.

   iii. The ability for a member to attain, maintain or regain functional capacity.

e. The FCMH must consider reimbursement for any service allowable under Section 1905(a) of the Social Security Act under EPSDT (referred to in Wisconsin as HealthCheck "Other Services" coverage criteria for all members under age 21 prior to denying coverage to any service.

   For a service to be reimbursed through HealthCheck "Other Services," the requirements outlined in the ForwardHealth Online Handbook Topics 22 and 41 must be me.

f. Members may appeal PIHP decision regarding medical necessity through the process described in Article IX. The Department will consider whether the FCMH would have covered the service on a FFS basis (except for certain experimental procedures). The Department retains authority to consider the medical necessity disputes brought to the Department's attention by persons or entities who are not members or their legal guardians.

5. In Lieu of Services

a. The FCMH may cover services for a member that are in addition to those services covered under the state plan per 42 CFR §438.3(e). In lieu of services can be covered by the FCMH on a voluntary basis as follows:

   i. 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;

   ii. the member is not required by the FCMH to use the alternative service or setting;

   iii. the approved in lieu of services are identified in the FCMH contract and will be offered at the option of the FCMH; and

   iv. The utilization and cost of in lieu of services is considered in developing the component of the capitation rates that represent the covered state plan services.

b. The FCMH may cover the following additional or in lieu of services:

   i. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization.

Article IV, section B: Services the FCMH Not Responsible for

Amend Article IV(B) to read:

B. The FCMH is not responsible to provide the following Medicaid services to its members:

a. Chiropractic services.

b. Community Recovery Services (CRS).

c. Community Support Program (CSP) services.

d. Comprehensive Community Services (CCS).

e. Crisis Intervention Benefit.

f. Directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring for individuals with tuberculosis.

g. Lead investigations, as defined in s. 254.11(8s), of persons having lead poisoning or lead exposure, as defined in s. 254.11(9).

h. Medication therapy management.

i. Non-emergency Medical Transportation (NEMT) as listed in Article IV Section A(6).

j. Prescription and over-the-counter drugs and diabetic and other drug related supplies (as defined by the Department dispensed by a provider licensed to dispense by the Wisconsin Department of Safety and Professional Services (DSPS)).

k. Provider-administered drugs, as discussed in the following handbook topics: Provider-Administered Drugs (Topic #5697), of the Covered and Non-covered Services chapter of the ForwardHealth Online Handbook.

l. School-Based Services (SBS), except the FCMH must use its best efforts to sign a Memorandum of Understanding (MOU) with all SBS providers in the service area to ensure continuity of care and to avoid duplication of services. SBS are those services identified in a student's Individualized Education Plan (IEP) and provided by a school district or CESA.

m. Targeted Case Management (TCM), except the FCMH must work with the TCM case manager as indicated in Addendum III.

n. Behavioral Treatment Services (Autism Services) as defined by the Department in ForwardHealth Online Handbook.

o. Residential Substance Use Disorder Treatment (RSUD) as defined by the Department in ForwardHealth Online Handbook.

p. Hub and Spoke Health Home benefit.

Shift Article IV, section B to Article IV, section C, the rest waterfalling afterwards.

Article V: Provider Network and Access Requirements

Article V: Introductory paragraph

Amend introductory paragraph to read:

The FCMH must demonstrate covered services within the provider network and are available and accessible to members per 42 CFR § 438.206, 438.68, and 438.14 and has the capacity to serve expected enrollment in its service area per 42 CFR § 438.207.

The FCMH must establish provider network access, availability, and capacity expectations within provider's contracts, to include standards, protocols, methods of monitoring, reporting, and remediation.

Article V, section A: Availability and Accessibility

Amend Article V, section A to read:

The FCMH must establish mechanisms to ensure compliance by network providers; regularly monitor to determine compliance; take corrective action if there is a failure to comply by a network provider; and make readily available to the department upon request records of such actions.

1. Provider Network

   The FCMH must:

   a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.

   b. Provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. That is in addition to the member's designated source of primary care if that source is not a women's health specialist.

   c. Provide for a second opinion from a network provider or arranges for the member to obtain one outside the network at no cost to the member.

   d. Provide necessary services, covered under the contract, to a particular enrollee, the FCMH must adequately and timely cover these services out of network for the member, for as long as the FCM's provider network is unable to provide them.

   e. Coordinate with out-of-network providers for payment and ensure cost to the member is no greater than it would be if the services were furnished within the network.

   f. Reimburse for emergency services provided out-of-network at a cost to the member no greater than if the services were provided in-network.

   g. Demonstrates network providers are credentialed as required by 42 CFR § 438.214.

   h. Demonstrates network includes sufficient family planning providers to ensure timely access to covered services.

2. Furnishing of Services and Timely Access

The FCMH must:

a. Require network providers meet standards for timely access to care and services, considering the urgency of the need for services.

b. Ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid FFS. The FCMH must ensure appointment and facility wait time standards do not discriminate against members.

c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

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

3. Access and Cultural Considerations

The FCMH must:

a. Participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.

b. Have written protocols ensuring HealthCheck access.

c. Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.

Article V, section B: Network Capacity

Amend Article V, section B to read:

The FCMH must demonstrate sufficient capacity to serve members in service areas and must make documentation readily available, demonstrating it complies with the following:

1. Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area.

2. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.

3. The FCMH notifies the Department and submists documentation regarding network providers when:
    a. The FCMH enters into the initial contract with the Department,
    b. Annually, or
    c. A significant change in benefit programs, geographic services area, member enrollment, new member population, or composition of or payments to the provider network occur.

4. The FCMH must, at a minimum, sustain a network that meets standards specified in Table-1. This does not preclude the FCMH's requirements to demonstrate sufficient capacity among covered network services. The FCMH must develop network adequacy standards specified in 42 CFR § 438.68(c)(1)(i)-(ix) and must include covered geographic service areas. The FCMH may have varying standards within the same provider type based on geographic service area.

5. The FCMH may request an exception to provider-specified network standards in Table 1 based, at a minimum, on the number of participating provider specialties in the specified service area.

6. DHS expects the FCMH submit member communications and transition plan 120 days before the intended geographic service area reduction.

Article V, section C: Indians, Indian Health Care Providers (IHCP)

Amend Article V, section C title to read:

Indians, Indian Health Care Providers (IHCP), and Indian Managed Care Entities (IMCE)

Amend Article V, section C to read:

1. The PIHP must demonstrate sufficient IHCPs participation in the network to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services as specified in 42 CFR § 457.1209 and 438.14. This section pertains to Indians, IHCP, and IMCE definitions defined in 438.14(a).

2. The FCMH must pay IHCPs, whether participating or not, for covered services provided to Indian members who are eligible to receive services. The FCMH shall pay all providers, including non-network providers, as follows:

    a. At a rate negotiated between the FCMH and the IHCP, or

    b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the FCMH would make for the services to a network provider which is not an IHCP; and

    c. Make all payments to all ICHPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR § 447.45 and 447.46.

3. The FCMH must permit any Indian member who is enrolled in the FCMH that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that ICHP as their primary care provider, if that provider has capacity to provide the services.

4. The FCMH must permit Indian members to obtain covered services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.

5. Where timely access to covered services cannot be ensured due to few or no IHCPs, the FCMH will be considered to have met the requirement in paragraph C(1) of this section if the FCMH permits Indian

members to access out-of-State IHCPs.

6. The FCMH must permit an out-of-network IHCP to refer an Indian member to a network provider.

7. An IMCE may restrict enrollment to Indians in the same manner as Indian Health Programs, as defined in 25. U.S.C. 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in § 438.3(d).

Article V, section D: Contract Certification

Amend Article V, section D to read:

The Department will conduct an annual network adequacy analysis confirming the FCMH's network adequately supports members' access, availability, and capacity standards specified in Table-1. The Department will also consider additional metrics or data sources to determine network adequacy, including member grievances and appeals, out-of-network reports, Consumer Assessment of Healthcare Providers and Systems surveys, and the Department's external quality review organization. The network adequacy analysis will result in either an approval, conditional, or exception status by service area county.

1. Approval status is granted when the Department's review and FCMH service area is within standards.

2. Conditional status is granted when the Department determines network conditions are such that the FCMH may continue providing services in an area under but must remediate the specific deficiencies. Conditional terms may require the FCMH to produce a corrective action plan, lead to decertification, enrollment suspension and/or other action in the interest of the members. While under conditional status the FCMH must provide Department member impact assessments and remedies to improve standards.

3. Exception status may be granted during annual review and upon expansion requests where limited services preclude the FCMH from meeting adequacy standards only if the following conditions are met:

    a. Reasons for limited services are outside the control of either or both the Department and FCMH.

    b. The FCMH provides documentation and justification for adequate network despite deficiencies.

    c. The FCMH monitors and provides periodic member access impact assessments.

    The Department will use this information to determine exception status or take alternative action.

4. The FCMH must establish provider network access, availability, and expectations within provider's contracts, to include standards, protocols, monitoring, reporting, and remediation.

Article V, section E: Healthcare Provider Network Files

Amend Article V, section E to read:

The FCMH must submit the Healthcare Provider Network and Healthcare Facility files weekly, upon significant changes, or upon the Department's request through the State SFTP. A significant network change prompting a file submission would include, but not limited to, inadequate provider type capacity and services, modifications to FCMH benefits, service area, provider network, and member enrollment. The file must be submitted in the

designated and format specified in the *HMO Provider Network File Submission Specification* and meet minimum threshold standards to be accepted.

Article V, section F: FCMH Network Providers

Amend Article V, section F to read:

The FCMH must provide assurances to the Department demonstrating the FCMH's capacity to serve expected enrollment in its services area per 42 CFR § 438.207 and Department standards for access to care in Table-1. The Department's network review is based on the provider network files, and MMIS enrollee data to determine Table-1 metrics. Wait times are assessed separately.

1. The Urban areas are Brown, Dane, Eau Claire, Fond du Lac, Kenosha, La Crosse, Marathon, Milwaukee, Outagamie, Ozaukee, Racine, Rock, Sheboygan, St. Croix, Walworth, Washington, Waukesha, and Winnebago Counties based on similar population density characteristics. All other Counties are considered Rural. Currently all of the counties the FCMH operates in are Urban areas.

2. The Provider-to-Enrollee Ratio is derived from the count of providers within distance standards, accepting new members, and place of service is within the given County as the numerator. A count of members within a given County is the denominator.

3. Distance standards are based on the most direct route, while the Drive Time is based on driving distance.

4. 2.4. The 010 – Inpatient/Outpatient Hospital consists of non-specialized hospitals or specializing in Pediatrics as a non-specialized hospital. In all other instances a non-specialized hospital is one which is not exclusive to a single category of service or specialty including, but not limited to, behavioral health, cardiology, or orthopedics.

5. An Urgent Care Center is a facility consisting of the below criteria. A hospital emergency department may not serve to meet this requirement.
    a. X-ray on site.
    b. Phlebotomy services on site.
    c. Approximately licensed providers on site with the resources to obtain and read an EKG and X-ray on site; administer PC, IM and IV medication/fluids on site; and perform minor procedures (ex. sutures, splinting) on site.
    d. Have an automated external defibrillator (AED), Oxygen, ambu-bag/oral airway equipment with adequately trained staff.
    e. At least two exam rooms.
    f. Available to members in the evening during weekdays and weekends.
    g. Advertise as an Urgent Care Center.

Provider Type	**Provider Specialty Code - Description**	**Population**	**Counties**	**Drive Time (min)**	**Distance (mls)**	**Provider-to-Enrollee Ratio - Accepting New Members**	**Wait Time**
Dental		Adult	Urban	45	30	1:1600	

	271 – General Dentistry Practitioner 289 – Dental Hygienist		Rural	90	75	1:1200	Routine: < 90 Days Emergent: < 24 Hrs
	274 – Pediatric Dentist 289 – Dental Hygienist	Pediatric	Urban	45	30	1:1600	
			Rural	90	75	1:1200	
Mental Health & Substance Use Providers	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse 120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug Abuse Counselor 123 – Certified Psychotherapist with SAC 124 – Certified Psychotherapist 126 – Qualified Treatment Trainee (QTT) 339 – Psychiatry 532 – Registered Alcohol & Drug Counselor 740 – Mental Health	Adult & Pediatric	Urban	45	30	1:900 Psychiatrist and Psychologist	< 30 days
			Rural	75	60	1:700 Psychiatrist and Psychologist	

Table - 1

Provider Type	Provider Specialty Code - Description	Population	Program	Counties	Drive Time (min)	Distance (mls)	Provider-to-Enrollee Ratio - Accepting New Members	Wait Time
Narcotic Treatment Service for Opiate	112 – Licensed Psychologist (PhD) 117 – Psychiatric Nurse	Adult	BC+, SSI, IHS	Urban / Rural	70	50	Substance Abuse Counselor, Substance	

Addiction (DHS 75.15) (Medication-Assisted Treatment (MAT)	120 – Licensed Psychotherapist 121 – Licensed Psychotherapist with SAC 122 – Alcohol & Other Drug Abuse Counselor 123 – Certified Psychotherapist with SAC 124 – Certified Psychotherapist 126 – Qualified Treatment Trainee (QTT) 339 – Psychiatry 532 – Registered Alcohol & Drug Counselor 740 – Mental Health						Abuse Counselor-In Training, or Clinical Substance Abuse Counselor ratio is 1:50	
OB/GYN	095 – Nurse Practitioner/Nurse Midwife 212 – Nurse Midwife 316 – Family Practice 318 – General Practice 328 – OB/Gynecologists 350 – Licensed Midwife	Adult & Pediatric	BC+, SSI, IHS	Urban	15	10	1:100	< 30 days
				Rural	45	30	1:80	

Table - 1

Provider Type	Provider Specialty Code - Description	Population	Program	Counties	Drive Time (min)	Distance (mls)	Provider-to-Enrollee Ratio - Accepting New Members	Wait Time
PCP	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice	Adult	BC+, SSI, IHS	Urban	15	10	1:100	< 30 days
				Rural	40	30	1:80	

	318 – General Practice 322 – Internal Medicine							
	090 – Certified Pediatric Nurse Practitioners 092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine 345 – Pediatricians 080 – Federally Qualified Health Center (HealthCheck related) 734 – Screener (HealthCheck) 735 – Screener/Case Management (HealthCheck)	Pediatric	BC+, SSI, IHS	Urban	15	10	1:100	< 30 days
				Rural	40	30	1:80	
Hospital	010 – Inpatient/Outpatient Hospital	Adult & Pediatric	BC+, SSI, IHS	Urban	45	30		
				Rural	75	60		
Urgent Care Center		Adult & Pediatric	BC+, SSI, IHS	Urban	45	30		
				Rural	75	60		

Article V, section G: Telehealth Services

Amend Article V, section G to read:

The FCMH must develop policies and procedures for internal monitoring and telehealth utilization. FCMHs will submit these policies and any applicable monitoring information to the Department as requested. Monitoring information may consist of visits per county. Telehealth services can be considered during the annual network adequacy review only secondary to physical provider location requirement.

Article V, section H: Online Provider Directory

Amend Article V, section G to read:

The FCMH 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 at no cost. 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.

Article VII: Member Rights and Responsibilities

Article VII, section A: Advocate Requirements

Amend Article VII, section A(1) to read:

Upon request from the Department, the FCMH must provide evidence of compliance with the job duties mentioned above, such as proof of complaint or grievance investigations and participation in cultural competency training.

Article VIII: Provider Appeals

Article VIII, section A: Provider Appeals to the Department

Amend Article VIII, section A to read:

1. Process to appeal to the Department

    a. Providers may appeal directly with the Department through the provider appeal process after exhausting the FCMH appeal process.

    b. The Provider has 60 calendar days from the FCMH's final appeal decision to submit all required information pertaining to the case(s) in question.

    c. The Department will seek rebuttal from the FCMH when it has determined that the provider's appeal necessitates further review.

    d. The Department may send an official Requestion for Additional Information notice to the FCMH. A response to the request for additional information must be received by the Department within 14 calendar days (extensions may be available upon request) via the Provider Appeals Portal. If the FCMH fails to submit the requested information by the date required by the Department, the Department may overturn the original denial and compel the FCMH to pay the claim. The Department will uphold the original denial if the provider fails to provide the requested information as outlined in the BadgerCare Plus Handbook.

2. Appeal Decision Issued by the Department

    a. The Department has 45 days from the receipt of all pertinent information to inform the provider and the FCMH of the final decision.

    b. If the Department's decision is in favor of the provider, the FCMH will pay provider(s) within 45 days of receipt of the Department's final determination.

    c. A reconsideration of a final decision will only be made if an error has been made or there was misrepresentation of facts.

d. The Department will review the appeal documents and make a Final Decision based on the contract (both the DHS-FCMH contract and the FCMH-provider contract, if submitted, will be used to make the decision).

e. The Department will not review decisions based on contractual requirements between the provider and FCMH, including appeals related to:
   i. Clinical level of care (e.g., observations vs. inpatient) provided to the member, or
   ii. Results of contractually agreed upon FCMH reviews of claims or medical records.

Article VIII, section B: FCMH Responsibility

Amend Article VIII, section B to read:

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

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

   b. Ensure that providers know, understand, and comply with all business standards regarding completion and submission of accurate, correct and timely claims. This includes correct coding and maintenance of medical record.

   c. Grant providers access to all online technology and communication offered by the FCMH (i.e., not limited to claim and appeal submission, policy resources, FCMH website). Electronic notification from the FCMH constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.

   d. Encourage providers to access and use the ForwardHealth Portal, including online Handbooks and Provider Updates.

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

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

4. The FCMH must provide a clear process for claim dispute escalation which must include the below elements in their contract or MOU with providers, in their provider manual, on the FCMH website, or through written notification for non-contracted providers.

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

b. The FCMH must provide an explanation of the process the provider should follow to appeal the FCMH's decision to the FCMH once all claim reconsideration action has been exahused. This must include a statement regarding the provider's rights to appeal to the FCMH, including the timeline and the name of the person and/or function at the FCMH to whom the provider appeal should be submitted.

c. The FCMH must provide a statement advising the provider of their right to appeal to the Department if the provider is not satisfied with the FCMH's decision on the appeal or the FCMH fails to respond to the appl within 45 calendar days from the date of receipt of the appeal.

5. The FCMH must adhere to the following timelines:

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

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

6. FCMH Provider Appeal Notification Requirements

a. The FCMH must acknowledge the receipt of each formal written appeal received from providers.

b. The FCMH must provide notification to the provider of the outcome of the formal appeal.

c. All notifications must include the member's name, Medicaid Member ID number, date of service, date of payment and/or nonpayment. Each page of the payment remittance document must include the date the denial action was taken and specific explanation of the payment amount or a specific reason for nonpayment.

d. If the appeal is overturned, an EOP from the reprocessed claim is acceptable if it indicates the claim was reprocessed.

e. If the appeal is upheld, the appeal response must clearly state why the claim will not be paid and include all contract language that supports the denial or recoupment of payment. In cases of denial of payment, written (or HIPAA 835 transaction) notification must occur on the date the payment was denied.

7. The FCMH must submit to the Department, on a quarterly basis, a provider appeal log and data summary containing information as stated in the Provider Appeal Quarterly Report data dictionary.

The provider appeal log and data summary must be submitted to the Department the last business day of

the April, July, October, and January for the prior quarter.

Article VIII, section C: Provider Responsibility

Amend Article VIII, section C to read:

The FCMH must educate providers of their responsibilities:

1. Receive access to and use the ForwardHealth Portal, including online handbooks and Provider Updates in order to understand and correctly bill a covered service.

2. Access online technology and communication/trainings offered by the FCMH (i.e., not limited to claim and appeal submission, policy resources, FCMH website). Electronic notification from the FCMH constitutes receipt of information or claim action; it is not necessary to wait for paper notification of claim action.

3. Understand and comply with all business standards regarding completion and submission of accurate, correct, and timely claims. This includes correct coding, maintenance of medical record and correct coordination with other insurances plans.

4. To reserve the right to appeal to the Department, the provider must exhaust all appeal rights with the FCMH if they disagree with the FCMH's appeal response. Failure to follow the provider appeal process with the FCMH will result in the appeal denial being upheld.

5. How to appropriately appeal to the Department and the required timelines. Provide the ForwardHealth Provider Appeal Portal website and refer to ForwardHealth Online Handbook topics #384 and #385.

Article X: Quality Assessment and Performance Improvement (QAPI)

Article X, section C: Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing)

Amend Article X, section C(1) to read:

The FCMH must have written policies and procedures for provider selection and qualifications. Initial credentialing consideration must be submitted to the FCMH through a written application. Each practitioner, including each member of a contracting group, must provide documentation of:

a. Primary source of licensure of verification;
b. Disciplinary status;
c. Eligibility for payment under the FCMH; and
d. Provider Number or National Provider Identifier.

The FCMH must complete the credentialing process within 180 days after receipt of all required documents from the providers.

The Wis. Adm. Code, Ch. DHS 105 and the ForwardHealth Handbook, contains information regarding provider certification requirements. The FCMH 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.

The FCMH 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. The FCMH can rely upon NTS providers' status as Medicaid-enrolled in lieu of credentialing at the provider level. The FCMH may have credentialing and recredentialing policies for facilities certified under DHS 75.15.

The FCMH 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.

Amend Article X, section C(2) to read:

The FCMH must periodically monitor, no less than every three years, the provider's documented qualifications to ensure that the provider still meets the FCMH's specific professional requirements. This includes ensuring that Medicaid enrolled providers have undergone the Department's periodic revalidation procedure. Providers must update their enrollment information with ForwardHealth and sign the Wisconsin Medicaid Provider Agreement and Acknowledgement of Term of Participation. Failure to revalidate with the Department will result in termination from Wisconsin Medicaid.

Amend Article X, section C(7) to read:

The 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.).

a. The FCMH must terminate a provider for cause in all the following circumstances:

   i. Criminal conviction. The provider any person with a 5 percent or more direct or indirect ownership interest in the provider was within the preceding 10 years convicted (as defined in 42 CFR § 1001.2) of a Federal or State criminal offense related to that person's involvement with Medicare, Medicaid or CHIP. This requirement applies unless the department determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. 42 CFR § 455.416(b).

   ii. Failure to Comply with Screening Requirements. Where any person with a 5 percent or more direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any screening methods required under 42 CFR Part 455 Subpart E. 42 CFR § 455.416(a).

   iii. Failure to Submit Fingerprints. Where the provider, or any person with a 5 percent or more direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by the Department within 30 days of a CMS or the Department request, unless the Department determines that the termination or denial of enrollment is not in the best interests of the Medicaid program and the Department documents that determination in writing. 42 CFR § 455.416(e).

   iv. Failure to Submit Timely and Accurate Information. The provider or a person with an ownership control interest, an agent, or managing employee of the provider failed to submit timely and accurate information, unless the Department determines that termination is not in the Medicaid Program's best interests and documents that determination in writing. 42 CFR § 455.416(d).

v. Onsite Review. The provider fails to permit access to provider locations for any site visit, unless the Department determines the termination is not in the best interests of the Medicaid program. 42 CFR § 455.416(f).

vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment.

The names of individual practitioners and institutional providers who have been terminated from the FCMH provider network as a result of quality issues must be immediately forwarded to the Department and reported to other entities as required by law (42 USC 11101 et. Seq.).

b. The FCMH may terminate a provider for cause in all the following circumstances:

i. Abuse of Billing Privileges. The provider submits a claim or claims for services that could not have been furnished to a specific individual on the date of service including when the beneficiary is deceased, where the directive physician or the beneficiary is not in the state when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

ii. Billing with Suspended License. Billing for services furnished while the provider's license is in a state of suspension.

iii. False or Misleading Information. The provider certified as "true" false or misleading information on their enrollment application to be enrolled or maintain enrollment in the State Medicaid program.

iv. Improper Prescribing Practices. The Department determines that a provider has a pattern of practice of prescribing drugs that is abusive or represents a threat to the health and safety of Medicaid beneficiaries or the pattern or practice of prescribing fails to meet Medicaid requirements.

v. Inability to Verify. The Department cannot verify the identity of any provider applicant. 42 CFR § 455.416(g)(2).

vi. Misuse of Billing Number. The provider knowingly sells to or allows another individual or entity to use its billing number, other than a valid reassignment of benefits.

vii. Noncompliance. The provider is determined to not be in compliance with enrollment requirements established by the Department. This does not include license expiration.

viii. Noncompliance with Licensure Standards. When the provider has been subject to an adverse licensure action resulting in the loss of license. This does not include license expiration.

ix. Onsite Review. The provider failed onsite review due to one of the following circumstances: no longer operational to furnish Medicaid covered items or services, or otherwise fails to satisfy any Medicaid enrollment requirement

x. Other. Any other reason that poses a threat of fraud, waste, or abuse to the Medicaid program.

xi. Prescribing Authority. The provider's Drug Enforcement Administration Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any state in which the provider practices suspends or revokes the provider's ability to prescribe drugs.

xii. Provider Conduct. The provider or any owner, managing employee, medical director as defined in 42 C.F.R. § 1001.2, of the provider is excluded from the Medicare or Medicaid programs.

Article X, section H: Performance Improvement Priority Areas and Projects

Amend Article X, section H(1) to read:

The FCMH is required to submit two PIPs each year.

a. One clinical and one non-clinical.
b. The Racial Disparity PIP referenced in Article X, section J of this contract may constitute the non-clinical.

Article X, section K: FCMH Quality Measures

Amend Article X, section K to read:

The FCMH is required to report on quality measures and operational details to support program operation. For details and information pertinent to submission of data and calculation of results, please refer to the *Foster Care Medical Home Quality Measures Operational Guide*.

1. Timeframe
   The Measurement Year (MY) starts on January 1 and ends on December 31 of the applicable contract year.

2. Measures and Targets
   The program will use the quality measures described in the Guide as finalized by the Department. Targets for each measure will be defined by the Department. Further details of the methodology for setting targets, including definitions, are specified in the Guide.

   a. Initial Measures
      Initial measures represent activities happening when children first enter Out of Home Care and are enrolled in the Foster Care Medical Home. These include:
      i. Acute health screen within 2 business days of enrollment
      ii. Initial Comprehensive Health Assessment within 30 days of enrollment
      iii. Timely Developmental and/or Mental Health Screen
      iv. Timely Developmental Assessment
      v. Timely Mental Health Assessment

   b. HealthCheck Periodicity
      All enrolled children in FCMH are expected to receive their HealthCheck exams at an enhanced periodicity:
      i. Every month for the first 6 months of age;
      ii. Every three months between ages 6 months and 2 years of age;
      iii. Twice a year after 2 years of age.

c. Dental Exams
Children enrolled in FCMH age 12 months and older are required to be seen twice yearly for comprehensive dental exams. Two measures capture related data, the first being for newly enrolled children to receive their first comprehensive dental exam within 3 months of enrollment and the second measures the ongoing receipt every six months for children age 12 months or older.

d. Blood Lead Testing
All children enrolled in the FCMH at ages 12 months, 18 months, and 24 months will be screened for blood lead toxicity. In addition, children between 24 and 72 months will be screened if there is no record of a previous blood lead screening test.

e. Immunization Status
Children enrolled in the FCMH will be fully immunized within 6 months of enrollment. The Department will use the latest HEDIS specifications applicable.

f. Outpatient Mental Health Follow Up
HEDIS Measure for Outpatient MH Follow Up within 30 days following Inpatient MH Hospitalization. The department will use the latest HEDIS specifications applicable.

g. Emergency Department Utilization
This is a utilization measure (# of ED visits per 1000 member months). The HEDIS AMB measure has two components—ED and Outpatient visits.

h. Follow-Up After ED Visit for Mental Illness
HEDIS Measure for Outpatient Mental Health Follow Up within 30 days following ED visit for mental illness or intentional self-harm. The department will use the latest HEDIS specifications applicable.

i. Anti-Psychotic Medication Measures
There are three measures that make up the Anti-Psychotic Medication objective:

i. Number and % of children starting on anti-psychotic medication after entering the FCMH program, for whom all metabolic measures were recorded (BMI, Glucose, and/or HbA1c, non-fasting Lipid profile) as baseline before or at the time of starting on anti-psychotics.

ii. Number and % of children already on anti-psychotic medication before entering the FCMH., for whom all metabolic measures were recorded (BMI, Glucose, and/or HbA1c, non-fasting Lipid profile) as baseline, within 60 days of entering the program.

iii. Number and % of children on anti-psychotic medication for whom all metabolic measures were updated at or near the 6-month mark from the last previous date of metabolic measurement.

j. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey

The CAHPS survey measures the experience of patients enrolled in the FCMH. The survey measures patient experience in the areas of getting needed care, getting care quickly, howe well doctors communicate, health plan costumer service, and how people rate the health plan. The Department will use the latest AHRQ specifications available.

Article XI: FCMH Administration

Article XI, section B: Organizational Responsibilities and Duties

Amend Article XI, section B(11)(i) to read:

i. Birth to Three Program Providers

The FCMH is required to contract with Birth to 3 Program service providers that have a contractual agreement with the Birth to 3 Program agencies within their service area to authorize and pay claims for their members that are enrolled in the Birth to 3 Program. Birth to 3 program services include physical therapy (PT), occupational therapy (OT), and speech and language pathology (SLP) services provided as Birth to 3 Program services.

The FCMH reimburses for Birth to 3 Program services when a member under the age of 3 receives an initial evaluation and assessment, as well as an Individualized Family Services Plan (IFSP), and the provider is employed by or under contract with a Birth to 3 Program Agency. The FCMH must reimburse for the initial evaluation and assessment, as well as re-evaluations, even when a member does not qualify for the Birth to 3 program.

The FCMH must authorize PT, OT, or SLP services that are provided with an initial evaluation and assessment that are identified in and requested at the same frequency, intensity, and duration listed in the member's IFSP. The FCMH should not impose additional medical necessity criteria for Birth to 3 Program services. The FCMH is encouraged to follow ForwardHealth policy for prior authorization of Birth to 3 Program services by not requiring Birth to 3 Programs to frequently re-submit authorization requests to the FCMH.

The FCMH is encouraged to follow the ForwardHealth policy for prior authorization of therapy services provided outside the Birth to 3 Program, and to require receipt of the completed Child Enrollment Status Regarding Birth to 3 Program form prior to authorizing any PT, OT, or SLP for a child under 3. The FCMH may impose their standard medical necessity criteria when authorizing therapy services outside the Birth to 3 Program for a child under 3.

If a provider's Birth to 3 Program services are provided in the member's natural environment, the provider must receive an enhanced reimbursement rate. The FCMH is encouraged to develop MOUs with county Birth to 3Program agencies in their service area.

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

Article XI, section C: Confidentiality of Records and HIPAA Requirements

Amend Article XI, section C(4) to read:

If the FCMH 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 DHS Privacy Officer and managed care analyst within the same business day the FCMH 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 FCMH shall take immediate steps to mitigate any harmful effects of the unauthorized use, disclosure, or loss. The FCMH 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.

Article XII: Reports and Data

Article XII, section I: Contract Specified Reports and Due Dates

Add before the reporting grid:

All reports requested by the Department must be submitted by the deadline provided. Failure to meet the submission deadline without an approved extension may result in a corrective action at the discretion of the Department.

Article XII, section K: Program Integrity

Amend Article XII, section K to read:

The FCMH must have documented administrative and management arrangements, written procedures, a mandatory compliance plan, and a Fraud Waste and Abuse (FWA) Strategic Plan that are designed to guard against fraud, waste, and abuse. The FCMH must cooperate with the Department on fraud, waste and abuse investigations.

1. Administrative Arrangements

   The FCMH arrangements must include the following:

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

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

   c. The assignment of dedicated staff responsible for identifying, mitigating, and preventing fraud, waste, and abuse.

      i. The activities and performance of the assigned staff are subject to audit and review by the DHS Office of the Inspector General (DHS OIG).

      ii. There must be at least one Special Investigation Unit (SIU) Investigator located in Wisconsin dedicated to in-state investigations and audits.

         1) The SIU Investigator may not serve a dual work role within the FCMH in any other capacity.
         2) For every 100,000 beneficiaries, there must be an additional investigator located in Wisconsin, and dedicated to in-state Medicaid investigations and audits.

3) A documented process to ensure a prompt response to detected issues, and for development

2. Written Procedures

FCMH written procedures must include:

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

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

c. Documented lines of communication between the compliance officer, senior management, and the FCMH's employees.

d. Disciplinary guidelines for enforcement of program integrity and schedule for publicizing.

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

i. Routine internal monitoring and auditing of compliance risks related to provider network, including both prepayment and post-payment program integrity strategies.

1) Post-payment program integrity strategies must include network provider audits of medical records for verification of actual provision of services and the appropriateness and accuracy of claims.

2) The FCMH's contract with its network providers must explain the audit process including authority used by the FCMH for audit citations as well as the authority to recoup overpayments or take other actions.

3) DHS is not a party to complaints, lawsuits, or other actions taken due to action taken by the FCMH because the contract between the FCMH and the network provider is between two private entities.

ii. Prompt response to compliance issues, both internal and related to the provider network, as they are raised.

iii. Timely investigation of potential compliance issues, both internal and related to the provider network, identified during self-evaluation and audits.

iv. Correction of such issues promptly and thoroughly to reduce the potential for recurrence.

v. Ongoing compliance with the requirements under the contract.

f. If the FCMH 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 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.

i. Whistleblowers should report program integrity concerns to the DHS OIG. Whistleblowers make a report through the hotline (877-865-3432) or through the online portal: (http://www/reprtfraud.wisconsin.gov/rptfrd/default.aspx).

ii. The FCMH is responsible for ensuring employees have access to this information.

g. Policies and procedures implement all payment suspensions imposed by DHS OIG.

3. Compliance Plan

The FCMH must submit their compliance annually. The PIHP's compliance plan, at minimum, covers the requirements in M(1) and M(1) of this contract and previously submitted as part of the annual compliance review. This is separate from the Fraud, Waste, and Abuse Strategic plan.

a. The FCMH must submit their current compliance plan and a crosswalk identifying any changes from the previous year no later than December 31 or the last business day of the calendar year.

b. Submit the compliance plan and crosswalk via the SharePoint Site under the "General Documents" section.

4. Annual Fraud, Waste, and Abuse (FWA) Strategic Plan

a. The FCMH is responsible for developing an annual FWA strategic plan which meets the requirements outlined in Addendum VII.

b. The FWA strategic plan must be approved annually by DHS OIG by December 31st.

i. The FCMH must submit a draft of their proposed FWA Strategic Plan by November 15th via the DHS OIG SharePoint site.

ii. The DHS auditor will review the FWA Strategic Plan according to the requirements outlined in Addendum VII.

iii. If changes are necessary, the FCMH must implement the changes and resubmit the FWA Strategic Plan back to the DHS auditor via the DHS OIG SharePoint site for additional review.

c. Failure to submit a plan meeting the requirements outlined in Addendum VII may result in a corrective action plan and/or financial sanction under Article XIV, section D.

d. The FCMH must document and be prepared to submit evidence of completion of all activities included in the annual FWA strategic plan during DHS's annual audit of the FWA strategic plan.

e. The FCMH implemented their first annual FWA strategic plan on January 1, 2023 and will implement a new plan annually thereafter.

f. DHS will audit the FCMH's compliance with their FWA strategic plans during the following year beginning with an audit of compliance with the 2023 FWA Strategic Plan in calendar year 2024.

g. DHS will evaluate for the completeness and quality of all activities.

h. FCMHs found to be out of compliance with their annual FWA Strategic Plan or in need of improvement will receive technical assistance following the first review by DHS.

i. DHS may impose a corrective action plan or financial sanction imposed under Article XIC, section D for FCMHs who fail to engage in technical assistance or DHS's audit process.

j. The FCMH must communicate any mid-year changes to the annual FWA strategic plan to DHS and submit an updated plan for DHS approval.

5. Reporting Fraud, Waste, and Abuse

The FCMH must cooperate with the Department on fraud, waste, and abuse investigations. Failure on the part of the FCMH to report fraud, waste, or abuse may result in DHS enforcing applicable sanctions under Article XIV, section D in this contract. Pursuant to 42 CFR § 455.23, the authority of determining credible allegations of fraud rests with the Department. All reports of potential and substantiated Medicaid fraud must be made to DHS OIG.

a. Reporting Potential Fraud, Waste, and Abuse

i. For each identified or reported case of potential fraud, waste, abuse, or questionable practice, the FCMH must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

ii. All cases of potential fraud, waste, abuse, or questionable practices must be reported DHS OIG via the hotline (877-865-3432) or online portal (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx) within 3 business days of the conclusion of the preliminary investigation. A case of potential fraud, waste, abuse, or questionable practice is referred to as a complaint.

1) Subject matter for complaints include any issue or risk that has the capacity to develop into a credible allegation of fraud, which includes but is not limited to

complaints, tips, trend analysis, pre-payment review, billing errors, and audits.

2) Do not report violations that occurred in the FCMH's non-Medicaid lines of business that do not result in the loss, or potential loss, of Wisconsin Medicaid funds.

3) Reports of potential and substantiated from the FCMH must not be made anonymously.

4) Reports to the hotline or through the portal may be subject to open records laws.

5) Documentation of preliminary investigations must be retained in accordance with Article XII, Section M(12) of this contract.

iii. The FCMH must submit a preliminary investigation summary at the time the complaint is filed through the hotline or portal. The preliminary investigation summary must include the following:

1) Date the potential fraud, waste, abuse, or questionable practice was identified or reported to the FCMH.
2) A detailed summary of the actions taken to investigate the issue.
3) A determination of whether the fraud, waste, abuse or questionable practice issue is substantiated.
4) A detailed explanation of the facts supporting the determination.
5) An explanation of whether a full investigation will be conducted.
6) A detailed explanation of the facts supporting a full investigation will or will not be conducted.
7) Planned next steps.

iv. All complaints made via the hotline or portal, whether substantiated or unsubstantiated, must be reported on the FCMH's QPIR and indicated as an ongoing or completed investigation.

v. A credible allegation of fraud referral form (F-02296) may be submitted with the complaint preliminary investigation substantiates fraud.

b. Reporting Substantiated Fraud

i. The FCMH must report all cases of substantiated fraud, as defined in Article XII, section M(2) of this contract, as a credible allegation of fraud referral using the F-02296 referral form via the DHS OIG SharePoint site or DHSOIGManagedCare@wisconsin.gov email address.

ii. The FCMH must submit all supporting information including available data, statements from appropriate parties, audit reports, records, and other materials supporting the allegations as exhibits with the referral form.

iii. The FCMH must use the DHS OIG SharePoint site as a secure method to upload the referral form and exhibits. Referrals and exhibits may also be emailed securely to DHSOIGManagedCare@wisconsin.gov.

iv. Following the submission of the credible allegation of fraud referral, the FCMH may continue to investigate the allegations as appropriate unless otherwise directed by DHS OIG, Department of Justice Medicaid Fraud Control and Elder Abuse Unit (MFCEAU), or other law enforcement or regulatory entity.

v. The FCMH must collaborate with its DHS OIG representative or MFCEAU investigator to provide any additional information or documentation requested for the case.

vi. If the FCMH forwards a report of potential or substantiated Medicaid fraud to any additional state or federal agency, the FCMH must notify the DHS OIG of the referral.

c. Reporting Substantiated Waste and Abuse

i. In accordance with Article XII, Section M(3)(a), the FCMH should have previously reported cases of substantiated waste or abuse as a complaint with potential waste or abuse to DHS OIG within 3 business days of the completion of the preliminary investigation.

ii. The FCMH must also report all substantiated and unsubstantiated complains on the plans QPIR.

iii. The QPIR entry indicating the case was in the investigation phase should be updated to indicated the investigation is complete and whether waste or abuse was or was not substantiated.

iv. The FCMH should also indication on the QPIR what action will be taken to mitigate the risk. Examples include educating the provider or recouping the overpayment.

6. Suspension of Provider Payments

The FCMH must have policies and procedures in place to implement all payment suspensions imposed by DHS OIG.

a. Pursuant to 42 CFR § 438.608(a)(8), the FCMH 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 a good cause not to suspend such payments.

i. The DHS Inspector General must review and authorize any request for a good cause exception.

b. The FCMH must have a documented process outlining the FCMH's response to information in the provider file from the Department notifying the FCMH of suspension of payment. The provider file

sent by the Department to the FCMH will have a field that will indicate the outcome of the credible allegation of fraud investigation. They are:

i. A—Suspension of payment currently active. The FCMH must suspend payment based on the effective date for the start of the investigation.
ii. C—The provider has been cleared of the credible allegation of fraud investigation. There will be an end date for the investigation.
iii. T—The provider has been terminated due to the outcome of the credible allegation of fraud investigation. The contract's termination date will be listed in the provider file.

c. The FCMH 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 FCMH's claims processing system and any required internal communications.

d. The FMH must have clearly defined criteria, policies, and procedures in place for suspending providers outside of suspensions issued by DHS OIG.

i. These policies and procedures must include notifications of DHS within 24 hours of the suspension of payments using the DHSOIGManagedCare@wisconsin.gov email address.

ii. The FCMH must also record these payment suspensions on the terminations/sanctions/suspensions tab of the Quarterly Program Integrity Report (F-02250).

7. Termination or Exclusion of Network Providers

The FCMH must reporting providers terminated for cause by the FCMH as well as providers the FCMH identifies as excluded to DHS OIG.

a. The FCMH must report terminated providers within 24 hours of the date the provider was notified of their termination or exclusion.

b. The FCMH must send an email to DHSOIGManagedCare@wisconsin.gov with "Terminated/Excluded Provider" as the subject line. The body of the email must include the name of the provider, NPI and MA ID numbers, date of termination or exclusion, reason for termination or exclusion, and the date the appeal window closes.

c. The information must also be captured on the Termination/Sanctions/Suspensions tab in the Quarterly Program Integrity Report (F-02250). DHS OIG may follow up for additional information depending on the reason for termination.

8. Treatment of Recoveries—Overpayments Made to Network Providers by the FCMH

Pursuant to 42 CFR § 438.608(d), the FCMH must attempt to recover all overpayments made to network

providers, including overpayments attributed to fraud, waste, and abuse, identified by the FCMH.

a. If the FCMH recovers the overpayments and retains the funds for all overpayments identified by the FCMH, provider, or DHS OIG.

b. If DHS OIG identifies the overpayment, the overpayment amount is an estimated overpayment based on the max fee schedules.

c. The FCMH is responsible for determining the actual overpayment amount.

d. The FCMH must have a documented process requiring the network providers to return any overpayments they received.

    i. The FCMH must share the documented process with all providers in the FCMH's network.
    ii. The FCMH 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.
    iii. The FCMH must require the provider to notify the FCMH of the reason for the payment.
    iv. The FCMH must appropriately reflect the recovery of all overpayments in the FCMH's encounter data and on Tab 3 of the Quarterly Program Integrity Report.
    v. The provider agreement language must require network providers to follow the same requirements when they self-identify an overpayment they have received.

9. Treatment of Recoveries—Overpayments Made to the FCMH by the State

The FCMH 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). The FCMH must submit the report via DHS OIG's SharePoint site. The report must contain the following information:

a. FCMH'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 FCMH, if any.
   *This provision does not apply to any amount of recovery retained under the False Claim Act cases or through other investigations.

10. Network Provider Audits

DHS OIG and DHS OIG's contracted program integrity (PI) vendors will conduct audits of the FCMH's network providers. DHS OIG will utilize the fee-for-service max fee tables when assigning value to services provided

in the audit. The FCMH must collaborate with DHS OIG and contracted PI vendors on all matters related to these audits including, but not limited to:

a. Coordinating deconfliction efforts relative to scope and sample to prevent a duplication of audit efforts between DHS OIG and the FCMH.

    i. DHS OIG will notify the FCMH by email and upload a deconfliction spreadsheet to the FCMH SharePoint for each network provider audit. The deconfliction spreadsheet will contain the scope and sample information pertaining to the potential audit.
    ii. The FCMH must indicate whether they are currently investigating the provider(s) and provider type(s) indicated on the deconfliction spreadsheet. DHS OIG will remove any conflicting information from the audit and the FCMH should continue with their investigation as planned.
    iii. The FCMH has 10 business days to review and respond to the deconfliction spreadsheet. The FCMH must upload their response to the SharePoint site.

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

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

d. Engaging in audit resolution which may include.

    i. Technical assistance to both the FCMH and provider;
    ii. Corrective action plans administered by DHS.
    iii. Referrals to MFCEAU or DSPS.
    iv. Termination of a network provider's Medicaid certification;,
    v. Financial sanctions administered by DMS, under Article XIV, Section D.
    vi. Other means by which the audit findings can be addressed.

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

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

    i. DHS OIG will not collect overpayments based upon its aduit, but the FCMH may choose to use the DHS OIG's estimated value of the audit findings and seek recovery of the overpayment from the audited network provider. The FCMH is entitled to keep the overpayment.

    ii. The FCMH should update the provider agreement to describe the following for the FCMH to pursue overpayments based on DHS OIG's audit findings.

        1) The provider may appeal DHS OIG identified overpayments to the FCMH; and
        2) The provider may appeal to the Department, following process outlined in Article VIII of this contract, if the provider disagrees with the FCMH decision to uphold the

overpayment recovery.

iii. The FCMH 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."

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

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

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

11. Corrective Action Plan and Sanctions

DHS will issue any formal corrective action plans or sanctions related to noncompliance with this Article in accordance with Article XIV, section D.

12. Quarterly Program Integrity Reporting Log

The FCMH must submit the Quarterly Program Integrity Reporting Log (F-02250) to DHS OIG on a quarterly basis.

a. 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.

b. The Quarterly Program Integrity Reporting Log consists of the following four separate reporting categories:

i. Program Integrity Log: Captures complaints regarding fraud, waste, and abuse received by the FCMH warranting preliminary investigation.

ii. Provider Education Log: Captures education given to network providers and subcontractors related to billing practices, billing errors, or fraud, waste, and abuse. The FCMH 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.

iii. Overpayment Recovery Log: Captures pertinent information regarding all overpayment recoveries, not just those recovered due to fraud, waste, and abuse.

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

v. Subcontractor Log must include the following information:

1) All subcontractors who provide any function or services for the FCMH related to securing or fulfilling the FCMH's obligations under the terms of this contract. Network providers are not considered subcontractors. Any subcontractor providing program integrity services on behalf of the FCMH must complete and submit its own QPIR.

2) Compliance of the subcontractor's disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in CFR § 455.104 and 438.602(c).

c. The Quarterly Program Integrity Report must be submitted via DHS OIG's SharePoint site.

i. DHS OIG will evaluate the submitted reports and may follow up with the FCMH to obtain additional information, provide technical assistance, or request further action.

ii. DHS may impose a corrective action plan or a financial sanction for non-compliance with reporting requirements and deadlines.

13. Quarterly Meetings

OIG facilitates meetings with the FCMH, DOJ MFCEAU, and the Division of Medicaid Services on a quarterly basis. The meetings are conducted virtually, and agendas are provided in advance. OIG will present program integrity information including annual training on payment suspensions and fraud, waste, and abuse detection.

a. The FCMH's Compliance Officer or representative must be in attendance to represent the FCMH.

i. Applicable staff from the FCMH's SIU/compliance departments or program integrity subcontractor(s) should attend the meetings. FCMH management can evaluate the agenda and determine which staff should attend.

ii. The Compliance Officer or FCMH representative(s) must communicate information presented at the meetings to the applicable staff that aren't in attendance such as SIU employees, compliance employees, or claims processing employees.

b. If the FCMH has a program integrity subcontractor who submits complaints on their behalf, the subcontractor must attend any meetings in which information about complaints is presented. DHS OIG will denote these topics on the agenda with an asterisk.

14. Corrective Action Plans and Sanctions

    The Department will issue all formal corrective action plans or sanctions related to noncompliance with this Article in accordance with Article XIV, section D. The FCMH is required to respond to any corrective action or performance improvement activities within the timeframes specified.

Article XIII: Functions and Duties of the Department

Article XIII, section E: Fraud, Waste, and Abuse Training

Remove Article XIII, section E and update the following sections to maintain order (i.e., section F becomes section E, section G becomes section F, etc.).

Article XIV: Contractual Relationship

Article XIV, section D: Sanctions, Financial Penalties and Remedial Actions for Violation, Breach, or Non-Performance of Contract

Remove Article XIV, section D(4)(c)(4).

Article XV: Fiscal Components/Provisions

Article XV, section A: Billing Members

Add as third paragraph in Article XV, section A:

Except in emergency situations, the FCMH 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 FCMH can demonstrate that it reasonably believed, based on the information provided by the Department, that the provider was Medicaid enrolled at the time the FCMH reimbursed the provider for service provision.

Addendum V: Report Forms and Worksheets

Addendum V, section B: FCMH Newborn Report

Amend Addendum V, section B to read:

The newborn report should be completed for infants born to mothers who are Foster Care Medical Home eligible and enrolled in the FCMH at the time of birth of the infant. The FCMH is encouraged to use the online form to submit newborn information, which will be received and processed more quickly and processed more quickly than forms sent by fax or mail. When newborn information is submitted online, ForwardHealth may be able to establish eligibility and FMCH enrollment for the newborn faster.

The requirement for the Newborn Report are included in the ForwardHealth online handbook. The handbook includes instructions for online submitting, links to the form and submission instructions.

Addendum VII: Fraud, Waste, and Abuse Strategic Plans

Addendum VII, section A: Fraud, Waste, and Abuse (FWA) Strategic Plans General Guidelines

Amend Addendum VII, section A to read:

1. The FCMH must submit their annual FWA strategic plans to the DHS Office of Inspector General (OIG) for review by November 15 using the DHS OIG SharePoint site.

a. FCMHs may consult with their DHS OIG representative throughout the calendar year while developing their annual FWA strategic plan to ensure a successful approval process.

2. The DHS OIG auditor will review the FWA strategic plan according to the rubric below and provide feedback to the FCMH regarding any necessary changes.

    a. The FCMH must make the necessary edits and submit the plan to the DHS OIG SharePoint site for additional review. This cycle will continue until compliant FWA strategic plan is submitted.

    b. The FCMH must ensure that DHS OIG's feedback, including any requested corrections or revisions, are incorporated into their strategic plans.

3. The FCMH are required to have approval of their annual FWA strategic plan prior to December 31.

Addendum VII, section B: FWA Strategic Plan Components

Amend Addendum VII, section B to read:

1. Data Analysis—Provide an overview of the data analysis that will be conducted to determine which fraud, waste, or abuse issues the FCMH will prioritize in their FWA strategic plan. The FCMH is responsible for conducting the data analysis and determining risk.

2. Program Integrity Initiatives—Identify a minimum of three program integrity initiatives that will be implemented during the calendar year to address the identified fraud, waste, or abuse issues identified in the data analysis. A program integrity initiative is the plan or action that will be implemented during the calendar year to address the identified fraud, waste, or abuse issue.

    a. Each program integrity initiative must:

        i. Identify the program integrity issue or risk the FCMH is attempting to address with each initiative.
        ii. Identify the goal of each initiative.
        iii. Identify the expected results of the initiative.
        iv. Identify the objectives or strategies that will be used to achieve the goal of each initiative.
        v. Describe the planned tasks for each quarter that are intended to achieve the identified goal.
        vi. Identify the anticipated completion date of the initiative.
        vii. Identify the personnel responsible for the completion of the initiative.
        viii. Identify the method by which the FCMH will measure compliance or return on investment on the initiative.

3. Additional Required Components

    The Following list can be used as an individual initiative or strategy within another initiative. All the additional required components must be included in the strategic plan.

    a. Prepayment activities.

b. Post-payment activities. These post-payment activities must include audits of medical records including reviewing for appropriate coding and medical necessity. Post-payment audits are only one example of post-payment activities, and the FCMH must consider all post-payment activities when developing their plan.

c. Verification of the provision of services to members:
   i. Includes the planned number of verifications.
   ii. Includes methodology for verifying services—explanation of benefits, phone calls, etc.
   iii. Includes methodology for tracking related reports of fraud and subsequent overpayment recoveries.

d. Plan to increase the quantity of credible allegations of fraud identified.

e. Planned provider education related to fraud, waste, and abuse.

Addendum VII, section C: FWA Strategic Plan Approval Process

Amend Addendum VII, section C to read:

DHS OIG and the FCMH will engage in the following process to review and approve the annual FWA strategic plans:

1. The FCMH will draft their annual FWA strategic plans in accordance with the requirements to this addendum.

2. FCMHs must submit their annual FWA strategic plan through the DHS OIG SharePoint site no later than November 15.

3. DHS OIG will use the FWA Strategic Plan Evaluation Rubric to evaluate compliance with the requirements of this addendum.

4. DHS OIG will either approve the FWA strategic plan or return the plan to the FCMH for changes based on DHS OIG feedback from the rubric assessment.

5. DHS OIG will upload the FWA Strategic Plan Feedback Form to the SharePoint site indicating whether the plan has been approved or needs additional work completed.

6. If the FWA Strategic Plan needs correction, the FCMH will incorporate DHS OIG's feedback and resubmit the FWA strategic plan. DHS OIG will provide the due date for returning the draft for the next review as part of the feedback to ensure the plan receives approval by December 31.

7. Steps4-6 are to be repeated until DHS OIG approves the FWA strategi plan.

8. The FCMH must have an FWA strategic plan approved by DHS OIG by December 31.

Addendum VII, section D: FWA Strategic Plan Implementation Process

Amend Addendum VII, section D introductory paragraph to read:

The FCMH will implement their approved FWA strategic plan each year on January 1. DHS OIG will monitor the Quarterly Program Integrity Report and other methods the FCMH indicate that they will be measuring their compliance with their FWA strategic plan. DHS OIG representative will contact the FCMH periodically during the year to offer support and technical assistance, and to ensure the FCMH is on track with their FWA strategic plan. If an updated FWA strategic plan is needed, DHS OIG can assist the FCMH in making the needed updates.

Amend Addendum VII, section D(4) to read:

The FCMH must report providers terminated for cause by the FCMH, as well as providers the FCMH identifies as excluded, to DHS OIG. The FCMH must report terminated providers within 30 days of the date that the appeals process is exhausted or the time for appeal has expired. The FCMH 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.

Addendum VII, section E: DHS OIG Audit of FCMH Compliance with the FWA Strategic Plan

Amend Addendum VII, section E introductory paragraph to read:

DHS OIG will audit the FCMH's compliance with their approved FWA strategic plan. DHS OIG will use technical assistance, corrective action plans, and financial sanctions to address as remedies for FWA strategic plan review audit findings. DHS OIG may request financial sanctions when:

Addendum VIII: Rates

Updated to CY23 rates.

Exhibit 4
Wisconsin Department of Health Services
CY 2023 Care4Kids Non-Risk Prepayment Rate Development
CY 2023 Non-Risk Prepayment Rates

		Milwaukee Adjustment			Southeastern Adjustment					
	Regional Variation	1.124	1.124	1.124	0.804	0.804	0.804			
		CY 2023 Milwaukee PMPMs			CY 2023 Southeastern PMPMs			CY 2023 PMPMs		
	Age Group	Title IV-E	Non Title IV-E	Total	Title IV-E	Non Title IV-E	Total	Title IV-E	Non Title IV-E	Total
CY 2023 PMPM	Age 0	$765.07	$1,916.83	$1,353.09	$546.94	$1,370.32	$967.31	$680.59	$1,705.17	$1,203.68
	Ages 1-5	340.54	478.91	410.90	243.45	342.37	293.75	302.94	426.03	365.53
	Ages 6-14	398.08	466.67	438.94	284.58	333.62	313.79	354.12	415.14	390.47
	Ages 15-20 F	448.76	540.55	518.51	320.82	386.43	370.67	399.21	480.86	461.25
	Ages 15-20 M	321.92	636.62	560.38	230.13	455.11	400.61	286.37	566.32	498.50
CY 2023 PMPM Total		$398.99	$579.24	$502.54	$285.23	$414.09	$359.26	$354.93	$515.28	$447.05
PMPM Non-Service Costs	Age 0	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20
	Ages 1-5	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
	Ages 6-14	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
	Ages 15-20 F	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
	Ages 15-20 M	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20	83.20
PMPM Non-Service Costs Total		$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20	$83.20
Access Payments Add-On	Age 0	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97
	Ages 1-5	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
	Ages 6-14	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
	Ages 15-20 F	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
	Ages 15-20 M	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97	59.97
Access Payments Add-On Total		$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97	$59.97
Non-Risk Prepayment Rates	Age 0	$908.24	$2,060.00	$1,496.26	$690.11	$1,513.49	$1,110.48	$823.76	$1,848.34	$1,346.85
	Ages 1-5	483.71	622.08	554.07	386.62	485.54	436.92	446.11	569.20	508.70
	Ages 6-14	541.25	609.84	582.11	427.75	476.79	456.96	497.29	558.31	533.64
	Ages 15-20 F	591.93	683.72	661.68	463.99	529.60	513.84	542.38	624.03	604.42
	Ages 15-20 M	465.09	779.79	703.55	373.30	598.28	543.78	429.54	709.49	641.67
Non-Risk Prepayment Rates Total		$542.16	$722.41	$645.71	$428.40	$557.26	$502.43	$498.10	$658.45	$590.22

PIHP Name	**Department of Health Services**
Children's Hospital and Health System	
Official Signature DocuSigned by: Mark Rakowski 32478A34E1174FB...	Official Signature DocuSigned by: krista Willing 68A37375B7AF47E...
Printed Name Mark Rakowski	Printed Name Krista Willing
Title Sr. Vice President	Title Assistant Administrator-Division of Medicaid Services
Date Click here to enter a date. 2/15/2023	Date Click here to enter a date. 2/15/2023