Wisconsin Foster Care Medical Home CONTRACT

between

WISCONSIN DEPARTMENT OF HEALTH SERVICES

DIVISION OF MEDICAID SERVICES

and

Children’s Hospital and Health System, Inc.

Issued January 1, 2024

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PREAMBLE

This contract is between the Wisconsin Department of Health Services (the Department) and the Prepaid Inpatient Health Plan (PIHP) participating in the State of Wisconsin Foster Care Medical Home (WI FCMH) program. These programs are approved by the Secretary of the United States Department of Health and Human Services pursuant to the provisions of the Social Security Act. An PIHP is an insurer offering comprehensive health care services delivered by providers. These providers may be both employees and partners of the PIHP, or they may have entered into a referral or contractual agreement with the PIHP for the purpose of providing contract-related services for enrolled members. The PIHP should work with providers for the further specific purpose of promoting coordination and continuity of preventive health services and other medical care related to behavioral health, emergency care, and social determinants of health. In exchange for making contract-covered services available to enrolled members, the PIHP will receive periodic fixed payments from the Department. The PIHP shall retain at all times during the Contract a valid Certificate of Authority to write disability insurance issued by the State of Wisconsin Office of the Commissioner of Insurance. The PIHP is not required to contract for both programs, and if they are not contracted for both, only the provisions applicable to their program apply. The PIHP does herewith agree:

I. Definitions and Acronyms

A. Definitions

1. **Abuse:** For program integrity purposes abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to WI FCMH, in reimbursement for services that are not medically necessary, or services that fail to meet professionally recognized standards for health. Abuse also includes member practices that result in unnecessary costs to the WI FCMH program.

2. **Access:** Per 42 CFR §438.320, as it pertains to external quality review, "access" means the timely use of services to achieve optimal outcomes, as evidenced by the PIHP successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined in 42 CFR §438.68 and 42 CFR §438.206.

3. **Actuarially Sound Capitation Rates:** Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the PIHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with CMS requirements.

4. **Actuary:** An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.

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

6. **Adverse Benefit Determination:** Includes any of the following:
    a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    b. The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed.
    c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" under 42 CFR § 447.45(b) is not an adverse benefit determination.
    d. The failure to provide services in a timely manner.

e. The failure of the PIHP to act within the standard resolution timeframes for grievances and appeals as detailed in the *Article IX of this contract.*

f. For a resident of a rural area with only one PIHP, the denial of a member's request to exercise their right to obtain services outside the network as detailed in Article VII. D.4. of this contract.

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

h. Adverse benefit determination does not include any of the following:

i. When the WI FCMH, provider, or subcontractor triages a member to a proper health care provider; or

ii. When an individual health care provider determines that a service is medically unnecessary.

7. **Affirmative Action Plan:** A written document that details an affirmative action program.

8. **Agent:** An entity that solicits and/or conducts marketing or research on behalf of the PIHP and/or takes or transmits any applications for insurance coverage.

9. **Appeal:** For member appeals, a review by the PIHP of an adverse benefit determination. For provider appeals, an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: A claim is denied by the PIHP for untimely claim filing. The Provider must appeal the denial action to the PIHP; an internal review by the PIHP is required.**Authorized Representative:** An individual appointed by the member, including a power of attorney or estate representative, who may act on the member's behalf on under certain circumstances with documented consent of the member. The role of the authorized representative primarily includes filing a grievance or appeal, and approving the member's care plan.

10. **BadgerCare Plus:** BadgerCare Plus is Wisconsin's health care program for low income individuals that merged BadgerCare, the family portion of the current Wisconsin Medicaid population, with Healthy Start to form a single program that expands coverage to Wisconsin residents. Effective April 1, 2014, the following populations are eligible for BadgerCare Plus:

a. Parents and caretakers with incomes at or below 100 percent of the Federal Poverty Level (FPL).

b. Pregnant members with incomes at or below 300 percent of FPL.

c. Children (ages 18 and younger) with household incomes at or below 300 percent of the FPL.

d. Childless adults with incomes at or below 100 percent of the FPL.

e. Transitional medical assistance individuals, also known as members on extensions, with incomes over 100 percent of the FPL.

11. **Budget Neutral:** Per 42 CFR §438.5(a), a standard for any risk sharing mechanism that recognizes both higher and lower expected costs among contracted PIHPs under a managed care program and does not create a net aggregate gain or loss across all payments under that managed care program.

12. **Business Associate:** A person (or company), meeting requirements in 45 C.F.R. § 160.103, that provides a service to a covered program that requires their use of individually identifiable health information.

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

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

15. **Care Coordination:** The purposeful organization by care management staff to seamlessly deliver comprehensive services in response to a member's needs and work toward achieving desired health outcomes.

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

17. **Care Management Staff:** Staff that assists in patient-centered, evidence-based, coordinated care and services designed to effectively manage health conditions and help members meet their self-identified goals.

18. **Care Plan:** Written documentation of decisions made in advance of care provided, based on a comprehensive assessment of a person's needs, preferences and abilities, defining how services will be provided. This includes establishing objectives (desired outcomes) with the client and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing cycle of activity as long as care is being provided.

19. **Case Management:** A collaborative process of assessing, planning, facilitating, coordinating, evaluating, and advocating for options and services to meet an individual's comprehensive health needs through communication and available resources to promote quality and cost-effective outcomes.

20. **CESA (Cooperative Educational Service Agencies):** The unit serving as a connection between the state and school districts within its borders. There are 12 CESAs in

Wisconsin. Cooperative Educational Service Agencies coordinate and provide educational programs and services as requested by the school district.

21. **Child in Out-of-Home Care:** Refers to a child taken into custody and determined by a judge to meet the need for continuation of custody under s. 48.21(4)(b) or a parent/legal guardian signs a Voluntary Placement Agreement with DMCPS or the county Child Welfare Agency. A child in out-of-home care may reside in a variety of different placement settings, including a foster home, a group home, or a relative's home. Although this contract uses the term "Foster Care Medical Home" the reference applies to all children placed in an eligible out-of-home care placement setting.

22. **Claim:** Bill for services, a line item of service, or all services for one member.

23. **Clean Claim:** A truthful, complete, timely and accurate claim that does not have to be returned for additional information.

24. **Cold Call Marketing:** Any unsolicited personal contact by the PIHP with a potential member for the purpose of marketing.

25. **Communication Materials:** Communication materials designed to provide members or potential members with clear, concise, and factual information about the PIHP's program, the PIHP's network, and resources about the WI FCMH program.

26. **Community Based Health Organizations:** Non-profit agencies providing community based health services. These organizations provide important health care services such as HealthCheck screenings, nutritional support, and family planning, targeting such services to high-risk populations.

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

28. **Comprehensive Care Plan (for Medicaid SSI members only):** Written documentation of a plan of action developed by the PIHP and the member that identifies strengths, needs, goals, and necessary interventions to be addressed within a specific timeframe. The Care Plan is a living document that reflects an ongoing cycle of activity as long as care is being provided.

29. **Confidential Information:** All tangible and intangible information and materials accessed or disclosed in connection with this Contract, in any form or medium (and

without regard to whether the information is owned by the State or by a third party), that satisfy at least one of the following criteria:

a. Personally Identifiable Information;

b. Individually Identifiable Health Information;

c. Non-public information related to the State's employees, customers, technology (including databases, data processing, and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; or

d. Information designated as confidential in writing by the State.

30. **Contract:** The agreement executed between the PIHP and the Department to accomplish the duties and functions, in accordance with the rules and arrangements specified in this document.

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

32. **Contractor:** An PIHP awarded a contract resulting from the PIHP certification process to provide capitated managed care in accordance with this Contract.

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

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

35. **Core Reporting (referred to as WICR in the annual PIHP Quality Guide):** HEDIS measures that PIHPs must report to DHS. DHS reports these measures to CMS as part of their oversight of the Medicaid Adults and Child Core Sets measure performance.

36. **Corrective Action Plan:** A written plan required by the Department for a PIHP to address one of the below situations:

a. Plan communicated by the State to the PIHP for the PIHP to follow in the event of any threatened or actual use or disclosure of any Confidential Information that is not specifically authorized by this Agreement, or in the event that any Confidential Information is lost or cannot be accounted for by the PIHP.

b. This also refers to the plan communicated to the State by the PIHP to address a deficiency in contractual performance.

37. **Culturally Competent:** A set of congruent behaviors, attitudes, practices and policies that are formed within an agency, and among professionals that enable the system,

agency, and professionals to work respectfully, effectively and responsibly in diverse situations. Essential elements of cultural competence include understanding diversity issues at work, understanding the dynamic of difference, institutionalizing cultural knowledge, and adapting to and encouraging organizational diversity.

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

39. **Department:** The Wisconsin Department of Health Services.

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

41. **Direct mail marketing:** Any materials sent to potential members by the PIHP or its agents through U.S. mail or any other mail service.

42. **Drivers of Health:** The condition in which people are born, grow, live, work and age which are "shaped by the distribution of money, power and resources" and maybe negative or positive. Examples include income, education, employment, housing, neighborhood conditions, transportation systems, social connections, etc.

43. **Disposable Medical Supplies:** Health care items that are consumable or disposable, or cannot withstand repeated use by more than one individual that are required to address an individual medical disability, illness, or injury.

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

45. **Educational Materials:** These are materials designed to provide members with information and resources regarding their health.

46. **Electronic Visit Verification (EVV):** An electronic system that uses technologies to verify that authorized services were provided. EVV visit data must be collected for care provided under service codes listed on the Department's EVV website. Workers are required to send information at the beginning and end of each visit to the EVV system including:

    a. Who receives the service
    b. Who provides the service
    c. What service is provided
    d. Where service is provided
    e. Date of service

f. Time in and out

47. **Emergency Medical Condition:**

a. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

i. Placing the health of the individual (or, with respect to a pregnant member, the health of the member or their unborn child) in serious jeopardy;

ii. Serious impairment of bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

b. With respect to a pregnant member who is in active labor:

i. Where there is inadequate time to effect a safe transfer to another hospital before delivery; or

ii. Where transfer may pose a threat to the health or safety of the member or the unborn child.

c. A psychiatric emergency involving a significant risk or serious harm to oneself or others.

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

e. Emergency dental care is defined as an immediate service needed to relieve the patient from pain, an acute infection, swelling, trismus, fever or trauma. In all emergency situations, the PIHP must document in the member's dental records the nature of the emergency.

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

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

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

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

52. **Encounter:**

a. A service or item provided to a patient through the health care system. Examples include but are not limited to:

i. Office visits

ii. Surgical procedures

iii. Radiology (including professional and/or technical components)

iv. Durable medical equipment

v. Emergency transportation to a hospital

vi. Institutional stays (inpatient hospital, rehabilitation stays)

vii. HealthCheck screens

b. A service or item not directly provided by the PIHP, but for which the PIHP is financially responsible. An example would include an emergency service provided by an out-of-network provider or facility.

c. A service or item not directly provided by the PIHP, and for which no claim is submitted but for which the PIHP may supplement its encounter data set. Such services might include HealthCheck screens for which no claims have been received and if no claim is received, the PIHP must have conducted a medical chart review. Examples of services or items the PIHP may include are:

i. HealthCheck Services

ii. Lead Screening and Testing

iii. Immunizations

d. Services or items as used above include those services and items not covered by BadgerCare Plus and Medicaid SSI, but which the PIHP chooses to provide as part of its managed care product. Examples include educational services, certain over-the-counter drugs, and delivered meals.

53.

54. **Encounter Record:** An electronically formatted list of encounter data elements per encounter as specified in the current Encounter User Guide. An encounter record may be prepared from paper claims such as the CMS 1500, UB-04, or electronic transactions such as ASC XX12N 837.

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

56. **Enrollment Specialist:** An entity contracted by the Department to perform PIHP choice counseling and PIHP enrollment activities. Choice counseling refers to activities such as answering questions and providing unbiased information on available managed care organization delivery system options, and advising on what factors to consider when choosing among PIHPs and in selecting a primary care provider. Enrollment activities refers to distributing, collecting, and processing enrollment materials and taking enrollments by phone, by mail, or in person.

57. **Excluded Services:** Services that Medicaid does not pay for.

58. **Expedited Grievance or Appeal:** An emergency or urgent situation in which a member or their authorized representative requests a review of a situation where further delay could be a health risk to the member, as verified by a medical professional.

59. **Experimental Surgery and Procedures:** Experimental services that meet the definition of Wis. Adm. Code §DHS 107.035(1) and (2) as determined by the Department.

60. **External Quality Review (EQR):** Per 42 CFR §438.320, the analysis and evaluation by an External Quality Review Organization of aggregated information on quality, timeliness, and access to the health care services that an PIHP or their contractors furnish to Medicaid beneficiaries.

61. **External Quality Review Organization (EQRO):** Per 42 CFR §438.320, an organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR §438.358, or both.

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

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

64. **Fiscal Agent (as cited in 42 CFR §455.101):** A contractor that processes or pays vendor claims on behalf of the Medicaid agency.

65. **ForwardHealth Handbook:** This Portal also provides users with access to health care information available via the Online Handbook. The Online Handbook is an interactive

tool containing current health care policy and procedural information for ForwardHealth programs.

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

67. **Functionally equivalent:** A service provided via telehealth where the transmission of information is of sufficient quality as to be the same level of service as an in person visit. Transmission of voices, images, data, or video must be clear and understandable.

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

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

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

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

72. **Health Care Coordinator:** An individual who serves as a clinical specialist to assess, develop, coordinate, and facilitate health care management for children in out-of-home placement. This individual should have equivalent training and experience of a person with a Master's Degree (preferred) or Bachelor's degree (required) with an additional two years of experience in health promotion, health advocacy, health education, clinical case management, child/family clinical social work, community outreach, or child welfare or related field.. All health care coordinators should have relevant experience in case management, home health nursing, special needs, SSI, child welfare, general child Medicaid population, and/or behavioral health; or must demonstrate proficiency and/or ability to serve the out-of-home care population as determined by PIHP.

73. **Health Care Professional:** A person who is trained and licensed to give health care. Examples include: A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-

language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, licensed midwives, or certified respiratory therapy technician.

74. **Health Care Services:** All Medicaid services provided by an PIHP under contract with the Department in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

75. **HealthCheck:** HealthCheck is Wisconsin's name for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for children under age 21. The EPSDT benefit is defined in federal law at §1905(r) of the Social Security Act. The benefit provides comprehensive and preventive health care services for all children under 21 years old. Federal and state regulations establish certain requirements for comprehensive HealthCheck screenings. A comprehensive HealthCheck screen includes all of the following components:

    a. A complete health and developmental history (including anticipatory guidance).
    b. A comprehensive unclothed physical examination.
    c. An age-appropriate vision screening exam.
    d. An age-appropriate hearing screening exam.
    e. An oral assessment plus referral to a dentist beginning at one year of age.
    f. The appropriate immunizations (according to age and health history).
    g. The appropriate laboratory tests (including blood lead level testing when appropriate for age).

76. **HealthCheck "Other Services":** HealthCheck "Other Services" is Wisconsin's term for the federal mandate (under EPSDT) that requires that states cover "other necessary health care, diagnostic services, treatment, and other measures" which a child (under age 21) may require to treat, correct or reduce illnesses and conditions regardless of whether the necessary service is covered in a state's Medicaid plan. The needed service must be allowable under federal Medicaid law (§1905(a) of the Social Security Act), and coverage is determined on a case-by-case basis.

77. **Health Information:** Any "health information" provided and/or made available by the Department to a Trading Partner, and has the same meaning as the term "health information" as defined by 45 CFR § 160.103.

78.

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

80. **Health Related Social Needs (HRSN):** Individually identified needs related to a social risk factor. Examples include homelessness or domestic abuse.

81. **HHS Transaction Standard Regulation:** 45 CFR, Parts 160 and 162.

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

83. **Highest Needs Members:** Members with complex needs, multiple comorbidities, and/or a history of frequent emergency department visits or inpatient admissions during the previous 12 months as identified by the PIHP's needs-stratification process.

84. **HIPAA:** The Health Insurance Portability and Accountability Act of 1996, federal legislation that is designed to improve the portability and continuity of health insurance.

85. **Homeless:** An individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is:

    a. A supervised shelter designed to provide temporary accommodations;

    b. A halfway house or similar institution that provides temporary residence for individuals; or

    c. A place not designed for, or ordinarily used as a regular sleeping accommodation for human beings (e.g., a hallway, bus station, or a lobby).

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

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

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

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

90. **Income Maintenance Agencies:** Agencies include tribes, consortia or counties that determine BadgerCare Plus and Medicaid SSI enrollment and ongoing case management. Members can apply for benefits online, by phone, by mail or in person with their local agency.

91. **Indian:** Pursuant to 42 CFR § 438.14(a), any individual defined at 25 U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR §136.12. The individual:

    a. Is a member of a Federally recognized Indian tribe;

    b. Resides in an urban center and meets one or more of the four criteria:

        i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

        ii. Is an Eskimo or Aleut or other Alaska Native;

        iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

        iv. Is determined to be an Indian under regulations issued by the Secretary;

    c. Is considered by the Secretary of the Interior to be an Indian for any purpose; or

    d. Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

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

    Individually Identifiable Health Information (IIHI): Patient demographic information, claims data, insurance information, diagnosis information, and any other information that relates to the past, present, or future physical or mental health or condition, provision of health care, payment for health care and that identifies the individual (or that could reasonably be expected to identify the individual).

93. **Information Gathering and Assessment (for Medicaid SSI members only):** A detailed evaluation where the care management staff collects all relevant information about the member's health care, and cultural and socioeconomic needs to conduct needs-stratification and to develop the Comprehensive Care Plan.

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

95. **Low Birth Weight:** Defined as a birth weight of less than 2,500 grams.

96. **Mandatory:** For the purpose of this contract, mandatory refers to a service area where the Department may, under Title 42 of the CFR and the State Plan Amendment, require members to enroll in a PIHP.

97. **Marketing** Any communication, sponsorship of community events, or the production and dissemination of marketing by the PIHP, its employees, affiliated providers, subcontractors, or agents to a potential member for the purpose of persuading such persons to enroll with the PIHP or to disenroll from another PIHP. Marketing does not include communication to a potential member from the issuer of a qualified health plan as defined in 45 CFR 155.200, about the qualified health plan.

98. **Marketing Materials:** Materials that are produced in any medium, by or on behalf of an PIHP that can be reasonably interpreted as intended to market PIHP to potential enrollees of the PIHP.

99. **Marketing Policy**: Policy that governs acceptable and prohibited promotional activities for the PIHP administering the WI FCMH.

100. **Marketplace**: The federal Health Insurance Marketplace (also called the "Exchange"), that offers standardized health insurance plans to individuals, families, and small businesses.

101. **Medicaid:** The BadgerCare Plus and Medicaid SSI Program operated by the Wisconsin Department of Health Services under Title XIX of the Federal Social Security Act, Wis. Stats., Ch. 49, and related state and federal rules and regulations.

102. **Medicaid SSI (Supplemental Security Income):** Wisconsin's Medicaid plans for the elderly, blind or disabled provide health care for members who are:

    a. Age 65 or older, blind or disabled,

    b. With family income at or below the monthly program limit, and

    c. Who are United States citizens or legal immigrants.

    Plan eligibility depends on member income, assets, and the type of care needed. Individuals who receive SSI payments automatically qualify for Medicaid and are eligible for additional social services through their income maintenance agency.

103. **Medical Status Code:** The two-digit (alphanumeric) code in the Department's computer system that defines the type of WI FCMH eligibility a member has. The code identifies the basis of eligibility, whether cash assistance is being provided, and other aspects of WI FCMH. The medical status code is listed on the PIHP enrollment reports.

104. **Medically Necessary:** A medical service, device or item that meets the definition of Wis. Adm. Code §DHS 101.03(96m).

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

106. **Member-Centric Care:** Member-centric care is care that explicitly considers the member's perspective and point of view. For example, a member-centric care plan will include treatment goals and expected outcomes identified by the member, often expressed in the member's own words. A member-centric needs assessment includes the needs expressed by the member whether or not those needs fit neatly into medical or health nomenclatures. Member-centric care actively engages the patient throughout the care process.

107. **Member Communication:** Materials designed to provide an PIHP's members with clear and concise information about the PIHP's program, the PIHP's network, and the WI FCMH program.

108. **Members with Special Needs:** Pursuant to 42 CFR § 438.208(c)(1), the terminology used in clinical diagnostic and functional development to describe individuals who require additional assistance for conditions that may be medical, mental, developmental, physical or psychological (this includes, but is not limited to, SSI members, members as determined by the PIHP to need or benefit from intensive medical or behavioral case management, members experiencing homelessness, members enrolled in the Obstetrical Medical Home (OBMH), or Birth to 3 members).

109. **National Culturally and Linguistically Appropriate Services (CLAS) Standards**[1]: The National CLAS Standards are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

110. **Natural Supports:** Personal associations and relationships typically developed in the member's community that are invested in the member's success, including but not limited to extended family members, and friends, who provide voluntary, unpaid supports to member.

111. **Needs-stratification:** The assignment of individual members to specific levels of care management, based on individual member's overall medical and social needs that could affect the health care outcomes for that member. Needs-stratification helps align an individual member's overall medical and social needs with the most appropriate level of care management for that member.

112. **Newborn:** A member less than 100 days old.

[1] https://www.thinkculturalhealth.hhs.gov/clas

113. **Other Sector Staff:** Various workers from other sectors (e.g., county child welfare agencies, or the member's school) who are invested in the member's care.

114. **Out-of-network provider:** Also called a "Non-Participating Provider**"** is a Facility or provider that the PIHP does not have a contract with to provide services to a member of the plan.

115. **Outcomes:** Per 42 CFR §438.320, changes in patient health, functional status, satisfaction or goal achievement that result from health care or supportive services.

116. **Outpatient Drug:** Outpatient Drug: any drug the meets that definition of covered outpatient drug as defined is Social Security Act s. 1927(k).

117. **Outreach Materials:** Materials used by the PIHP to help bring awareness of services to members.

118. **Paid Advertising**: Otherwise known as paid media, includes, but is not limited to, the airing of campaign messages or advertisements by purchasing space in media outlets.

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

120. **Pay-for-Performance (P4P):** DHS initiative to measurably improve quality of care provided to Medicaid members in focused areas. Includes PIHP capitation withhold that can be earned back by PIHPs based on their performance relative to quality targets for measures applicable to them.

121. **Performance Improvement Projects (PIPs):** Annual projects that PIHPs are required to undertake as part of Quality Assessment Performance Improvement (QAPI).

122. **Personally Identifiable Information:** An individual's last name and the individual's first name or first initial, in combination with and linked to any of the following elements, if the element is not publicly available information and is not encrypted, redacted, or altered in any manner that renders the element unreadable:

    a. The individual's Social Security number;

    b. The individual's driver's license number or state identification number;

    c. The individual's date of birth;

    d. The number of the individual's financial account, including a credit or debit card account number, or any security code, access code, or password that would permit access to the individual's financial account;

    e. The individual's DNA profile; or

    f. The individual's unique biometric data, including fingerprint, voice print, retina or iris image, or any other unique physical characteristic.

123. **Pharmacy Services Lock-in Program:** A program implemented by the Department to coordinate the provision of health care services for PIHP members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications. Members enrolled in the program will have one pharmacy provider and one primary prescriber for restricted medications.

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

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

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

127. **Post Stabilization Services:** Medically necessary non-emergency services furnished to a member after they are stabilized following an emergency medical condition.

128. **Potential member:** A BadgerCare Plus or SSI member who is subject to mandatory managed care enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet a member of a specific PIHP.

129. **Potentially Preventable Readmissions (PPR) initiative:** DHS initiative requiring PIHPs to collaborate with their providers to reduce preventable hospital readmissions within 30 days of discharge from inpatient care.

130. **Prepaid Inpatient Health Plan (PIHP):** An entity that provides medical services to members under contract with the State agency, on the basis of monthly prepayments that have been developed based on historical spending for the out-of-home care population with adjustments based on the WI FCMH service delivery requirements. The PIHP provides, arranges for, or otherwise has responsibility for the provision of all health care services, including inpatient hospital or institutional services for its members; and it does not have a comprehensive risk contract.

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

132. **Prescription Drug Coverage:** Drugs and drug products covered by Medicaid include legend and non-legend drugs and supplies listed in the Wisconsin Medicaid drug index which are prescribed by a physician, by a dentist licensed, by a podiatrist, by an

optometrist, by an advanced practice nurse prescriber, or when a physician delegates the prescribing of drugs to a nurse practitioner or to a physician's assistant.

133. **Priced Amount:** The fee-for-service equivalent rate assigned to an encounter.

134. **Pricing Percentage:** Refers to percent priced for a defined time period such as a calendar or fiscal year. This measure is calculated by the PIHP and is reported to the Department as a component of the Estimated Data Completeness measure.

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

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

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

138. **Prospective Risk Adjustment:** Per 42 CFR §438.5(a), a methodology to account for anticipated variation in risk levels with the contracted PIHP that is derived from historical experience of the contracted PIHP and applied to rates for the rating period for which the certification is submitted.

139. **Protected Health Information (PHI):** Health information, including demographic, that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual, that identifies the individual or provides a reasonable basis to believe that it can be used to identify an individual. PHI is a subset of IIHI.

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

141. **Provider Network:** A list of physicians, hospitals, urgent care centers, and other health care providers that an PIHP has contracted with to provide medical care to its members.

These providers are “network providers,” “in-network providers” or “participating providers.” A provider that has not contracted with the plan is called an “out-of-network provider” or “non-participating provider.”

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

143. **Qualified Health Plan:** As established by the Affordable Care Act (ACA), an insurance plan that is certified by Marketplace and meets ACA requirements such as coverage of essential health benefits.

144. **Quality:** Per 42 CFR §438.320, as it pertains to external quality review, the degree to which a PIHP increases the likelihood of desired outcomes of its enrollees through:

    a. Its structural and operational characteristics.

    b. The provision of services that are consistent with current professional, evidenced-based-knowledge.

    c. Interventions for performance improvement.

145. **Rate Cell:** A set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.

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

147. **Rating Period:** A period of 12 months selected by the Department for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR §438.7(a).

148. **Readily Accessible:** Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

149. **Reconsideration of a Claim:** A request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

150. **Recovery:** Refers to an approach to care which has its goals as a decrease in dysfunctional symptoms and an increase in maintaining the person’s highest level of wealth, wellness stability, self-determination and self-sufficiency. Care that is consistent with recovery emphasizes the member’s strengths, recognizes their ability to cope under difficult circumstances, and actively engages as partners in the provision of health care.

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

152. **Resubmission of a Claim**: A claim or a portion of a claim that was denied is resubmitted through the claims process with changed or added information.

153. **Retrospective Risk Adjustment:** Per 42 CFR §438.5(a), a methodology to account for variation in risk levels with the contracted PIHP that is derived from experience concurrent with the rating period of the contracted PIHP subject to the adjustment and calculated at the expiration of the rating period.

154. **Risk Adjustment (Previously known as Chronic Illness & Disability Payment System (CDPS)):** Per 42 CFR §438.5(a), a methodology to account for the health status of enrollees via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of PIHPs contracted with the State.

155. **Screening:** The use of data-gathering techniques, tests, or tools to identify or quantify the health and/or cultural needs of a member. Screening methods may include telephonic contact, mailings, interactive web tools, or encounters in person with screeners or health care providers. For Medicaid SSI members, the screening must be an in-person or telephonic interview where an PIHP identifies the member's medical, dental, behavioral health and social needs.

156. **Secretary:** The Secretary of HHS and any other officer or employee of the Department of HHS to whom the authority involved has been delegated.

157. **Service Area:** An area of the State where the PIHP has agreed to provide WI FCMH services to members. The Department monitors enrollment levels of the PIHP by the PIHP's service area(s). The PIHP indicates whether they will provide dental or chiropractic services by service area. A service area may be a county, a number of counties, or the entire State.

158. **Service Authorization:** Approval of a member's request for the provision of a service.

159. **Significant Change:** Any change within a PIHP's ability to fulfill the major components of the contract requirements, including but not limited to a change in provider network, service area, organizational structure or staff, or benefit package.

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

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

162. **Social Risk Factors:** Individual-level adverse determinants of health. Examples include social isolation or housing instability.

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

164. **Standard Plan:** Effective April 1, 2014, all members eligible for BadgerCare Plus will be enrolled in the BadgerCare Plus Standard Plan. Standard Plan is the benefit package for BadgerCare Plus and Medicaid SSI defined in the ForwardHealth online handbooks and through State Plan Authority.

165. **State:** The State of Wisconsin.

166. **State Fair Hearing:** The process used by the Wisconsin Division of Hearing and Appeals to adjudicate member appeals of PIHP adverse benefit determinations.

167. **Subcontract:** Any written agreement between the PIHP and another party to fulfill the requirements of this Contract. However, such terms do not include insurance purchased by the PIHP to limit its loss with respect to an individual member, provided the PIHP assumes some portion of the underwriting risk for providing health care services to that member.

168. **Telehealth:** The use of telecommunications technology by a certified provider to deliver services allowable under s. DHS 107.02(05) and Wis. Stat. § 49.45 (61) and 49.46 (2) (b) 21. to 23., including assessment, diagnosis, consultation, treatment, or transfer of medically relevant data in a functionally equivalent manner as that of an in-person contact. Telehealth may include real-time interactive audio-only communication. Telehealth does not include communication between a certified provider and a recipient that consists solely of an electronic mail message, text, or facsimile transmission.

169. **Third Party Liability (TPL):** The legal obligation of a third party (other than Medicaid) to pay for part or all of a claim. Since Medicaid is legally the "payer of last resort," the identification of other payer obligations is a major requirement in the adjudication of claims (see Addendum IV.A. for additional definitions pertaining to TPL).

170. **Trade Secret:** Per Wis. Stat. §134.90(1), trade secrets are information, including a formula, pattern, compilation, program, device, method, technique or process to which all of the following apply:

    a. s.134.90(1)(c)1. The information derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use.

    b. s.134.90(1)(c)2. The information is the subject of efforts to maintain its secrecy that are reasonable under the circumstances.

171. **Trading Partner:** Refers to a provider or PIHP that transmits any health information in electronic form in connection with a transaction covered by 45 CFR Parts 160 and 162, or a business associate authorized to submit health information on the Trading Partner's behalf.

172. **Transaction:** The exchange of information between two parties to carry out financial or administrative activities related to health care as defined by 45 CFR §160.103.

173. **Transitional Care:** Processes to ensure continuity of care that include, but are not limited to, medication reconciliation, ensuring members have a comprehensive understanding of their treatment plan, and assisting members with scheduling follow-up appointments with their primary care provider or specialists as needed after a member is discharged from an emergency department, hospital, nursing home, or rehabilitation facility. Per 42 CFR § 438.208(b)(2), processes to coordinate services the PIHP furnishes to the member between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.

174. **Trauma-informed Care:** An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

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

176. **Usual sources of care:** Doctor, clinic, health center, or other place that an individual reports visiting when sick. Persons who report the emergency department as the place of their usual source of care are defined as having no usual source of care.

177. **Validation:** Per 42 CFR §438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

178. **Voluntary:** Refers to any service area where the Department cannot require members to enroll in an PIHP.

179. **Waste:** Practices that, directly or indirectly, result in unnecessary costs to Medicaid funded programs, such as overusing services. Waste is generally not the result of criminally negligent actions but rather by the inappropriate utilization of services, misuse of resources, and claims billed in error.

180. **Wisconsin Interdisciplinary Care Team (WICT):** A group of health care professionals, including PIHP partners, and other ancillary staff representing diverse disciplines who work together to share expertise, knowledge, and skills to help members meet their self-identified goals. An effective WICT requires interdependent collaboration, open communication, and shared decision-making working toward a common goal.

181. **Wisconsin Statewide Health Information Network (WISHIN):** Wisconsin's health information network that shares electronic health information securely between participating physicians, clinics, hospitals, pharmacies, clinical laboratories, and PIHPs across the state.

Per 42 CFR § 438.10, PIHPs must use the definitions for managed care terminology found above when communicating with members to ensure consistency in the information provided to members. Terms that are not defined above shall have their primary meaning identified in Wis. Adm. Code chs. DHS 101-108.

B. Acronyms:

Acronym	Meaning
AA	Affirmative Action
AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
ACOG	American Congress of Obstetricians and Gynecologists
ADRC	Aging and Disability Resource Center
ASAM	American Society of Addiction Medicine
ASO	Administrative Service Organization
BC or BC+	BadgerCare or BagderCarePlus
BQO	Bureau of Quality and Oversight
BRS	Bureau of Rate Setting
CAH	Critical Access Hospital
CAP	Corrective Action Plan
CBRF	Community Based Residential Facility
CCS	Comprehensive Community Services
CDPS	Chronic Illness & Disability Payment System
CEHRT	Certified Electronic Health Record Technology
CEO	Chief Executive Officer
CESA	Cooperative Educational Service Agencies
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CLA	Childless Adult
CLAS	Culturally and Linguistically Appropriate Services
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
CPT	Current Procedural Terminology
CRC	Civil Rights Compliance
CRS	Community Recovery Services

CSA	Child Support Agency
CSP	Community Support Program
CY	Calendar Year
DATA	Drug Addiction Treatment Act
DMCPS	Division of Milwaukee Child Protective Services
DCTS	Division of Care and Treatment Services
DMS	Division of Medicaid Services
DOT	Directly Observed Therapy
DQA	Division of Quality Assurance
DRG	Diagnosis Related Groupings
DSPS	Department of Safety and Professional Services
DSS	Department of Social Services
DVT	Deep Vein Thrombosis
EFT	Electronic Funds Transfer
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ERISA	Employee Retirement Income Security Act
EVV	Electronic Visit Verification
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Federal Department of Health and Human Services
HIPAA	The Health Insurance Portability and Accountability Act
PIHP	Health Maintenance Organization
HPSA	Health Professional Shortage Area
ICD	International Classification of Diseases
IDSS	Institute for Data, Systems, and Society
IFSP	Individualized Family Service Plan
IHCP	Indian Health Care Provider
IIHI	Individually Identifiable Health Information
IMD	Institutes for Mental Disease
IRS	Internal Revenue Service

LEP	Limited English Proficiency
LTC	Long Term Care
MA	Medical Assistance/Medicaid
MAPP	Medicaid Purchase Plan
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NEMT	Non-Emergency Medical Transportation
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limits
NTS	Narcotic Treatment Services
OBMH	Obstetric Medical Home
OCI	Office of the Commissioner of Insurance
OIG	Office of the Inspector General
ONC	Office of National Coordinator
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary Care Provider
PE	Pulmonary Embolism
PHI	Protected Health Information
PIP	Performance Improvement Project
PNCC	Prenatal Care Coordination
PPR	Potentially Preventable Readmissions
P4P	Pay for Performance
QAPI	Quality Assessment Performance Improvement
QPIR	Quarterly Program Integrity Report
RHC	Rural Health Center
SBS	School Based Services
SCHIP	State Children's Health Insurance Program
SFTP	Secure File Transfer Protocol
SIU	Special Investigations Unit
SMV	Specialized Medical Vehicles
SSA	Social Security Administration
SSI	Supplemental Security Income
TCM	Targeted Case Management
TMSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability

UM	Utilization Management
URAC	Utilization Review Accreditation Commission
VFC	Vaccines for Children
WCAG	Web Content Accessibility Guidelines
WIC	Women, Infant, and Children
WICR	Wisconsin Core Reporting
WICT	Wisconsin Interdisciplinary Care Team
WIR	Wisconsin Immunization Registry
WISHIN	Wisconsin Statewide Health Information Network

II. Enrollment and Disenrollment

A. Enrollment

1. Enrollment Authority

Enrollment in the PIHP is voluntary by the member as authorized in 2014 under an Alternative Benefit Plan (ABP) State Plan Amendment (TN#13-034) and as allowed in federal law under §1937 of the Social Security Act (2010).

Children placed in eligible out-of-home care settings, in Milwaukee, Racine, Kenosha, Waukesha, Washington and Ozaukee Counties, who are under the jurisdiction of the child welfare system in one of these counties are eligible for PIHP enrollment. Enrollment will be allowed to continue for up to 12 months after the child is discharged from out-of-home care, as long as the child remains eligible for full benefit Medicaid and continues to reside in one of the six identified counties. Children residing in secure facilities or Residential Care Centers (RCC) are not eligible for enrollment.

If there are two or more participating PIHPs in the child's service area, the child's parent/legal guardian will be given the option of choosing to enroll in one of the PIHPs or they may choose to receive services through Medicaid FFS.

If at any time during the Contract period the Department obtains a State Plan Amendment, a waiver or revised authority under the Social Security Act (as amended), the conditions of enrollment described, including but not limited to voluntary enrollment and the right to voluntary disenrollment will be amended by the terms of said waiver and a State Plan Amendment.

2. Enrollment Determination

The Department will identify and provide informing materials to the PIHP for members who meet the initial FCMH enrollment criteria with one of the following medical status codes:

Medical Status Code	Description
33	Foster Care, IV-E Eligible
34	Foster Care, non IV-E
37	Foster Care, special needs, IV-E eligible
3P	Pre-adoption foster care, special needs, non IV-E

3. Enrollment Section

The Department will work closely with the PIHP to establish an informing plan with the Department's contracted enrollment specialist.

The enrollment specialist will respond on the same or following working ay to

telephone calls or requests for information about the program. The PIHP shall refer parent/legal guardian to the enrollment specialist for assistance with the enrollment process.

A PIHP representative will provide information on services consistent with the current Medicaid program. Information will be available in English, Spanish, Lao, Russian and Hmong if the members, or their authorized representatives are conversant only in those languages. Information will be available in other media as required for persons with visual impairments, without reading skills, and with other communication limitations.

PIHP member informing materials and procedures must receive approval by the Department during the readiness review prior to implementation.

a. Inform the member, parent/legal guardian of provisions for voluntary disenrollment required by 42 CFR 434 Subpart C. Relevant provisions include lack of access to quality care and to necessary specialty services covered under the State Plan (42 CFR 434.27(3)).

b. Inform the member, parent/legal guardian of the provisions for involuntary disenrollment.

4. Enrollment Rosters

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

For each month of coverage through the term of the Contract, the Department will transmit "PIHP Enrollment Rosters" to the PIHP. These rosters will provide the PIHP with ongoing information about its WI FCMH enrollees and disenrollees and will be used as the basis for the monthly capitation claim payments to the PIHP. The PIHP Enrollment Rosters will be generated in the following sequence:

a. The Initial and Final Enrollment Rosters in the X12 834 format that will be available via the ForwardHealth Trading Partner Portal. These rosters will provide the PIHP with ongoing information about its FCMH members and will be used as the basis for the monthly PIHP nonrisk payments as described in this contract.

   i. The X12 834 Initial Enrollment Report will list all of the PIHP's members and those disenrolled for the enrollment month that are known on the date of report generation. The Initial Enrollment Report will be available to the PIHP on or about the twenty-first of each month. A monthly nonrisk prepayment shall be generated for each member listed as an ADD or CONTINUE on this report. Members who appear as PENDING on the Initial Report and are reinstated into the PIHP prior to the end of the month will appear as

a CONTINUE on the Final Report and a payment will be generated for those members.

ii. The X12 834 Final Enrollment Report will list all of the PIHP's members for the enrollment month, which were not included in the Initial or who have had a status change since the Initial Enrollment Report. The Final PIHP Enrollment Report will be available to the PIHP on or around the first business day of the enrollment month. A monthly nonrisk prepayment will be generated for every member listed as an ADD or CONTINUE on this report.

iii. The Initial and Final Rosters will identify changes in member demographics and medical status codes, since the last enrollment roster.

b. The X12 820 Payment Listing Report will identify all members for which a non-risk prepayment was made or recouped for the specified enrollment dates. The report will be available via the ForwardHealth Trading Partner Portal on the Tuesday after the first Friday of every month.

5. Other Reports

a. The Monthly Member COB File is a report of members enrolled with the PIHP who had third-party coverage last month. The report will be available on the ForwardHealth MCO Portal on or around the first of each month.

b. Member Health History Report

c. Monthly initial and final reports (MGD-135-M and MGD-137-M, respectively) that are currently pushed out on the MCO portal, sorted by MCO assigned ID.

6. Enrollment Policy

The PIHP 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.

7. Enrollment Errors

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

8. Open Enrollment

The PIHP shall accept members eligible for coverage under this Contract, in the order in which they are enrolled. The PIHP will not discriminate against individuals eligible to enroll on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability and will not use any

policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status, sex, sexual orientation, gender identity or disability.

9. Re-Enrollment

A FCMH member who voluntarily disenrolled from the PIHP can re-enroll if they meet the covered population eligibility criteria as specified in the contract and remains in an eligible out-of-home care setting. A FCMH member who disenrolled from the PIHP after discharge from an out-of-home care setting is not eligible to re-enroll. The need for the PIHP to perform a comprehensive assessment on the re-enrolling member depends on how long they were disenrolled from the PIHP.

a. If the member is re-enrolled less than six months after the member's last disenrollment from the PIHP, the P IHP does not have to perform a comprehensive initial health assessment. The PIHP may use the previously developed comprehensive health care plan for that member. The comprehensive health care plan must be reviewed and updated if indicated.

b. If the member is re-enrolled at least six months after the member's last disenrollment from the PIHP, then the PIHP must perform a comprehensive initial health assessment of the member. The PIHP must develop a new comprehensive health care plan for that member.

B. Disenrollment

Disenrollment requests will be processed as soon as possible and will generally be effective the first day of the next month of the request, unless otherwise specified. If the Department fails to make a disenrollment determination within 30 days of receipt of all necessary information, the disenrollment is considered approved. The PIHP must direct all members with disenrollment requests to the Department's Enrollment Specialist for assistance and/or for choice counseling.

1. Voluntary Disenrollment

All legal guardians for members enrolled in FCMH shall have the right to disenroll their child from the PIHP at any time for any reason. The PIHP will promptly forward to the enrollment specialist all requests from the member's parent/legal guardian for disenrollment. Disenrollment requests will be processed as soon as possible and will be effective the last day of the month. Payment(s) made for the member disenrolled the last day of the month will be recouped based on a daily rate. The PIHP must direct all members with disenrollment requests ot the Department's Enrollment Specialist for assistance and/or for choice counseling.

2. System Based Disenrollments

System based disenrollments happen automatically in the system as a result of changes to the member's eligibility. If an PIHP believes a member should have

had a system-based disenrollment but has not, the PIHP may request disenrollment through the Department's PIHP Enrollment Specialists.

a. Loss of WI FCMH Eligibility

If a member is no longer eligible for enrollment due to death or loss of full benefit Medicaid eligibility during their 12-month extension for more than one month, they shall be disenrolled. The date of disenrollment shall be effective on the first date of Medicaid ineligibility.

b. Out-of-Service Area Disenrollment

The member was placed in or moves to a location outside of the PIHP's certified service area. The date of disenrollment shall be the date the placement/move occurred, even if this requires retroactive disenrollment to reflect the date of the out-of-county placement/move.

c. Ineligible Placement Setting Disenrollment

The member is placed in a Residential Care Center. The date of disenrollment shall be the date the placement/move occurred, even if this requires retroactive disenrollment. Recoupments will be made to the monthly payment to reflect the date of the ineligible placement/move.

d. Inmates of a Public Institution

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

C. Exemptions

Exemption requests will be processed as soon as possible and will be effective the first day of the next month of the request, unless otherwise specified. The PIHP must direct all members with exemption requests to the Enrollment Specialist for assistance.

Exemption requests will not be backdated, unless an exception is granted by the Department. The PIHP will not be liable for services, as of the effective date of the exemption.

Below are listed the exemption criteria that the Department uses to grant exemptions. Even if a member meets the exemption criteria, the Department may, in its sole discretion, deny an exemption. Members who are denied an exemption may request a State Fair Hearing to appeal the denial.

1. Just Cause

Just cause is defined as a situation in which the PIHP cannot provide the member with appropriate medically necessary contract services for reasons beyond its control. The PIHP may not request just cause disenrollment because of an adverse

change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative disruptive behavior resulting from their special needs (except when their continued enrollment in the PIHP seriously impairs the entity's ability to furnish services to either this particular member or other members) (42 CFR 438.56). This exemption does not have an end date. The exemption is requested by the PIHP and approved by the Bureau of Quality Oversight (BQO). The PIHP requesting a just cause exception must provide documentation justifying the request. This exception lasts for a minimum of 2 years. If a member would like to transition back after two years, they must submit documentation demonstrating that they have remedied the issue that the PIHP cited as reasoning for their inability to provide care. A member's request to transition back to the PIHP does not guarantee that they will be allowed to transition back.

2. Nursing Home

   For BadgerCare Plus and Medicaid SSI members in a nursing home Cares Income Maintenance (MIM) or the PIHP may request this exemption. This exemption is approved by the Enrollment Specialist or Fiscal agent staff.

   The PIHP is responsible for nursing home costs until the date of the disenrollment. Although the PIHP may request the exemption after 30 or 90 days in the nursing home, the exemption is effective the first of the month following the request.

   a. Medicaid SSI

      The PIHP may request an exemption after an SSI member has been in a nursing home 90 days and is expected to remain in the facility. In the event the member transfers from the nursing home to a hospital and back to the nursing home, the applicable 90 day period shall run continuously from the first admission to the nursing home and shall include any days in the hospital. The PIHP must wait until after 90 days before requesting an exemption, which will occur the first of the next month.

   b. BadgerCare Plus

      The PIHP may request disenrollment when a member is in the nursing home longer than 30 days and is expected to remain in the facility. The PIHP must wait 30 days before requesting an exemption, which will be effective the first of the next month.

3. Commercial Insurance

   Members who have commercial insurance (PIHP or otherwise) may be eligible for an exemption from a BadgerCare Plus or Medicaid SSI PIHP if the commercial insurance does not participate in BadgerCare Plus or Medicaid SSI. In addition, members who have commercial insurance that limits them to a restricted provider network (e.g., PPOs, PHOs, etc.) may be eligible for an exemption from enrollment in a BadgerCare Plus or Medicaid SSI PIHP. The

member requests this exemption and it is approved by the Enrollment Specialist or fiscal agent. This exemption lasts for one year.

The PIHP may request assistance from the Department's contracted Enrollment Specialist in situations where the member has commercial insurance that limits the members to providers outside the commercial insurance plan's network.

When the Department's member eligibility file indicates commercial PIHP coverage limiting a member to providers outside the WI FCMH PIHP network and the member seeks services from the WI FCMH PIHP network providers, the WI FCMH network providers may refuse to provide services to that member and refer them to their commercial network, except in the case of an emergency.

4. Experimental Transplant

   Members who have had a transplant that is considered experimental such as a liver, heart, lung, heart-lung, pancreas, pancreas-kidney, stem cell or bone marrow transplant shall have a permanent exemption from PIHP enrollment. Kidney and cornea transplants are not experimental.

   a. The exemption will begin on the first day of the month in which the surgery is performed.

   b. For autologous bone marrow transplants, the person will be permanently exempted from PIHP enrollment beginning on the date the bone marrow was extracted.

   c. Members who have had one or more of the transplant surgeries referenced above prior to enrollment in an PIHP will be permanently exempted. The effective date will be either the first of the month not more than six months prior to the date of the request, or the first of the month of the PIHP enrollment, whichever is later.

   d. Experimental transplant exemption requests may be made by the PIHP or member and are approved by the State nurse consultant. The exemption request must include medical documentation of the transplant including medical records of the transplant, the date of the transplant, the procedure, and transplant facility.

5. Admission to a Birth-to-3 program (BadgerCare Plus Only)

   This exemption applies when a child is under the age of 3 and is admitted to a Birth-to-3 program. The exemption request must be made by the case head of the member. Birth-to-3 exemption requests are approved by the Enrollment Specialist. Exemptions are backdated no more than two months from the date the request is received. The exemption lasts until the end of the month of the child's third birthday.

6. Native American

   Members who are Native American or American Indian and members of a federally recognized tribe are eligible for an exemption. The case head must

request his exemption and it is approved by the Enrollment Specialist or fiscal agent. This exemption does not have an end date. The exemption applies to all members on the case, even if not all case members are tribal members.

7. Continuity of Care

   Continuity of Care exemptions may be granted when a person is newly enrolled or about to be enrolled in an PIHP and is receiving care from a provider that is not part of the PIHP network. The exemption must be requested by the member and may be approved by the Enrollment Broker, fiscal agent or the State Nurse Consultant. Continuity of Care exemptions are generally short term, granted for 6 months or less.

8. Voluntary (SSI Medicaid Plans – Dual Eligible Members with Medicaid and Medicare or MAPP members)

   This exemption applies when a member is not required to enroll in an SSI Medicaid PIHP due to the member having Medicare or MAPP eligibility. This exemption is approved by the Enrollment Specialist or fiscal agent. This exemption does not have an end date. It will end if and when a member elects to transition into an PIHP.

9. Long Term Complex Care (BadgerCare Plus and SSI Medicaid Plans)

   This exemption applies when a member has a long term/permanent medical condition which requires care in multiple PIHP networks or providers who do not take PIHPs. This exemption is requested by the member and approved by the state nurse consultant. This exemption is granted for a maximum of one year. At that time, the member must reapply for the exemption to continue.

10. SSI Waiver Program Opt Out (SSI Medicaid)

    This exemption applies when a member is participating in a waiver program through their county, making them exempt from PIHP enrollment/non-enrollable. This exemption is requested by the member and approved by the Enrollment Specialist. This exemption does not have an end date.

11. Federally Qualified health Center (FQHC)

    This exemption applies when a member is receiving services from a FQHC and the FQHC is not affiliated with any PIHP. Managed care staff or PIHP enrollment staff may apply this exemption. This exemption does not have an end date.

12. Distance

    This exemption applies when the nearest PIHP affiliated medical facility is more than twenty miles away from the member. This exemption may also be used when a member has moved from one PIHP service area to another and needs to access care while getting their address changed. This exemption must be requested by the member and is approved by the Enrollment Specialist or fiscal agent. This exemption can last up to 12 months.

13. Low Birth Weight

This exemption applies when a newborn's weight at birth is 1200 grams or below. It is requested by the PIHP and approved by fiscal agent when documentation (delivery room notes or a newborn report) is submitted by the PIHP or hospital/provider showing that a newborn's weight is 1200 grams or below. This exemption lasts until the end of the month of the child's first birthday.

14. High Risk Pregnancy

This exemption applies when a member has a medical condition which poses a direct risk to the health of the member and/or the unborn child. This exemption is approved by the state nurse consultant. The length of this exemption is two full months past the expected date of delivery.

III. FCMH Health Care Management

A. General Requirements

The PIHP must establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care.

1. The PIHP must assign a lead care coordinator to:
    a. Serve as the primary contact for the department on care coordination issues on behalf of individual members.
    b. Collaborate with Division of Milwaukee Child Protective Services (DMCPS) and child welfare agencies to ensure that children suspected to be victims of physical or sexual abuse, or neglect receive any necessary evaluations (e.g., physical abuse/sexual abuse exams, comprehensive neglect evaluations, forensic interviews, mental health crisis services, etc).
    c. Establish effective lines of communication between the PIHP, the health care providers (including behavioral/mental health providers) and child welfare professionals.
        i. Effective communication incudes developing procedures to ensure that information pertinent to the care and treatment of children are shared in a timely and comprehensible manner.
        ii. All communication strategies must recognize the child welfare professional as the individual with ultimate responsibility for the child's overall health and well-being. This means that the child welfare professional must be a central participant in the communication plan. The child welfare professional can provide critical guidance pertaining to the family dynamics as it relates to communicating with the child's parents/legal guardian.
        iii. Communication plans must be shared with health care coordinators and providers as indicated.
    d. Establish a process that streamlines responses to request for medical information, especially as these requests pertain to court proceedings.
    e. Education DMCPS and child welfare professionals, legal staff, out-of-home care providers, and parents/legal guardians about health care issues pertinent to children in out-of-home care.
    f. Assist DMCPS and child welfare agencies in providing ongoing training for out-of-home care providers who provide care for medically complex or fragile children.

g. Educate medical personnel about issues that are known to impact the health and medical care of children in out-of-home care. This education should include key information related to understanding the impact of adverse childhood experiences as it relates to interacting with the child in the health care setting.

h. Address access issues and concerns related to the PIHP.

2. The PIHP must assign a health care coordinator (HCC) to each child at the time of their enrollment in the medical home. The HCC oversees all aspects of the child's health care within the context of a larger health care coordination team. The PIHP must ensure that:

   a. The HCC has trauma-informed care training and experience working with children with special health care needs or children in out-of-home care. The HCC does not need to be separately enrolled as a Medicaid provider. See below for specific requirements related to the duties of the HCC.

   b. Other staff, in collaboration with the HCC and under the supervision of the Program Supervisor, will comprise the health care coordination team and may assist with duties related to service coordination. Delegated duties may include the scheduling of appointments, gathering medical history information, and obtaining current developmental and behavioral health screening information to be passed on to the clinical staff for scoring and review. There are no specific experience requirements for these individuals, but they must be provided with trauma-informed care training and training specific to children in out-of-home care.

   c. HCCs are allowed adequate time to effectively coordinate the delivery of integrated care.

      The PIHP must have strategies in place to monitor workload and to assure that each HCC's assigned caseload does not regularly exceed 100:1. The HCC and other staff collaborating with the HCC must be allowed adequate time to effectively coordinate the care of each child on their caseload. In developing case load standards, the PIHP should consider the following:

         i. Workload—the complexity of the cases (refer below to *Guidelines for Determining Levels of Care Management Needs*).

         ii. The need for HCCs and other staff to coordinate and collaborate with child welfare professional.

         iii. The need for face-to-face contacts wit the child, OHC providers, and other instrumental to meeting needs of the child.

         iv. Management duties which include:

1) Time to gather and ensure all medical, developmental, and behavioral health history is provided to the primary care provider prior to the 30-day comprehensive health assessment.

2) The need to provide necessary documentation timely to DMCPS and child welfare agencies for court proceedings (which are sometimes scheduled with little lead time) or other case-related meetings.

3) Time to adequately document case management activities.

3. The PIHP must ensure that the results of the comprehensive initial health assessment (defined in Article I and described in Addendum II- form the basis for the comprehensive health care plan. This includes ensuring that all recommended diagnostic assessments and treatment services are scheduled as indicated, including physical health, dental, mental health, and developmental assessments and/or treatments.

4. The PIHP must establish a process that maximizes the ability for the HCC to be informed of the results of assessments, evaluations and screenings that would necessitate an update or of the child's care plan.

5. The PIHP must have procedures to ensure that each child has an individualized, health care plan in place within 60 days of enrollment in the medical home. See below for specific requirements related to the comprehensive health care plan.

6. The PIHP must ensure that children with emotional, behavioral, mental, or substance abuse problems have an individualized crisis plans. which include a list of progressive interventions to resolve/de-escalate an emotional crisis/safety situation.
The crisis plan must be developed with input from the member and those who know the member best and must be distributed to all critical service/support providers in the member's life, including the out-of-home care provider. The crisis response plan could be included as a part of the overall comprehensive coordinated services plan or be a separate document.

7. The PIHP must have a process for prioritizing the care management needs of each child. This includes adequate care for members with higher needs (e.g., children identified as medically complex or Level I) who require Health Care Coordinators with more specialized education and training (e.g., Advanced practice Social Workers, Licensed Professional Counselors, Registered Nurses).

8. The PIHP must establish protocols to assess each child's level of care management need. This assessment must occur at initial enrollment and as the child's needs change over time. Though not required, the PIHP may use the guidelines below to determine levels of care management needs.

9. The PIHP must have policies and procedures in place to ensure that, to the extent feasible, transitional care planning is included in the care planning for children exiting the medical home.

10. The PIHP must use information technology to improve communication within and across health care settings and to reduce fragmentation in the delivery of services to the member.

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

B. Guidelines for Determining Levels of Care Management

Care management is a process hat links children to services and resources in a coordinated effort to maximize health development of children in out-of-home care and provide them with optimal health care. The focus of care coordination in this context is on the physical, dental, and behavioral/mental health care needs for the child. The HCC is responsible for ensuring that this important information is communication and followed up on.

1. Children in out-of-home care have differing levels of services needs that often change over time. Levels of care may include:

    a. Level III—Information sharing (short-term technical assistance, information, and/or referral);

    b. Level II—Significant but not necessarily long-term assistance in planning and coordinating multiple services;

    c. Level I—Intensive case management (children at risk of institutionalization, family experiences severe social and environmental risk factors and is at risk for disintegration).

The HCC must periodically reassess the child's level of service needs and, in collaboration with DMCPS or the child welfare agency, must recognize when more intensive care coordination may be needed. For example, needs may be greater during key periods in a child's life, such as entry into out-of-home care, change in health care status, discharge from inpatient hospitalization, after a change in placement, at reunification, at time of discharge from out-of-home care, or during transition to adolescence or adulthood.

C. Duties of Health Care Coordinators

1. The primary goal of the HCC is to collaborate with the child welfare professional and the child's team of health care providers to develop and implement a comprehensive health services plan of care that ensures integration of both health and social service needs. Other staff, in consultation with the HCC and under the supervision of the Program Supervisor, may assist with and/or conduct any of the

duties below as appropriate.

The role of the HCC can be characterized as a problem-solving process that involves four essential steps:

a. Case identification.

b. Comprehensive assessment and planning.

c. Referral and intervention.

d. Monitoring outcomes.

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

a. Assessing the child and family's strengths and needs for the purpose of informing the development of the comprehensive care plan. The child welfare professional will be an essential partner in this activity, especially as it relates to reviewing the recommendations from the Child and Adolescent Needs and Strengths (CANS) assessment.

b. Establishing a plan for ongoing and timely communication with eh child's primary care provider.

c. Collaborating and coordinating with the child welfare professional, OHC provider and parent/legal guardian to schedule, as necessary and appropriate, face-to-face visits to introduce care team members, review program benefits, and obtain current developmental and behavioral health screening information using a validated screening tool.

d. Collaborating with an interdisciplinary team of providers and relevant stakeholders, including parents and legal guardians, out-of-home caregivers, and natural supports, to develop, implement, and maintain a single coordinated care plan for each child.

e. Ensuring that health information is transferred to a new primary care provider when a child is transferred between agencies or foster homes, or discharged from foster care.

f. Arranging and facilitating the provision of all PIHP services and coordination with services provided through other systems and programs.

g. Establishing measurable health care management goals that:

i. Have measurable steps with benchmarks;

ii. Assigned time frames;

iii. Outline individuals responsible for the completion of the plan; and

iv. Are frequently reevaluated for progress towards the established goals and desired outcomes.

h. Holding meetings as needed with the child, parent/legal guardian, out-of-home care provider, child welfare professional, health care provider staff, and others involved in the delivery of services to the child to monitor and evaluate progress/success.

i. Maintaining documentation of all PIHP services delivered to each child.

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

k. Coach members, caregivers, legal guardians, and other natural supports to:

i. Recognize and utilize the member and supports' strengths.

ii. Provide support in effectively navigating the health care system including health records (electronic and paper), communication with health providers, and advocating for member's wellbeing.

iii. Increase individuals' confidence and competence in recognizing, understanding, and supporting the individual needs of the member.

iv. Develop knowledge and skills for sustainable achievement of the care plan goals.

3. Care Coordinator Training Requirements

a. Care coordinators are required to partake in an onboarding training as new hires.

b. Ongoing training is required in, but not limited to:

i. Cultural and linguistic responsiveness.

ii. Evidence based practices related to serving members in out of home care placement.

iii. Best practices in the fundamentals of care coordination.

iv. Trauma informed care.

v. Mandated reporter training.

vi. Can substitute licensure continuing education requirements for appropriate licensed coordinators.

D. Information Gathering (Assessment)

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

a. The need for immediate appointment scheduling and referrals.

b. The need for immediate medication management.

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

d. The need for stabilization services for mental/behavioral health concerns.

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

a. Obtain information related to the child's medical history, including Emergency Department visits, inpatient history, and current medications.

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

c. Review the recommendations from the CANS assessment and any other behavioral/mental health screen for mental health and other behavioral health concerns.

d. Obtain input from the child welfare professional to determine if there are specific, court-ordered services that need to be identified in the child's comprehensive health care plan.

e. Obtain input from the child's primary care provider to determine the need for additional referrals, diagnostic or treatment services.

f. Review the results of other health assessments and screens, including the results of the comprehensive initial health assessment (defined in Article I and described in Addendum II) to ensure that the care plan addresses all identified health care needs.

g. Develop an individualized strength and resilience inventory in partnership with the member and the Member Care Coordination Team, when possible,t hat is reflective of the member and family's values, beliefs, and aspirations.

E. Comprehensive Care Plan—Requirements

The HCC must ensure that each child has a comprehensive health care plan that is based on information collected during the information gathering (assessment) process. The initial care plan must be developed within the first 60 days of the child's enrollment in the PIHP.

In developing the comprehensive health care plan the child's HCC will do the following:

1. Ensure that the care plan is child centric and comprehensive.

A child-centric plan addresses the unique needs of the child—recognizing the need for an enhanced schedule for physical, behavioral and dental care, as

necessary; assuring continuity of care; and flexibility on location of services consistent with evidence-informed practices. For example, mental health services could be delivered in the home or another community-based setting, rather than in a clinic or hospital setting.

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

a. Relevant prior and current diagnoses.

b. Current medications.

c. The names of all individuals who are instrumental to the child's care and treatment, including the name and contact information for the child's legal guardian.

d. The names of external supports (e.g., school nurse, public health nurse, community-based case managers, B to 3 lead care coordinator).

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

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

g. The enhanced periodicity schedule for comprehensive HealthCheck exams.

h. The tracking and timely follow up on referrals.

i. Short and long-term treatment goals.

j. Barriers to care.

k. An individualized crisis/action plan for behavior management (if appropriate).

l. An action plan for exacerbation of a chronic condition.

m. Transitions between inpatient and outpatient settings, including home care. The transition plan must address the need for prompt follow up with the child's PCP after an inpatient stay or emergency room visit.

n. Patient self-management, anticipatory guidance for caregivers, and home care (if appropriate).

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

p. Last date of contact with different team members (child/youth, parents, out-of-home caregivers, 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.

2. Ensure that the child's PCP and child welfare professional are primary participants in the development and periodic reviews of the comprehensive care plan. The child's PCP is the lead for the child's overall health care needs. And, the child welfare professional has the overall responsibility for all aspects of the child's care.

   The participation of the PCP and child welfare professional will be key in eliminating duplication; mitigating caregiver confusion regarding the child's health care treatment plan; and will be paramount to ensuring full coordination and integration of the child's medical and non-medical needs.

3. Collaborate with the child welfare professional to obtain and incorporate input from the following:

   a. The child, as appropriate.

   b. The child's out-of-home care provider.

   c. The child's parent/legal guardian.

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

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

4. Collaborate with the broader health care team to prioritize the services necessary to address or further assess the child's health care needs across the health care system, including primary care, specialty care, inpatient care and care that will be obtained outside of the PIHP provider network.

5. Collaborate with he child welfare professional to establish specific communication plans for each child.

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

F. Ongoing Monitoring

Ongoing monitoring includes all activities related to implementing and maintaining the child's comprehensive health care plan. The child's assigned HCC is responsible for all ongoing monitoring activities.

1. Ongoing monitoring includes:

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

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

The health care plan must be reviewed and updated after the child is discharged from an inpatient mental health hospitalization within 30 days of such discharge.

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

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

e. Communicating with individuals instrumental to the child's care and support, especially the child's primary care provider and the child welfareprofessional.

f. The HCC must periodically review the child's health care plan in collaboration with the child's primary care provider, the child welfare professional, the child's parent/legal guardian, and out-of-home care provider.

g. The plan must be reviewed and updated as indicated but at least every six months.

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

i. The HCC must collaborate with the child welfare professional to determine the need for and to secure additional health care services as necessary.

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 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. Transitional planning begins at enrollment.

   c. Identifies all individuals critical to 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 WI 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 list of medication from all available sources and a prescription renewal, when appropriate. Include:
        i. All indicators for beginning or ending medication, changing dosage amounts, etc.,
        ii. List of prescribers for each medication, and
        iii. Refill prescriptions either provided to the member and their caregivers or called into 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).
    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 treatment 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.

IV. Services

A. Provisions of Contract Services

1. The PIHP must promptly provide or arrange for the provisions of all services required under Wis. Stats., s. 49.46(2), s. 49.471(11), s. 49.45(23), Wis. Adm. Code Ch. DHS 107 and the Online ForwardHealth Handbook.
2. The PIHP Contract Administrator, or their designee, is responsible for subscribing to ForwardHealth Updates and Alerts, and disseminating them to PIHP staff for analysis and implementation.
3. The PIHP must provide services in an amount, duration and scope that is no less than the amount, duration, and scope for the same services furnished to the member under fee for service Medicaid as defined in published policy within the Wisconsin Health Care Program Online ForwardHealth Handbook, as set forth in 42 CFR § 438.210(a)(2), 42 CFR § 440.230, and 42 CFR part 441, subpart B.
4. Pursuant to 42 CFR §438.210(a)(3), the PIHP:
    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. In addition, the PIHP must comply with the care coordination.

B. Medical Necessity

1. The actual provision of any service is subject to the professional judgment of the PIHP providers as to the medical necessity of the service, except that the PIHP must provide assessment, evaluation, and treatment services ordered by a court.
2. Per 42 CFR §438.210(a)(4), the PIHP can make decisions to provide or deny medical services on the basis of medical necessity and appropriateness as defined in the State Plan and 101.03(96m) or place appropriate limits on a service for the purpose of utilization control provided that:
    a. The services furnished can reasonably achieve their purpose, as required in 42 CFR §438.210(a)(3)(i);
    b. 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
    c. 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.

3. The PIHP must specify what constitutes "medically necessary" in a manner that is no more restrictive than that used in the Medicaid program as indicated in 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 DHS 107, Wisconsin Health Care Programs Online Handbook and PIHP Contract Interpretation Bulletins, and the ForwardHealth Provider Updates; and

4. The PIHP is responsible for covering services related to:

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

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

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

5. PIHPs 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 met.

6. Disputes between the PIHP and members about medical necessity can be appealed through the process described in Article IX. The Department will consider whether WI FCMH would have covered the service on an FFS basis (except for certain experimental procedures).

C. In Lieu of Services

1. A PIHP 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 PIHPs on a voluntary basis as follows:

   a. 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;

   b. The member is not required by the PIHP to use the alternative service or setting;

   c. The approved in lieu of services are identified in the PIHP contract and will be provided at the option of the PIHP;

   d. And the utilization and cost of in lieu of services is taken into account in developing the component of the capitation rates that represent the covered state plan services.

2. The PIHP may cover the following services:

a. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization. The network provider must document the medical necessity of the service in the member's medical record.

D. The PIHP is not responsible to provide the following Medicaid services to its members:

1. Non-emergency Medical Transportation (NEMT) as listed in Article IV Section E(4).
2. Prenatal Care Coordination (PNCC), except the PIHP must sign a Memorandum of Understanding (MOU) with the PNCC.
3. Targeted Case Management (TCM), except the PIHP must work with the TCM case manager as indicated in Addendum III.
4. School-Based Services (SBS)
   a. the PIHP must use its best efforts to sign a Memorandum of Understanding (MOU). SBS are those services identified in a student's Individualized Education Plan (IEP) and provided by a school district or CESA.
   b. The PIHP must not consider physical, occupational, and speech and language therapy services supplied in school settings automatically duplicative when it is considering the medical necessity of a requested community based therapy.
5. Certain Tuberculosis-related services, including directly observed therapy (DOT), patient education and anticipatory guidance, symptom and treatment monitoring.
6. Crisis Intervention Benefit.
7. Community Support Program (CSP) services.
8. Comprehensive Community Services (CCS).
9. Community Recovery Services (CRS).
10. Chiropractic services, unless the PIHP elects to provide chiropractic services.
11. Lead investigations, as defined in s. 254.11(8s), of persons having lead poisoning or lead exposure, as defined in s. 254.11(9).
12. Medication therapy management.
13. Prescription, 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)).
14. 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.

15. Behavioral Treatment Services (Autism Services) as defined in ForwardHealth Online Handbook

16. Residential Substance Use Disorder Treatment

17. Hub and Spoke Integrated Recovery Support Services Health Home for SUD Treatment Pilot Program

E. Key Components of Service

In providing services to children the PIHP must consider the goals of the CMH program. Specific goals of the FCMH program include: integrated and comprehensive health service delivery; timely access; high quality and flexibility of care; transitional planning and cross-system coordination; and well-being outcomes. The FCMH must facilitate the following health care services:

1. An Out-of-Home Care Health Screen (aka Foster Care Health Screen)

    a. Purpose: The purpose of this screen is to identify any immediate medical, dental, or urgent mental health needs a child may have, including additional health conditions which the out-of-home providers and child welfare caseworker should be aware of.

    b. Timeframe: Within two business days of entry into out-of-home care.

    c. Performed by: The screen should be performed at a Child Advocacy Center (CAC). The exam may be performed by a provider designated by the PIHP to have sufficient training/expertise to perfume the out-of-home care health screen consistent with the required clinical standards and required hours of operation.

    d. Required Components:

        i. Identification of health conditions that require prompt medical attention such as acute illness, chronic disease(s) requiring immediate medical management and/or treatment (e.g., asthma, diabetes, seizure disorder), signs of infection or communicable disease, nutritional problems, pregnancy, and significant developmental or mental health conditions.

        ii. Unclothed, symptom-targeted physical examination, including injury surveillance.

        iii. Identification of medical treatment and/or follow up that may be required prior to the comprehensive initial health assessment which is completed within 30 days of entering out-of-home care.

    e. The PIHP is not required to provide an Out-of-Home Care Health Screen under the following circumstances:

        i. Newborns detained directly from the hospital.

        ii. Children detained during an inpatient hospitalization.

iii. Children who are detained at the time of a forensic exam.

iv. Children who are detained subsequent to a forensic exam but meet the criteria for an exemption. These cases are reviewed by a CAC provider and a determination is made by the CAC provider with consideration of the following criteria:

a. The Out-of-Home Care Screen will occur within 7-days of the Forensic Exam.

b. The child has been in a safe environment since the Forensic Exam.

c. There are no known acute health issues per worker and review of the Forensic Exam notes.

v. Other unique caes scenarios may be reviewed by the Care4Kids Medical Director(s) and exemptions may be granted on a case by case basis if performing the Out-of-Home Care Health Screen would be duplicative of services recently provided.

A visit to the Emergency Department does not meet criteria for an Out-of-Home care Health Screen exemption, even if seen by a CAPS provider in the ED.

Children who are determined to be exempt requiring an OHC Screen are to be characterized as a Level 1 Triage patient upon entering Care4Kids. Follow appropriate policy/procedure found in: "Workflow for Initial 30 Days from Removal".

2. The assignment of a Health Care Coordinator (HCC) to each child enrolled in the PIHP; member to HCC ration may not regularly exceed 100:1. Please refer to Article III, D-G for the services provided by an HCC.

3. Comprehensive Initial Health Assessment

a. Purpose: The Comprehensive Initial Health Assessment should be performed by a clinician who is knowledgeable about the trauma-informed evaluation and treatment of children in out-of-home care. The assessment should be comprehensive with respect to the identification of possible acute and chronic physical health, behavioral/mental health, oral health and developmental problems and must be in compliance with Wisconsin HealthCheck requirements. It should include components of either developmental and/or behavioral health screenings as indicated for each child based on age and history, including any prior evaluations.

b. Timeframe: The Comprehensive Initial Health Assessment is required for all children entering out-of-home care and must occur within 30 days of enrollment.

c. Performed by: The Comprehensive Initial Health Assessment should be performed at a Center of Excellence (COE). A COE refers to a pediatric

health care clinic that has been specifically designated to meet the health care needs of children living in out-of-home care. COE staff receive training in a way that is responsive to the prior trauma that children in out-of-home care may have experienced. Services provided at a COE include but are not limited to:

i. Comprehensive Initial Health Assessment

ii. Standardized screening (developmental, mental health)

iii. Referrals for early intervention, mental health evaluations as indicated

iv. Subspecialty referrals, including dental

v. Ongoing primary care well child exams

vi. Transition health planning

d. It is strongly encouraged that children receive both the Comprehensive Initial Health Assessment and ongoing periodic, preventive well child care from a COE in order to receive the best possible care by a qualified professional that understands the unique needs of children in out-f-home care. A child can be seen for ongoing primary care by an in-network provider that is not within a COE, when maintaining a previously established relationship with an existing primary care provider for the purpose of continuity of care. Required Components (See Addendum II).

4. Completion of a comprehensive oral examination by a dentist for all children 12 months of age and above within 3 months of enrollment. If a comprehensive oral examination was conducted within 6 months prior to enrollment, ensure a follow-up comprehensive exam occurs within 3 months of enrollment or 6 months from the comprehensive exam, whichever comes later.

5. Referral to a qualified mental health or substance abuse professional for evaluation and/or treatment services in a timely manner if a mental health or substance abuse or need is identified by any of the following sources:

    a. Child and Adolescent Needs and Strengths (CANS)

    b. Out-of-Home Care Health Screen or other medical assessment

    c. Crisis service intervention team

    d. Any medical, human service, or educational professional working with the child

    e. Out-of-home care provider, kin, or birth parent

    If a mental health or substance abuse issue or need is identified at the Comprehensive Initial Health Assessment, referral to a qualified mental health or substance abuse professional must take place within 30 days.

6. Completion of an Initial Comprehensive Health Care Plan within 60 days of the child's enrollment in the FCMH which must be updated every six months thereafter at a minimum.

7. Ongoing monitoring of health status and provision of periodic preventive well child health care that is compliant with Wisconsin HealthCheck requirements.

8. Development of a transition of health care plan to ensure continuity of care at discharge from the PIHP. The transition health care plan should identify the presumed source of ongoing insurance coverage, primary care provider, and any specialty care necessary to meet ongoing care needs, including peer support, and connections with natural support systems and community agencies as appropriate.

9. Metabolic screening and measurement of growth parameters (including BMI) for any child who is prescribed one or more antipsychotic medication, including identification of lead provider responsibility (refer to Addendum VII).

10. Monitoring of the rate and types of psychotropic medication usage among members, stratified by age and number of medications prescribed, including identification of the lead provider responsibility (refer to Addendum VII).

F. Additional Information Regarding Services

1. Physician and Other Health Services

   Services required under Wis. Stats. §49.46(2), and Wis. Adm. Code ch. DHS 107, include (without limitation due to enumeration) private duty nursing services, nurse-midwife services and independent nurse practitioner services; physician assistant services and physician services, including primary care services, are not only services performed by physicians, but services under the direct, on-premises supervision of a physician performed by other providers such as nurses of various levels of certification.

2. Pre-existing Medical Conditions

   The PIHP must assume responsibility for all covered pre-existing medical conditions for each member as of the effective date of coverage under the Contract. The aforementioned responsibility does not apply in the case of persons hospitalized at the time of initial enrollment.

3. Emergency Ambulance Services

   The PIHP may require submission of a trip ticket with ambulance claims before paying the claim. Claims submitted without a trip ticket need only be paid at the service charge rate. The PIHP must:

   a. Pay a service fee for an ambulance response to a call in order to determine whether an emergency exists, regardless of the PIHP's determination to pay for the call.

   b. Pay for emergency ambulance services based on established WI FCMH criteria for claims payment of these services.

c. Either pay or deny payment of a clean claim from an ambulance service within 45 days of receipt of the clean claim.

d. Respond to appeals from ambulance providers within the time frame described. Failure will constitute the PIHP's agreement to pay the appealed claim to the extent FFS Medicaid would pay.

4. Transportation

Most non-emergency Medical Transportation (NEMT) is coordinated by the Department's NEMT manager. The NEMT manager arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include public transportation such as a city bus, non-emergency ground ambulance, rides in specialized medical vehicles (SMV), or rides in other types of vehicles depending on a member's medical transportation needs, as well as compensated use of private motor vehicles for transportation to and from BadgerCare Plus and Medicaid SSI covered services. Non-emergency medical transportation also includes coverage of meals and lodging in accordance with the ForwardHealth policy.

The PIHP must direct members to the DHS NEMT manager for non-emergency transportation. Members may visit the Wisconsin Medicaid and BadgerCare Plus Non-emergency Medical Transportation webpage for more information.

The PIHP must promptly provide or arrange for the provision of transportation services, including non-emergency air transport, not reimbursed by the NEMT manager as listed in the ForwardHealth Online Handbook Topic #11898.

5. Transplants

a. The PIHP must cover cornea, kidney, liver, heart, lung, heart-lung, pancreas, and pancreas-kidney transplants. These services are no longer considered experimental.

b. The PIHP is not required to cover stem cell or bone marrow transplants.

c. As a general principle, the WI FCMH program does not pay for transplants that it determines to be experimental in nature.

The State Plan requires PIHPs to follow written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or providers to be consistent with the accessibility of high quality care to members.

6. Dental Services

All dental services must be covered by the PIHP. The PIHP shall assist the out-of-home care provider in scheduling a dental examination within three months of enrollment, or a re-call exam if a comprehensive oral examination was conducted within 6 months prior to enrollment.

a. All Medicaid covered dental services as required under DHS 107.07, Wisconsin Health Care Programs Online Handbooks and Updates.

b. Dental re-call exams and cleanings should be performed at least every six months, or more frequently as indicated by the child's risk status.

c. PIHPs providing dental coverage in the Racine County service area will be required to participate in a dental pilot program authorized int eh 2015-2017 biennial budget.

d. Diagnostic, preventive, and medically necessary follow-up care to treat a dental disease, illness, injury or disability of members while they are enrolled in the PIHP.

e. Completion of orthodontic or prosthodontic treatment begun while a member was enrolled in the PIHP if the member became ineligible for Medicaid or disenrolled from the PIHP, no matter how long the treatment takes. The PIHP will not be required to complete orthodontic or prosthodontic treatment n a member who began treatment before PIHP enrollment who subsequently was enrolled in the PIHP.

   [Refer to the chart following this page of the contract for the specific details of completion of orthodontic or prosthodontic treatment in these situations.]

f. The PIHP must pay all charges relating to dental surgeries when a hospital or freestanding ambulatory care setting is medically indicated. These charges include, but are not limited to, physician, anesthesia, and facility charges.

g. Right to Audit—The Department will conduct validity and completeness of audits of dental claims. Upon request, the PIHP must submit claims to the Department along with any other records the Department deems necessary for the completion of the audit. Payment of incomplete or inaccurate claims will subject the PIHP to administrative sanction outlined in Article XIV, section D.

h. Requirements to Dental Service Providers—If the PIHP subcontracts with a dental benefits administrator, the participating dentist has the right to appeal to both the PIHP and the Department, according to the Department's provider appeal requirements. This right to appeal is in addition that of the provider's right to appeal. PIHPs must pay at a minimum the Medicaid fee-for-service rates for dental services. Providers rendering services must be paid at a minimum the Medicaid fee-for-service rates.

Responsibility for Payment of Orthodontic and Prosthodontic Treatment

When There is an Eligibility Status Change During the Course of Treatment

	Who pays for completion of orthodontic and prosthodontic treatment* when there is an enrollment status change		
	First PIHP	Second PIHP	FFS
Person converts from one status to another: 1. FFS to the PIHP covering dental.		N/A	X
2a. PIHP covering dental to the PIHP not covering dental, and person's residence remains within 50 miles of the person's residence when in the first PIHP.	X		
2b. PIHP covering dental to the PIHP not covering dental, and person's residence changes to greater than 50 miles of the person's residence when in the first PIHP.			X
3a. PIHP covering dental to the same or another PIHP covering dental and the person's residence remains within 50 miles of the residence when in the first PIHP.	X		
3b. PIHP covering dental to the same or another PIHP covering dental and the person's residence changes to greater than 50 miles of the residence when in the first PIHP.			X
4. PIHP with dental coverage to FFS because: a. Person moves out of the PIHP service area but the person's residence remains within 50 miles of the residence when in the PIHP.	X		
b. Person moves out of the PIHP service area, but the person's residence changes to greater than 50 miles of the residence when in the PIHP.		N/A	X
c. Person exempted from PIHP enrollment.		N/A	X
d. Person's medical status changes to an ineligible PIHP code and the person's residence remains within 50 miles of the residence when in that PIHP.	X	N/A	
e. Person's medical status changes to an ineligible PIHP code and the person's residence changes to greater than 50 miles of the residence when in that PIHP.		N/A	X
5a. PIHP with dental to ineligible for WI FCMH and the person's residence remains within 50 miles of the residence when in that PIHP.	X	N/A	
5b. PIHP with dental to ineligible for WI FCMH and the person's residence changes to greater than 50 miles of the residence when in that PIHP.		N/A	X
6. PIHP without dental to ineligible for WI FCMH.		N/A	X

7. Emergency and Post-Stabilization Services

a. 24-Hour Coverage

*

Orthodontia treatment is available only to members under age 21 to address concerns identified during a wellness visit such as an interperiodic or HealthCheck screen.

The PIHP must provide all emergency contract services and post-stabilization services as defined in this Contract 24 hours a day, seven days a week, either by the PIHP's own facilities or through arrangements approved by the Department with other providers.

The PIHP must:

i. Have one toll-free telephone number that members or individuals acting on behalf of a member can call at any time to obtain assistance in determining if emergency services are needed, to obtain authorization for urgent care and to obtain authorization for transportation. This telephone number must provide access to individuals with authority to authorize treatment as appropriate. Responses to these calls must be provided within 30 minutes. If the PIHP fails to respond timely, the PIHP will be liable for the cost of subsequent care related to that illness or injury incident whether the treatment is rendered by in or out-of-plan providers and whether the condition is emergency, urgent or routine.

   Authorization here refers to the requirements defined in the Standard Member Handbook Language, regarding the conditions under which a member must receive permission from the PIHP prior to receiving services from a non-PIHP affiliated provider in order for the PIHP to reimburse the provider.

   ii. Be able to communicate with the caller in the language spoken by the caller or the PIHP will be liable for the cost of subsequent care related to that illness or injury incident whether the treatment is in or out-of-plan and whether the condition is emergent, urgent, or routine. These calls must be logged with the time, date and any pertinent information regarding the persons involved, resolution and follow-up instructions.

   iii. Notify the Department and child welfare agency with which the PIHP has a MOU or in which the PIHP has enrollment of any changes to this toll-free telephone number for emergency calls within seven business days of the change.

b. Coverage of Payment of Emergency Services

The PIHP must promptly provide or pay for needed contract services for emergency medical conditions and post-stabilization services, regardless of whether the provider that furnishes the service has a contract with the entity. The PIHP may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, or PIHP of the member's screening and treatment within ten (10) days of presentation for emergency services. The PIHP in coordination with the attending emergency physician, or the

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

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

ii. The PIHP may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

iii. The PIHP may not deny payment for emergency services for a member with an emergency medical condition (even if the absence of immediate medical attention would not have had the outcomes specified in Article I.A.52.a.i-iii. of the definition of Emergency Medical Condition) or for a member who had PIHP approval to seek emergency services.

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

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

c. Coverage and Treatment of Post-Stabilization Care Services

i. The PIHP is financially responsible for:

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

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

1) The PIHP does not respond to a request for pre-approval of further post-stabilization care services within one(1) hour;

2) The PIHP cannot be contacted; or

3) The PIHP and treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation In this situation, the PIHP must give the treating physician the opportunity to consult with the PIHP care team or medical director. The treating physician may continue with care of the member until the PIHP care team or medical director is reached or one of the following occurs:

A) A network physician assumes responsibility for the member's care at the treating hospital or through transfer;

B) The treating physician and PIHP reach agreement; or

C) The member is discharged.

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

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

d. Additional Provisions

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

ii. When emergency services are provided by non-affiliated providers, the PIHP is liable for payment only to the extent that WI FCMH pays, including Medicare deductibles, or would pay, FFS providers for services to WI FCMH populations. For more information on payment to non-affiliated providers, see Article XV, Section D, part 4. The PIHP must not make any payments to providers with a financial institution outside the United States. In no case will the PIHP be required to pay more than billed charges. This condition does not apply to:

a) Cases where priority payment arrangements were established and

b) Specific subcontract agreements.

e. Memoranda of Understanding (MOU) or Contract with Hospitals/Urgent Care Centers for the Provisions of Emergency Services

The PIHP may have a contract or a MOU with hospital or urgent care centers within the PIHP's service area to ensure prompt and appropriate payment for emergency services. Unless a contract or MOU specifies otherwise, the PIHP is liable to the extent that FFS would have been liable for a situation that meets the definition of emergency. The Department reserves the right to resolve disputes between the PIHP, hospitals and urgent care centers regarding emergency situations based on the emergency definition. For situations where a contract or MOU is not possible, the PIHP must identify for hospitals and urgent care centers procedures that ensure prompt and appropriate payment for emergency services. Refer to Article VIII, Provider Appeals.

8. Family Planning Services and Confidentiality of Family Planning

a. The PIHP must give members the opportunity to have a different primary physician for the provision of family planning services. This physician does not replace the primary care provider chosen by or assigned to the member.

b. The member may choose to receive family planning services at any Medicaid-enrolled family planning clinic. Family planning services provided at non-network Medicaid-enrolled family planning clinics are paid FFS for PIHP members including pharmacy items ordered by the family planning provider.

c. All information and medical records relating to family planning shall be kept confidential including those of a minor.

9. Pharmacy Coverage

a. Pharmacy Coverage

PIHPs must carve out all SSA §1927 covered outpatient drugs to fee-for-service (covered outpatient drugs include drugs dispensed in a pharmacy,

administered in a doctor's office, or clinic; drugs reimbursed at bundled rate are not considered outpatient drugs).

Per Article III.A., the PIHP must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Service.

b. Pharmacy Services Lock-In Program

DMS will manage a Pharmacy Services Lock-In Program to coordinate the provision of health care services for PIHP members who abuse or misuse pharmacy benefits by seeking duplicate or medically unnecessary services, for restricted medications.

Abuse or misuse is defined under Recipient Duties in DHS 104.02, Wisconsin Administrative Code. Restricted medications are most controlled substances.

PIHP members enrolled in the Pharmacy Services Lock-In Program will be locked into one pharmacy where prescriptions for restricted medications must be filled and one primary prescriber who will prescribe restricted medications.

PIHP members will remain enrolled in the Pharmacy Services Lock-In Program for two years. At the end of the two-year enrollment period, DMS or the PIHP will assess if the member should continue enrollment in the Pharmacy Services Lock-In Program.

Policy on the Pharmacy Services Lock-In Program can be found in the BadgerCare Plus and Medicaid Pharmacy Provider Handbook.

i. The Division of Medicaid Services (DMS) or its designated representative must:

a) Manage the Pharmacy Services Lock-In Program and communicate directly with the PIHPs regarding their members.

b) Monitor prescription drug usage for members enrolled in the Pharmacy Services Lock-In Program.

c) Accept select review requests from the PIHP for potential Pharmacy Services Lock-In Program members. Not all select reviews may result in intervention letters or lock-in for the member.

d) Accept referrals from the PIHP for the Pharmacy Services Lock-In Program. DMS or its designated representative will proceed with Pharmacy Services lock-in for referred members.

e) Request additional information from the PIHP for referrals. The PIHP must provide requested information to DMS or its designated representative.

f) Identify the lock-in pharmacy and the PIHP must identify the lock-in primary prescriber for each member. In addition, the PIHP must identify any alternate prescribers for restricted medications, as appropriate.

g) Send letters of notification to the lock-in member and PIHP for the lock-in pharmacy.

h) Provide an electronic monthly report to the PIHP that identifies any members in the Pharmacy Services Lock-In Program for the specific PIHP.

i) Coordinate with the PIHP for the Pharmacy Services Lock-In Program policies and procedures.

ii. PIHP Responsibilities

a) PIHPs may request select reviews based on prescription drug utilization for potential Pharmacy Services Lock-In Program members. Not all select review requests may result in intervention letters or lock-in for the member.

b) PIHPs may provide Pharmacy Services Lock-In Program referrals to the DMS or its designated representative. The DMS or its designated representative will proceed with Pharmacy Services lock-in for all PIHP-referred members.

c) The PIHP should evaluate referred Pharmacy Services Lock-In Program members at the end of the two-year enrollment period, to determine if the member should continue enrollment in the Pharmacy Services Lock-In Program and notify the DMS or its designated representative.

d) The PIHP must be responsible for preparing all documentation and acting as the DMS representative for member appeals to the Division of Hearings and Appeals related to the Pharmacy Services Lock-In Program referrals.

e) The DMS may request additional information from the PIHP for referrals. The PIHP must provide requested information to the DMS or its designated representative.

f) PIHPs lock-in primary prescribers may designate alternate prescribers for restricted medications, as appropriate.

g) PIHPs must send letters of notification to the lock-in member and the DMS or its designated representative. PIHPs must notify primary prescribing provider and alternate prescribers when assigned for a lock-in member.

h) PIHPs must communicate with the DMS or its designated representative.

i) The DMS or its designated representative will identify the lock-in pharmacy and the PIHP will identify the lock-in primary prescriber for each member. In addition, the PIHP will identify any alternate prescribers for restricted medications, as appropriate.

j) PIHPs may refer members to the DMS or its designated representative for the Pharmacy Services Lock-In Program if any of the following are documented by the PIHP:

1) Evidence of a member intentionally providing incorrect information such as ForwardHealth eligibility status or medical history to a provider to obtain restricted medications.

2) Evidence of a member being convicted within one year of a crime related to restricted medications. Crimes include: forgery, theft, distribution, etc.

3) Two or more occurrences of violating a pain management contract within six months from the same or different prescribers. A prescriber must agree to continue managing the member after the Lock-In Program has been initiated.

4) Any combination of four or more medical appointments/urgent care visits/emergency department visits within a 14 day time period at which the member is seeking a restricted medication as the primary reason for the visits.

5) A member required an ER visit or hospitalization due to suicide attempt, poisoning, or overdose from the use of restricted medication(s) in the last ninety days.

10. Electronic Visit Verification

The PIHP must use Electronic Visit Verification (EVV) for designated service codes. The PIHP must submit a daily authorizations file for all EVV required services. The PIHP must use a daily file that contains all verified EVV visits to ensure that claims processed for EVV services can be associated with EVV visit information. Encounter details without a valid EVV record may be excluded in

future rate-setting development. The PIHP must outline expectations for contracted providers regarding the use of an EVV system within subcontracts and/or provider manuals. The PIHP must also provide assistance and support to both the Department and the Department's contracted EVV vendor for training, outreach, and utilization of the data collection system, as requested. The PIHP is required to submit accurate, complete, and timely data. Failure to comply with EVV may result in a corrective action plan and/or the application of remedies for violation, breach, or non-performance of the contract under Article XIV. D.

11. Telehealth Services

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

G. Mental health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies

The PIHP must provide WI FCMH covered services, but the PIHP is not restricted to providing only those services. The PIHP may provide additional or alternative treatments if the other treatment modalities are more appropriate and result in better outcomes than WI FCMH covered services.

1. Conditions on Coverage of Mental Health/Substance Abuse Treatment:

   a. On the effective date of this Contract, the PIHP must be certified to provide or have contracted with facilities and/or providers enrolled to provide the mental health and substance abuse treatment services identified in Wis. Admin. Code s. DHS 107.13(1)-(4), s.107.22(4), and certain sections of the ForwardHealth Online Handbook:

   b. s. DHS 107.13(1) – Inpatient care in a hospital IMD (Online Handbook – Hospital, Inpatient)

   c. s. DHS 107.13(2) – Outpatient Psychotherapy Services (Online Handbook – Outpatient Mental Health, Outpatient Mental Health in the Home and Community for Adults)

   d. s. DHS 107.13(3) – Alcohol and Other Drug Abuse Outpatient Treatment Services (Online Handbook – Outpatient Substance Abuse)

   e. s. DHS 107.13(3m) – Alcohol and Other Drug Abuse Day Treatment Services (Online Handbook – Substance Abuse Day Treatment)

   f. s. DHS 107.13(4) – Mental Health Day Treatment or Day Hospital Services (Online Handbook – Adult Mental Health Day Treatment)

   g. Narcotic Treatment Services (Online Handbook – Narcotic Treatment)

h. s. DHS 107.22(4) HealthCheck "Other Services" (Online Handbook – Child/Adolescent Day Treatment, In-Home Mental Health/Substance Abuse Treatment Services for Children)

i. Certification requirements for mental health and substance abuse treatment providers eligible to provide the above services are found in Wis. Adm. Code §§ DHS 105.21 – 105.25.

j. The PIHP may request variances of certain certification requirements for mental health providers. The Department will approve the variances to the extent allowed under federal or state law.

k. Department decisions to waive the requirement to cover these services shall be based solely on whether there is an enrolled provider that is geographically or culturally accessible to members, and whether the use of psychiatrists, or psychologists alone improves the quality and/or the cost-effectiveness of care.

l. In compliance with said provisions, the PIHP must further guarantee all enrolled WI FCMH members access to all covered, medically necessary mental health and substance abuse treatment.

m. In providing substance abuse treatment to members, the PIHP is encouraged to utilize, as well as encourage its provider network to utilize, the National Quality Forum's "National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices" and The Washington Circle's "Adopted Measures."

2. Mental Health Parity Compliance (BadgerCare Plus and Medicaid SSI)

The BadgerCare Plus and Medicaid SSI PIHP must comply with the Mental Health Parity Rule requirements of 42 CFR § 438.930. The Mental Health Parity Rule, in 42 CFR § 438.910(b)(2), requires the PIHP to provide mental health or substance abuse benefits to members in every classification in which medical benefits are provided (e.g., inpatient, outpatient, emergency care, prescription drugs).

The PIHP must not establish any of the following when it has been determined that mental health or substance abuse treatment is medically necessary for the member:

a. Any aggregate lifetime or annual dollar limits on mental health or substance abuse benefits;

b. Any financial requirement or treatment limitation to mental health or substance abuse benefits;

c. Any limit on the number of hours of outpatient treatment that the PIHP must provide or reimburse; and

d. Any monetary limit or limit on the number of days of inpatient hospital treatment.

The PIHP prior authorization requirements must comply with the requirements for parity in mental health and substance abuse benefits in 42 CFR § 438.910 (d). The same section of the Mental Health Parity Rule also specifies that the PIHP may not impose non-quantitative treatment limits (NQTL) for mental health or substance abuse benefits in any classification unless, the PIHP has processes, strategies evidentiary standards, or other factors used in applying the NQTL to mental health or substance abuse benefits that are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical benefits.

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

Additional information on covered services is available in Addendum V, as well as in Provider Updates and through interChange.

3. Mental Health/Substance Abuse Assessment Requirements:

   a. The PIHP must adjudicate mental health or substance abuse treatment service determinations following member requests or referrals from a primary care provider or physician in the PIHP's network. Any denials of service or selection of particular treatment modalities must be governed by an assessment conducted by qualified staff in a certified program who are experienced in mental health/substance abuse treatment, a review of the effectiveness of the treatment for the condition (including best practice, evidence based practice), and the medical necessity of treatment. A member's motivation to participate in treatment shall not be considered a factor in determining medical necessity and may not be used as a rationale for withholding or limiting treatment of a client/member. The PIHP will use the Wisconsin Uniform Placement Criteria (WI-UPC), or the placement criteria developed by the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in DHS 75. The requirement in no way obligates the PIHP to provide care options included in the placement criteria that are not covered services under FFS.

   The PIHP must involve and engage the member in the process used to select a provider and treatment option. The purpose of the participation is to ensure members have culturally competent providers and culturally appropriate treatment and that their medical needs are met. This section does not require the PIHP to use providers who are not qualified to treat the individual member or who are not contracted providers.

4. SUPPORT Act Compliance

   The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, requires that behavioral health services, including mental health treatment, substance use disorder treatment, and interventions for

developmental delays be made available to Children's Health Insurance Program (CHIP) populations, which are included in the BadgerCare Plus program.

In accordance with section 5022(d) of the Act, the PIHP must assure that age appropriate, validated screening tools are used to identify behavioral health needs for individuals ages 0-18 in primary care settings. Validated screening tools for children can be found at https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results?topic_status=P.

The PIHP must assure that screenings are conducted according to the most recently published AAP/Bright Futures periodicity schedule: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

On an annual basis, the PIHP must report to the Department the specific tools and/or protocols used by their primary care providers when screening children for the following behavioral health areas:

a. General Development;

b. Autism spectrum disorder;

c. Tobacco, alcohol or drug use;

d. Depression;

e. Any additional areas/tools.

This report must be submitted to DHSDMSBBPAdmin@dhs.wisconsin.gov , Attn: Behavioral Health Policy Section in Excel format by July 1st of each calendar year.

5. Assurance of Expertise for Child Abuse, Child Neglect and Domestic Violence:

The PIHP must consult with human service agencies on appropriate providers in their community. The PIHP must arrange for examination and treatment services by providers with expertise in dealing with medical and psychiatric aspects of caring for victims and perpetrators of child abuse and neglect, treating post-traumatic stress syndrome, and domestic violence. Providers also must be aware of statutory reporting requirements and local community resources for the prevention and treatment of child abuse and neglect and domestic violence.

The PIHP must notify all persons employed by or under contract to the PIHP who are required by law to report suspected child abuse and neglect and ensure they are knowledgeable about the law and about the identification requirements and procedures. Services provided must include and are not limited to court-ordered physical, psychological and mental or developmental examinations and medical and psychiatric treatment appropriate for victims and perpetrators of child abuse and neglect.

The PIHP must further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

6. Court-Related Children's Services

    a. The PIHP is liable for the cost of providing assessments under the Children's Code, Wis. Stats. s. 48.295, and is responsible for reimbursing for the provision of medically necessary treatment if unable to itself provide for such treatment ordered by a juvenile court. The medical necessity of court-ordered evaluation and treatment is assumed to be established and the PIHP is allowed to provide the care through its network, if at all possible. The PIHP may not withhold or limit services unless or until the court has agreed.

7. Court-Related Substance Abuse Services

    a. The PIHP is liable for the cost of providing medically necessary substance abuse treatment, as long as the treatment occurs in the PIHP-approved facility or by the PIHP-approved provider ordered in the subject's Driver Safety Plan, pursuant to Wis. Stats., Ch. 343, and Wis. Adm. Code DHS 62. The medical necessity of services specified in this plan is assumed to be established, and the PIHP shall provide those services unless the assessment agency agrees to amend the member's Driver Safety Plan. This is not meant to require PIHP coverage of substance abuse educational programs, or the initial assessment used to develop the Driver Safety Plan. Necessary PIHP referrals or treatment authorizations by providers must be furnished promptly. It is expected that no more than five days will elapse between receipt of a written request by the PIHP and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the fifth day, an assumption will exist that an authorization has been made until such time as the PIHP responds in writing.

    There are mental health and substance abuse coverage limitations specified in the ForwardHealth Provider Updates.

8. Emergency Detention and Court-Related Mental Health Services

    a. The PIHP is liable for the cost of all emergency detention and court-related mental health/substance abuse treatment, including stipulated and involuntary commitment provided by non-PIHP providers to PIHP members where the time required to obtain such treatment at the PIHP's facilities, or the facilities of a provider with which the PIHP has arrangements, would have risked permanent damage to the member's health or safety, or the health or safety of others. The extent of the PIHP's liability for appropriate emergency treatment is the current FFS rate for such treatment.

        i. Care provided in the first three business days (72 hours), plus any intervening weekend days and/or holidays, is deemed medically necessary and the PIHP is responsible for payment.

ii. The PIHP is responsible for payment for additional care beyond the time period in paragraph a. above only if notified of the emergency treatment within 72 hours, excluding weekends and holidays, and if given the opportunity to provide such care within its own provider network. The opportunity for the PIHP to provide care to a member admitted to a non-PIHP facility is accomplished if the county or treating facility notifies and advises the PIHP of the admission within 72 hours, excluding weekends and/or holidays. The PIHP may provide an alternative treatment plan for the county to submit at the probable cause hearing. The PIHP must submit the name of an in-plan facility willing to treat the member if the court rejects the alternative treatment plan and the court orders the member to receive an inpatient evaluation.

iii. If the county attempts to notify the person identified as the primary contact by the PIHP to receive authorization for care, and does not succeed in reaching the PIHP within 72 hours of admission excluding weekends and holidays, the PIHP is responsible for court-ordered care beyond the initial 72 hours. The county must document the attempts to notify with dates, times, names and numbers attempted to contact, and outcomes. The care provided to the PIHP member by the non-PIHP provider is deemed medically necessary, and coverage by the PIHP is retroactive to the date of admission.

b. The PIHP is financially liable for the member's court ordered evaluation and/or treatment when the PIHP member is defending themself against a mental illness or substance abuse commitment:

i. If services are provided in the PIHP facility; or

ii. If the PIHP approves provision in a non-contracted facility; or

iii. If the PIHP was given the opportunity but failed to provide the county with the name of an inpatient facility and, as a result, the member is sent for court ordered evaluation to an out-of-plan provider; or

iv. If the PIHP gives the county the name of an in-plan facility and the facility refuses to accept the member.

c. The PIHP is not liable for the member's court ordered evaluation and treatment if the PIHP provided the name of an in-plan facility and the court ordered the evaluation at an out-of-plan facility.

9. Institutionalized Individuals

If inpatient or institutional services are provided in the PIHP facility, or approved by the PIHP for provision in a non-contracted facility, the PIHP shall be financially liable for all children enrolled under this Contract for the entire period for which capitation is paid. The PIHP remains financially liable for the entire period a capitation is paid even if the child's medical status code changes, or the child's relationship to the original BadgerCare Plus case changes.

10. Transportation Following Emergency Detention

    The PIHP shall be liable for the provision of medical transportation to the PIHP-affiliated provider when the member is under emergency detention or commitment and the PIHP requires the member to be moved to a participating provider, provided the transfer can be made safely. If a transfer requires a secured environment by local law enforcement officials, (i.e., Sheriff Department, Police Department, etc.), the PIHP shall not be liable for the cost of the transfer. The county agency or law enforcement agency makes the decision whether the transfer requires a secured environment. The PIHP is not prohibited from entering into an MOU or agreement with local law enforcement agencies or with county agencies for such transfer.

11. Coordination of Services with Community Agencies

    a. The PIHP must assign a representative to coordinate services with public health agencies or treatment programs within the PIHP's service area, including out-of-network providers.

    b. These might include but are not limited to county health agencies, crisis intervention agencies, community support programs, comprehensive community service programs, or inpatient programs. The PIHP must work with the agency/program to coordinate a member's transition to or from covered mental health and substance abuse care within the PIHP's network.

    c. Any member transitioning from crisis intervention services must be able to access an appropriate level of ongoing care within 30 days of the crisis.

    d. The PIHP is not required to pay for ongoing services outside the PIHP network, unless the PIHP has authorized those services.

12. Memoranda of Understanding (MOU)/Contract Requirement and Relations with other Human Service Agencies

    The PIHP must coordinate the services it provides to members with services a member receives through Medicaid Fee-for-Services or through community and social support providers. The PIHP shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members. The PIHP must work cooperatively with other community agencies, to treat mental health and/or substance abuse conditions as legitimate health care problems.

    The PIHP must make a good faith attempt to negotiate either an MOU or a contract with the county(ies) in its service area. The MOU(s), contract(s) or

written documentation of a good faith attempt must be available during the certification process and when requested by the Department. Failure of the PIHP to have an MOU, contract or demonstrate a good faith effort, as specified by the Department, may result in the application by the Department of remedies as indicated in this Contract.

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

13. Sub-Acute Psychiatric Community-Based Psychiatric and Recovery Center Services

a. Services

This benefit will be limited to behavioral health: short term residential (non-hospital residential treatment program) per diem (over midnight census) using code: H0018 under the CBRF provider ID. Sub-acute community based clinical treatment may be used in lieu of inpatient psychiatric hospitalization.

This benefit will be reimbursed at $450 per diem.

Included in this per diem cost are services such as:

i. Comprehensive interdisciplinary biopsychosocial mental health assessment;

ii. Crisis assessment, intervention and stabilization;

iii. Psychiatrist and Advanced Practice Nurse Prescriber to include medication assessment, review, consultation and prescribing;

iv. Psychosocial group education;

v. Individual counseling;

vi. Peer support;

vii. Family consultation, as needed;

viii. Individualized community linkage to ongoing services and supports within the community.

Post-discharge services will be provided on an individual outpatient basis in cooperation and consent with the members' PIHP. These outpatient mental health services will be included as part of the PIHP capitation.

b. Provider Qualifications

i. The provider must be a licensed Community Based Residential Facility (CBRF).

ii. The provider must be experienced with at least 5 years as a community based provider of non-institutional sub-acute psychiatric services.

iii. DQA certification as an Outpatient Mental Health clinic is required.

iv. The staffing plan shall include the following positions:

a) Director

b) Clinic Coordinator

c) Community Recovery Specialist

d) Peer Recovery Specialist

e) Mental Health Professional

f) Registered Nurse

g) Advanced Practice Nurse Prescriber

h) Medical Director

i) Other professional and/or para-professional staff as required to meet the needs of the members.

14. Certified Peer Specialist Services

The PIHP may elect to provide an enhanced behavioral health benefit to eligible members through the use of Certified Peer Specialist providers. This benefit is available for WI FCMH PIHP enrolled adults (18 years and older) with a mental health and/or substance abuse diagnosis, especially members with a co-morbid diagnosis, who are at risk of hospitalization or who may have been hospitalized.

Peer Specialists will be supervised by the PIHP rendering provider, who must be a qualified mental health professional. Peer Specialists will be certified and trained by the Department's Division of Care and Treatment Services (DCTS). DTCS maintains oversight of the training, certification and supervision requirements for peer specialist providers eligible for providing this benefit to PIHP members.

Peer specialist services will be billed under their supervising clinician's NPI, using HCPCS code H0038 – Self-help/peer services. Up to 16 units may be billed per week. A unit is 15 minutes.

Travel time to and from the member visits may not be billed separately, this time considered covered within the direct time reimbursement.

15. Narcotic Treatment Services

Within a reasonable distance from a member's residence, the PIHP must provide access to narcotic treatment services (NTS) or medication-assisted treatment

(MAT) for opioid dependence vial eligible facilities and/or providers. PIHPs must regularly monitor their NTS and MAT provider networks to ensure that members have access to these services. Narcotic treatment services include member assessment, screening for drugs of abuse, screening for certain infectious diseases, prescription and administration of narcotic medication, and substance abuse counseling. The ForwardHealth Online Handbook section for 'Narcotic Treatment' outlines policy for services provided by narcotic treatment programs certified under Wis. Adm. Code § DHS 75.59. For members who require narcotic treatment, PIHPs must ensure access to providers authorized to prescribe opioid dependency agents. Authorized providers include Wis. Adm. Code § DHS 75.59 facilities or physicians who have obtained a Drug Addiction Treatment Act (DATA) 2000 waiver allowing them to prescribe buprenorphine-based agents. The requirement to provide narcotic treatment services does not include coverage of opioid dependency agents themselves, which are covered by ForwardHealth. PIHP providers must adhere to all policy and prior authorization requirements for coverage of opioid dependency agents.

H. Routine Services Associated with Qualifying Clinical Trials

1. The PIHP must authorize and cover all routine patient costs associated with participation in qualifying clinical trials as described in Forward Health update #23037.
    a. Authorization of routine services associated with qualifying clinical trials must:
        i. Be expedited and complete by the PIHP within 72 hours; and
        ii. Be determined without regard to geographic location or network affiliation of the healthcare provider or principal investigator of the qualifying clinical trial, including out-of-state providers or out-of-network providers.
    b. Service authorization must be based on an attestation of the appropriateness of the qualifying clinical trial by the health care provider and principal investigator using the Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial.
    c. Service authorization determinations must not require submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary or burdensome.

I. HealthCheck

HealthCheck, a federally mandated benefit, is key to ensuring that children receive the preventive and follow up care they need, including appropriate dental, mental health, developmental, and specialty care. To the maximum extent possible, the PIHP must make every effort to ensure that HealthCheck exams are provided by primary care providers who understand the concept of trauma-informed care and who provide services based on this understanding and approach.

1. The PIHP must provide comprehensive HealthCheck screens following the enhanced periodicity schedule recommended by the American Academy of Pediatrics (AAP) for children in out-of-home care:

    a. Every month for the first six months of age;

    b. Every 3 months from 6 months to 2 years of age;

    c. Twice a year after 2 years of age.

    The PIHP must schedule interperiodic visits when medically necessary. Interperiodic visits are follow up appointments that occur between the regularly scheduled comprehensive screens. These appointments may be necessary to follow up on a condition or need identified during the comprehensive HealthCheck screen.

2. The PIHP must provide the comprehensive initial health exam within 30- days of enrollment. This exam must meet the HealthCheck requirements and must be performed according to AAP guidelines for children in out-of-home care (see Addendum III).

    Subsequent comprehensive HealthCheck exams must consist of, at a minimum, reassessments of the member's health, development, and emotional status to determine the need for additional services and interventions.

3. The PIHP must ensure that comprehensive HealthCheck exams for children through two years of age include blood lead toxicity testing. Universal testing of children in this age range is a federal Medicaid requirement.

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

4. Provide treatment referrals resulting from the HealthCheck physical exam when findings indicate the need for further evaluation, diagnosis, and treatment. All appointments for further diagnosis or treatment as a result of the screening should be scheduled within 60 days of the date of the HealthCheck screening. All Medicaid services on a HealthCheck referral should be provided within six months of the screening date.

5. Provide other necessary health care services, as medically-necessary, even if those services are not otherwise covered or, exceed coverage limitations (i.e., HealthCheck "Other Services"). The PIHP is responsible for all HealthCheck "Other Services" with the exception of services specified in Article IV(A)(1) in the Contract. Refer to Topic #2391 In the ForwardHealth Online Handbook for examples of HealthCheck "Other Services."

J. Immunization Program

As a condition of certification as a WI FCMH provider, the PIHP must share member immunization status with the local health departments and other non-profit HealthCheck providers upon their request without the necessity of member authorization. The

Department also requires that the local health departments and other non-profit HealthCheck providers share the same information with the PIHP upon request. This provision ensures proper coordination of immunization services and prevents duplication of services.

The PIHP must have a signed user agreement with the Wisconsin Immunization Registry (WIR) or must be able to demonstrate that its major providers have signed WIR user agreements.

K. Abortions, Hysterectomies and Sterilizations

The PIHP shall comply with the following state and federal compliance requirements for the services listed below:

1. Abortions must comply with the requirements of Wis. Stats., s. 20.927, Wis. Stats., s. 253.107 and with 42 CFR Part 441, Subpart E-Abortions.
2. Hysterectomies and sterilizations must comply with 42 CFR Part 441, Subpart F—Sterilizations.

Sanctions in the amount of $10,000.00 may be imposed for non-compliance with the above compliance requirements.

The PIHP must abide by Wis. Stats., s. 609.30.

L. Health Homes

1. Health Home Providers

   Health home providers coordinate care across all settings, including medical, behavioral, dental, pharmaceutical, institutional and community care settings.

   Covered health home activities include:

   a. Comprehensive care management
   b. Care coordination
   c. Health promotion
   d. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
   e. Patient and family support, including authorized representatives
   f. Referral to community and social support services

   When arranging for direct care services for the member, the health home provider must follow the PIHP's requirements regarding prior authorization for PIHP-covered services, referrals to in-network providers, and claim submission.

2. SUD Health Home Treatment Pilot Program

   a. Members diagnosed with or identified as being at risk of having Substance Use Disorder (SUD) or who have been identified as being at risk of

developing conditions frequently associated with SUD, may be referred with the member's consent for specialized Hub and Spoke services.

PIHPs are encouraged to enter into MOUs with the Department contracted hub and spoke pilot sites in the PIHP service area to coordinate services. Hub and spoke pilot sites are reimbursed by the Departemnt for providing six core SUD Health Home services, as detailed in ForwardHealth Update 2022-37.

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b. When serving co-enrolled members, the PIHP must work with the health home providers to develop Memorandums of Understanding (MOUs) that:

i. Clearly delineate the respective roles of the PIHP and health home to avoid duplication of care coordination activities.

ii. Identify engagement activities of the PIHP to support member access of needed health care identified by the health home.

iii. Identify level of data sharing necessary to ensure the goals of the health home services are accomplished.

c. Department approved pilot sites and the geographic service areas where they provide the benefit are available on the Department website for the program.

The PIHP is encouraged to monitor this link for a current list of participating hub sites.

d. Pilot hub sites will determine eligibility and enroll members at the hub site for SUD Health Home services. Members must have a diagnosis of SUD and at least one other chronic condition or be at risk of developing another chronic condition to participate. The risk factors include but are not limited to: mood disorder, anxiety disorders, diabetes, heart disease, COPD, hypertension, asthma, HIV/AIDS, hepatitis A, B, and C, liver/kidney disease, PTSD, psychotic disorders, Traumatic Brain Injury and cognitive disorders, ADHD, and chronic pain.

M. PIHP Moral or Religious Objection

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

1. To the Department and Enrollment Specialist so the Department can notify members of the PIHP's non-coverage of service;
2. With the PIHP's certification application for a WI FCMH contract;

3. Whenever the PIHP adopts the policy during the term of the contract;
4. It must be consistent with the provisions of 42 CFR 438.10;
5. It must be provided to potential members before and during enrollment;
6. It must be provided to members within ninety (90) days after adopting the policy with respect to any particular service; and
7. In written and prominent manner, the PIHP shall inform members via their website and member handbook of any benefits to which the member may be entitled under BadgerCare Plus and Medicaid SSI but which are not available through the PIHP because of an objection on moral or religious grounds. The PIHP must inform members about how to access those services through the State.

V. Provider Network and Access Requirements

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

A. Availability and Accessibility

The PIHP 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 PIHP 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. This 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 PIHP must adequately and timely cover these services out of network for the member, for as long as the PIHP's provider network is unable to provide them.

   e. Coordinate with out-of-network providers for payment and ensure the 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 providers are credentialed as required by 42 CFR § 438.214.

2. Furnishing of Services and Timely Access

The PIHP 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 PIHP 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 PIHP provider, who is accepting new patients.

3. Access and Cultural Considerations
The PIHP 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 or gender identity.

b. Have written protocols ensuring access to children's Healthcheck and adult members access to screening, diagnosis and referral services.

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

B. Network Capacity

The PIHP 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 PIHP notifies the Department and submits documentation regarding network providers when:

a. The PIHP enters into the initial contract with the Department,

b. annually, or

c. a significant change in benefit programs, geographic service area, member enrollment, new member population, or composition of or payments to the provider network occur.

4. The PIHP must, at a minimum, sustain a network that meets standards specified on Table 1 of Section F of this article.. This does not preclude the PIHP'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. PIHPs 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 PIHP submit member communications and transition plan 120 days before the intended geographic service area reduction.

C. Indians, Indian Health Care Providers (IHCP), and Indian Managed Care Entities (ICME)

1. The PIHP must demonstrate sufficient IHCPs participate 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 PIHP must pay IHCPs for covered services provided to Indian members who are eligible to receive services. The PIHP shall pay all providers, including non-network providers, as follows:

   a. At a rate negotiated between the PIHP 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 PIHP would make for the services to a network provider which is not an IHCP; and

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

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

4. The PIHP 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 PIHP will be considered to have met the requirement in Article V.C.1. of this section if the PIHP permits Indian members to access out-of-State IHCPs.

6. The PIHP 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).

D. Contract Certification

The Department will conduct an annual network adequacy analysis confirming the PIHP's network adequately supports members' access, availability, and capacity standards specified in Table 1 of Section of F of this Article. 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 the PIHP service area is within standards.

2. Conditional status is granted when the Department determines network conditions are such that the PIHP may continue providing services in an area under but must remediate the specific deficiencies. Conditional terms may require the PIHP 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 PIHP must provide the Department member impact assessments and remedies to improve standards.

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

    a. Reason for limited services are outside the control of either or both the Department and PIHP.

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

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

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

E. Healthcare Provider Network Files

The PIHP must submit the Healthcare Provider Network and Healthcare Facility Network files by the last business day of the month, 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, modification to PIHP benefits, service area, provider network, and member enrollment. The file must be submitted in the designated format specified in the *HMO Provider Network File Submission Specification Guide* and meet minimum threshold standards to be accepted. Submit each line item with the providers' taxonomy.

F. PIHP Network Reviews

The PIHP must provide assurances to the Department demonstrating the PIHP's capacity to serve expected enrollment in its service 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 the metrics in Table-1 of WI FCMH Provider Network Adequacy Standards.

1. 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
Dental	271 – General Dentistry Practitioner 289 – Dental Hygienist	Adult	BC+, SSI, IHS	Urban	45	30	1:1600	Routine: < 90 Days Emergent: < 24 Hrs
				Rural	90	75	1:1200	
	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	BC+, SSI, IHS	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**
OB/GYN	095 – Nurse Practitioner/Nurse Midwife 212 – Nurse Midwife 316 – Family Practice 318 – General Practice 328 – OB/Gynecologists 350 – Licensed Midwife	Adult & Pediatric (age 12-18)	WI FCMH	Urban	15	10	1:100	< 30 days
				Rural	45	30	1:120	
PCP	092 – Certified Family Nurse Practitioners 093 – Other Nurse Practitioners 100 – Physician Assistants 316 – Family Practice 318 – General Practice 322 – Internal Medicine	Adult	WI FCMH	Urban	15	10	1:100	< 30 days
				Rural	40	30	1:120	
	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	WI FCMH	Urban	15	10	1:100	< 30 days
				Rural	40	30	1:120	
Hospital	010 – Inpatient/Outpatient Hospital	Adult & Pediatric	BC+, SSI	Urban	45	30		
				Rural	75	60		
Urgent Care Center		Adult & Pediatric	BC+, SSI	Urban	45	30		
				Rural	75	60		

G. Telehealth Services

PIHPs must develop policies and procedures for internal monitoring and telehealth utilization. PIHPs will submit these policies and any applicable monitoring information to the Department as requested. Monitoring information may consist of the number of visits per county. Since distance, time, and ratio standards are dependent on fixed locations, telehealth utilization will be considered in the event a network adequacy standard is not met.

VI. Marketing and Member Materials

PIHPs are required to implement and enforce the requirements regarding communication and marketing processes, including Title 42 Code of Federal Regulations Part 438.10 and 42 CFR 438.104.

The Department encourages the PIHP to perform outreach to newly enrolled members, to provide health education, and information to members and/or to the general community, and to participate in community events, and to engage with the WI FCMH population.

A. Materials for Members and Potential Members

1. General Requirements

a. Basic Rules

i. The PIHP must provide all information in this section to members and potential members.

ii. The PIHP may provide member information required in 42 CFR § 438.10 electronically only if all of the following are met:

a) The forma is readily accessible;

b) The information is placed in a location the PIHP website that is prominent and readily accessible;

c) The information is provided in an electronic form which can be electronically retained and printed;

d) The information is consistent with the content and language requirements of 42 CFR § 438.10; and

e) The member is informed that the information is available in paper form without charge upon request and the PIHP provides it upon request within five (5) business days.

iii. Each PIHP must have in place mechanisms to help members and potential members understand requirements and benefits of the program.

b. Language and Format

i. Prevalent non-English Languages

Where applicable, the PIHP must provide materials and services in those languages identified in the following table.

Service Area	2024 Service Area Prevalent Non-English Languages			
1	Spanish	Hmong	Burmese	Mandarin Chinese
2	Spanish	Hmong	Somali	

3	Spanish	Hmong	Lao	
4	Spanish	Hmong	Arabic	Mandarin Chinese
5	Spanish	Mandarin Chinese	Vietnamese	Russian
6	Spanish	Hmong	Mandarin Chinese	Burmese

ii. Oral Interpretation Services

a) The PIHP must make oral interpretations in any language available to members and potential members.

b) Oral interpretation shall be free of charge to members and potential members.

iii. Written Translation

The PIHP must make written translation available in each prevalent language identified in Article VI.A.1.b.

iv. Auxiliary aids and services

a) Auxiliary aids, such as TTY/TDY and American Sign Language (ASL), must be available to members and potential members.

b) Auxiliary aids shall be provided to members free of charge.

v. Taglines

Suggested conspicuously visible taglines translated int the prevalent non-English languages identified across all Rate Regions are provided in a fillable Word Document and PDF are available for download at:

a) https://www.dhs.wisconsin.gov/publications/p02057.docx

b) https://www.dhs.wisconsin.gov/publications/p02057.pdf.

vi. Written Materials

a) Written materials that are critical to obtaining services, including, at minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices must:

1) Be available in the prevalent non-English languages for the PIHP's Service Area,

2) Be made available in alternative formats and through the provision of auxiliary aids and services upon request of the member or potential member at no cost,

3) Include conspicuously visible taglines in the prevalent non-English languages in the Sate,

explaining availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and

4) Include the toll-free telephone number of the number of the entity providing choice counseling.

b) All written materials must:

1) be in easily understand language and format,

2) use a font size no smaller than 12 point,

3) be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of the member or potential member with disabilities or limited English proficiency.

c. Notification to Members

i. The PIHP must notify members and potential members:

a) That oral interpretation is available for any language and written translation is available in prevalent non-English languages;

b) That auxiliary aids and services are available upon request and at no cost for members with disabilities; and

c) How to access oral interpretation and auxiliary aids and services.

ii. The PIHP must make any physician incentive plan available upon request.

d. Standard Member Handbook

i. The PIHP must use the state developed Standard Member Handbook. The Member Handbook must meet the following requirements:

a) Timeframe to provide:

1) Within 10 days of final enrollment notification to the PIHP, the PIHP must provide a hardcopy member handbook to new members.

2) The PIHP must give members notice of any state-identified significant changes to the information at least 30 days before the intended effective date of the change.

b) Handbook Content

The content of the member handbook includes information that allows the member to understand how to effectively use the program. This information must include at minimum:

1) Services covered by the PIHP

2) How and where to access any benefits provided by the state (pharmacy, non-Emergency Medical Transportation, dental, and cost sharing)

   A) In the case of counseling or referral services the PIHP does not cover due to moral or religious objections, the PIHP must inform the member that service is not covered by the PIHP.

   B) The PIHP must informal all members how they can obtain information from the State about how to access services.

3) Benefits and Prior Authorizations

   A) The amount, duration, and scope of benefits available in sufficient detail to ensure the member understands the benefits they are entitled to.

   B) The extent to which and how, after-hours and emergency coverages are provided, including:

      i) What constitutes an emergency medical condition and emergency services.

      ii) The member has a right to use any hospital or other setting for emergency care.

   C) Prior authorizations are not required for emergency services.

4) Procedures for obtaining benefits, including prior authorization and referral requirements for specialists and any benefit not provided by the member's primary care provider.

5) Any restrictions on the member's freedom of choice of network provider.

6) How members may obtain benefits, including family planning services and supplies from out-of-network providers.

A) Including an explanation that the PIHP cannot require a member to obtain a referral before choosing a family planning provider.

7) Any copays that are required by the State.

8) Member rights and responsibilities.

9) How to select and change primary care providers.

10) The Department developed or approved grievance, appeals, and fair hearings procedures and timeframes. Including:

A) Right to file grievances and appeals.

B) Requirement and timeframes for file a grievance or appeal.

C) Availability of assistance in the filing process.

D) Right to request a state fair hearing after the PIHP has made an adverse determination.

11) How to exercise an advanced directive.

12) How to access auxiliary aids and services, including additional information in alternative formats and languages.

13) The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.

14) How to report suspected fraud or abuse.

c) Distribution

1) The PIHP must provide the member handbook to members using one or more of the following methods:

A) Mail a printed copy to the member's mailing address,

B) By email after obtaining the member's agreement to receive the information by email,

C) Posted to the PIHP's website and advised the member in paper or electronic form that the handbook is availing on the internet and includes the internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost, or

D) Any other method that can reasonably be expected to result in the member receiving the handbook.

e. Provider Directory

i. Distribution

a) The PIHPs must post a provider directory on their website for members, network providers and the Department to access;

b) PIHP's must make the provider director available in paper form upon request and at no cost to the member;

c) The PIHP must update the provider directory at least monthly but no later than 30 days after receiving updated provider information;

d) The PIHP must have a machine-readable file and format available on the PIHP's website.

ii. Provider Directory Contents

a) PIHP is required to list the following information about network providers:

1) Provider's name;

2) Provider's street address(es);

3) Provider's phone number(s);

4) Provider's gender;

5) Provider's website (if available);

6) Provider's Specialty;

7) If the provider is accepting new patients;

8) Provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office;

9) Provider completed cultural competence training;

10) Accommodations for people with physical disabilities, including offices, exam rooms, and equipment;

11) Provider's hospital affiliation;

12) Provider's medical group affiliation;

13) Provider's board certification.

b) The PIHP must include the following information on provider type in the directory:

1) Physicians, including specialists.

2) Hospitals.

3) Pharmacies.

4) Behavioral health providers.

5) Long term services and supports providers, as appropriate.

2. State Requirements

a. The PIHP is required to distribute member communication materials to managed care members.

b. Member and non-member communication materials must adhere to the following guidelines:

i. Must be primarily focused on providing public health messages, benefit education, care management, accessing services, or improving health literacy for both Medicaid and potential Medicaid members.

ii. Use professional language access staff (for language access services and auxiliary aids and services), as needed, where technical, medical, or treatment information or other matters, where impartiality is critical, are to be discussed or where use of a family member or friend, as interpreter is otherwise inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical.

iii. All member communication materials must be written at a sixth-grade comprehension level.

iv. The PIHP may provide information about enrollment, including renewals, in the WI FCMH program. The PIHP must direct potential members to:

a) Apply online at the ACCESS website: www.access.wisconsin.gov

b) Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf;

c) Call ForwardHealth Member Services at 1-800-362-3002;

d) Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to:

www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

e) For Medicaid SSI information please direct members or potential members to:

f) The Department Link - https://www.dhs.wisconsin.gov/ddb/apply.htm

g) Social Security Administration Resources – How to apply for Medicaid SSI:

1) https://www.ssa.gov/disabilityssi/

2) https://www.ssa.gov/ssi/text-apply-ussi.htm

c. The PIHP must:

i. Maintain a current list of "On Call" interpreters who can provide interpreter services. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act.

ii. Document all requests and results for any language access services provided to members and be available to the Department upon request.

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

iv. The PIHP must notify members of transition of care requirements as defined in 42 CFR § 438.62.

v. The PIHP must have members opt-in for mobile media communication and provide recipients the option to unsubscribe from receiving communications.

d. Member Handbook

i. In addition to the requirements in Article VI.A.1.d., the PIHP must include information on these Standard Member Handbook requirements:

a) The telephone number that can be used for assistance in obtaining emergency care or for prior authorization for urgent care.

b) Location of facilities.

c) Hours of service.

d) HealthCheck.

e) Information about how to access the provider directory.

f) Languages spoken by the provider.

g) SSI Comprehensive assessments (for Medicaid SSI members only).

h) Medical terminology definitions.

ii. The PIHP must post their WI FCMH member handbook on their website following the requirements of 42 CFR § 438.10(g) and (h). Annually, the PIHP must notify all members that the member handbook is available online and can be mailed hard copy upon request.

iii. With Department approval, the PIHP may send member handbooks, provider directories, newsletters, an other new member information (which does not contain Protected Health Information) electronically to members that provide an email address to the PIHP, provided the PIHP meets the timeframes regarding distribution of the member handbooks. The PIHP may also choose to send the annual materials electronically to members that have provided an e-mail address.

iv. Notification about the availability of the member handbook and provider directory must be mailed to each case head, but the PIHP may choose to mail to each individual member.

v. As needed, the PHIP must provide periodic updates to the handbook and notify members of changes to the information listed above. The PIHP must provide members at least a 30-day notice, in writing, of any significant changes to the handbook before the intended effective date of the change. Such changes must be approved by the Department prior to printing. The PIHP must work with the Department to review these changes in accordance with the timeline established in Article VI.A.2.

vi. When the PIHP reprints their member handbooks, they must include all of the changes to the standard language as specified in this Contract.

vii. The member handbook (or other substitute member information approved by the Department that explains the PIHP's services and how to use the PIHP) must be maid available upon request within a reasonable timeframe in the top prevalent languages for each rate region. The handbook must tell members how to obtain a copy of the handbook in those languages. The Department will translate the standard handbook language into the top prevalent languages for each rate region. The PIHP may use the translated standard handbook language as appropriate in its service area. However, the PIHP must have local resources review the final handbook language to ensure that the appropriate dialect(s) is/are used in the standard translation. The PIHP must also arrange for translation into any other dialects appropriates for its members. The PIHP also must arrange for the member handbook to be provided in braille, larger fonts or be orally translated for its visually limited members.

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

ix. The PIHP must submit their member handbook for review and approval no more than 60 days after the effective date of the Contract.

x. Any exceptions to the standard language must be approved in advance by the Department and will be approved only for exceptional reasons. If the standard language changes during the course of the Contract period, due to changes in federal or state laws, rules or regulations, the PIHP must insert the new language into the member handbooks as of the effective date of any such change and notify members of the changes.

e. Additional Communication Requirements

i. The PIHP are encouraged to include the following information on their websites:

a) Service area; and

b) links to community resources or partners such as community-based health organizations, local health departments, prenatal care coordination agencies, school-based services, targeted case management agencies, school-based mental health services, and Birth-to-Three Program providers.

ii. The PIHP must notify the Department if they currently use or intend to use social media (e.g., Facebook, Twitter, etc.). Notification must include the name of the page, a link, and/or account information. The PIHP is responsible for ensuring that no laws are violated (e.g., the Health Insurance Portability and Accountability Act, or HIPAA).

B. Marketing Materials

The PIHP must comply with 42 CFR § 438.104 including the requirements in Article VI.B. Marketing materials are defined in Article I.

1. Federal Requirements

The PIHP must:

a. Not distribute any marketing materials without first obtaining Department approval;

b. Distribute the materials to its entire service area;

c. Comply with the information requirements of 42 CFR § 438.10 to ensure that, before enrolling, the beneficiary receives, from the PIHP or the State, the accurate oral and written information they need to make an informed decision on whether to enroll;

d. Not seek to influence enrollment in conjunction with the sale or offering of any private insurance;

e. Not, direction or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities;

f. Specify the methods by which the HMO assures the Department that marketing, including plans and materials, is accurate and does not mislead, confuse, or defraud the beneficiaries or the Department. Statements that will be considered inaccurate, false, or misleading include, but are not limited to, any assertion or statement (whether written or oral) that:

iii. The beneficiary must enroll in the PIHP in order to obtain benefits or in order not to lose benefits; or

iv. The PIHP is endorsed by the Centers for Medicare and Medicaid Services (CMS), the Federal or State government, or similar entity.

2. State Requirements:

a. Allowed Marketing Practices

i. The PIHP may use results, rankings, and quality metrics in their marketing materials and are permitted to include the Department, national quality organizations', or other external quality organizations' results in member marketing.

ii. Eligible PIHP marketing activities include member and non-member written communications, websites, and other marketing media. Quality in PIHP marketing activities is limited to health, service delivery, or member experience topics only.

iii. The PIHP may only reference their own quality results, rankings, metrics, etc. in their marketing materials.

iv. The PIHP must state the measure used for the result, ranking, or score, and the source(s) of the result, ranking, or score in any quality-based marketing.

v. The PIHP must submit quality data and/or supporting quality documentation with the marketing materials to validate the PIHP quality claims. It is the responsibility of the PIHP to supply the data and/or supporting quality documentation to the Department for all measures. Quality data submitted must be from the most recent available year, and may not be more than 36 months old.

vi. The PIHP must include in their quality related marketing submission to the Department the exact quality statement to be used in marketing, quality data to support the statement, and any additional supporting documentation to verify PIHP quality claims.

vii. The PIHP must comply with any restrictions on use of national quality measures or quality measures external to the Department by relevant external authorities. Where the Department marketing policy conflicts with national or external quality organizations' policy on permitted use of quality results, the Department will defer to the national or external quality organizations' policy unless explicit written permission has been granted by the external quality organization.

viii. For television and radio advertisements, the PIHP must provide the Department with the scripts and a schedule indicating when the advertisements will be aired, including date and station. If the exact air dates are unknown, the PIHP can identify the block of advertising time.

b. Prohibited Marketing Activities

i. The PIHP are prohibited from marketing to recipients of other forms of Medicaid who are not the PIHP's members.

ii. PIHPs are prohibited from:

a) Offer of material or financial gain to potential members as an inducement to enroll. This includes telling potential members about money they could receive from incentive and reward programs.

b) Materials which contain the assertion that the client must enroll in the PIHP in order to obtain benefits or avoid losing benefits.

c) Practices that discriminate against an individual or class of individuals on the basis of any classification protected under federal or state law.

d) Activities that could mislead, confuse, or defraud members or potential members or otherwise misrepresent the PIHP, its marketing representatives, the Department, or CMS.

e) Materials that contain false information.

f) Practices that are reasonably expected to have the effect of denying or discouraging enrollment.

g) Use the ForwardHealth or other Department issued logos and/or names with any paid or non-paid mass media and advertising, even if used in conjunction with health messaging. This includes using the logo on member policy.

h) Use paid advertising, including mass media, that does not primarily focus on providing public health messages or improving health literacy.

i) Participate in any activity that interferes with a potential member's ability to seek out enrollment or plan information on their own terms; this includes marketing through unsolicited contacts.

j) Solicit to potential members to enroll with a specific health plan. Potential members must seek out plan information.

k) Portray competing health plans in a negative manner or encourage members to disenroll from competing health plans.

c. Policies Related to Medicaid Managed Care Program Providers

i. The PIHP is required to inform all providers in their network of the policies contained within this Section.

ii. Providers may educate and inform their patients about the PIHP with which they contract.

iii. Providers may inform their patients of the benefits, services, and specialty care services offered through the PIHP in which they participate.

iv. Providers may give a member contact information for a particular PIHP, but only at the member's request.

v. Providers may to assist potentially eligible individuals with enrollment in the Medicaid managed care program by helping them:

a) Apply online at the Access website: www.access.wisconsin.gov;

b) Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf; or

c) Call or go to their county IM agency or tribal agency to complete an application; for a map of the different IM agencies per county, go to: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

vi. Providers may assist potentially eligible individuals with the WI FCMH express enrollment process, as described on the ForwardHealth Portal at www.forwardhealth.wi.gov, if they qualify.

vii. Providers may refer patients with questions about the WI FCMH program to an HMO Enrollment Specialist at 1-800-291-2002.

viii. The PIHP may conduct orientations, health fairs, or community baby showers for their members in a private setting at a provider's office.

ix. Providers are prohibited from recommending one health plan over another, offering patients incentives to select one health plan over another, or assisting the patient in deciding to select a specific health plan, Incentives for the purposes of marketing and member materials are any form of financial compensation, including material items, travel or transportation reimbursement, childcare services, etc., offered to members or potential members.

d. Other Medicaid and Medicare Programs

i. The PIHP may provide general information on FamilyCare, PACE, FamilyCare Partnership, or IRIS to Medicaid

managed care members. The PIHP must refer individuals to the ADRC for options and enrollment counseling.

ii. The PIHP is prohibited from marketing other lines of Wisconsin Medicaid programs to current Medicaid members to entice enrollment with the PIHP.

e. Qualified Health Plans and Medicaid PIHP

i. The PIHP may inform their current and former members transitioning to the Marketplace that they may apply for coverage, compare plans, and enroll in the Marketplace and that the health plan is a participating QHP in the Marketplace. Likewise, the PIHP is allowed to inform their Marketplace members that they may be eligible for Medicaid and direct them to the appropriate resources.

ii. The PIHP may participate in community-wide outreach and marketing activities surrounding Marketplace participation.

iii. The PIHP is prohibited from asserting that a member must enroll in the PIHP's QHP in order to obtain benefits or avoid losing benefits.

iv. If the PIHP has information on its website about the Marketplace or about transitioning members, it should include a link to the following DHS website: https://www.dhs.wisconsin.gov/guide/wigov.htm.

C. Department Review and Approval of Communication and Marketing Materials

1. Process

a. The PIHP must submit all communication originating from the PIHP or their providers relating to the WI FCMH to the Department for approval prior to publication or display.

b. If the PIHP identifies as a QHP and a Medicaid Health Plan must receive Department approval prior to distribution of materials.

c. The PIHP must submit a completed a Member Communications/Outreach Material Checklist with each review request submitted to the Department.

d. The PIHP must submit a completed Events Spreadsheet for requests specific to event participation.

e. The PIHP must correct any problems and errors the Department identifies.

f. The PIHP agrees to comply with Wis. Admin. Code and practices consistent with the Balance Budget Amendment of 1997 P.L. 105-33 Sec. 4707(a) [42 U.S.C.1396v(d)(2)].

g. The Department will not approve any materials that are confusing, fraudulent, or misleading, or that do not accurately reflect the scope, philosophy, or covered benefits of the WI FCMH program.

h. The PIHP must provide the Department with final copies after materials are approved.

i. The Department has the discretion to request previously approved documents for re-review at any time.

j. The PIHP must submit event schedules annually or upon substantial updates. The schedule must be submitted five (5) days prior to an updated event if materials were previously approved by the Department, otherwise submit ten (10) days prior to the event with materials for Department approval. The Event Schedule, at a minimum, must include:

    i. the Event;

    ii. Purpose;

    iii. Location, Address, City, and Zip;

    iv. Materials Distributed;

    v. Promotional Activities;

    vi. Raffles, Incentives, or Rewards, and

    vii. Description/Values;

    viii. Sponsor(s);

    ix. Event Date(s); and

    x. Date Reviewed by the Department.

The information may be submitted in either Word, PDF, or Excel format.

2. Review and Approval Timeframe

a. The Department will review and either approve, approve with modifications, or disapprove all communication materials and marketing/outreach materials within 10 business days. Member Handbooks will be reviewed within 30 days. If the PIHP does not receive a response from the Department within the prescribed time frame, the PIHP must contact their Program Specialist. A response will be prepared within two business days of this contact.

b. Materials requiring additional time for Department

The Department may require additional time to review materials that need Secretary's Office or Communications Team review. The Program Specialist will notify the PIHP within three (3) business days of the expected time needed to review the materials.

c. Expedited Review

i. The PIHP must clearly mark time-sensitive member communication and outreach material. The Department will approve, approve with modifications, or disapprove within three business days. The Department reserves the right to determine whether the materials are indeed time sensitive. If the PIHP does not receive a response from the Department within three business days, the PIHP must contact the Program Operations and Technical Assistance Section Manager. A response will be prepared within one business day of this contact.

ii. Materials that can be reviewed by the Managed Care Team and that may be eligible for expedited review include:

a) Notifications to members:

1) Letters notifying members of minor changes in the PIHP provider network (Exception: Privacy violations or significant changes in the PIHP provider network, such as major contract terminations, are not eligible for expedited review).

b) Care coordination, wellness program, or disease management information, including materials to education members on the management of certain conditions.

c) Incentives to members

1) For expedited review, incentives must be less than $25, and the material has clear instructions for members or providers to follow in order to qualify for the incentives. Incentives for the purposes of marketing and member materials are any form of financial compensation, including material items, travel or transportation reimbursement, child care services, etc., offered to members or potential members.

2) The PIHP must prohibit the use of rewards or incentives to be used toward the purchase of items such as alcohol, tobacco products, and firearms.

3) The PIHP may provide information about its rewards and incentives programs to potential members on its website only.

4) The PIHP must provide the option to unsubscribe from health rewards/wellness incentive programs at any point during enrollment.

5) The Department will review incentives over $25 using the typical 10-day review timeline.

d) Notifications about the PIHP policies and procedures for member grievances.

3. Materials that do not require Department approval

a. Educational materials prepared by the PIHP or by their contracted providers and sent to the PIHP's entire membership do not require Department approval unless there is specific mention of the PIHP.

b. Educational materials prepared by outside entities (e.g., American Cancer Society) do not require the Department's approval.

4. Additional Requirements for Member Communication and Marketing Materials

a. PIHP Website

i. All new and updated information relating to the Medicaid managed care programs that the PIHP intends to post on its website must be approved by the Department prior to posting and must be consistent with the Department standards and state law.

ii. The PIHP must notify the Department when their website is in place and when approved updates are made.

b. Surveys

i. The PIHP may survey current members only. The PIHP is prohibited from contacting former and potential members for a survey, including a survey to determine why the former member disenrolled.

ii. All survey methods must be approved by the Department prior to use.

iii. All surveys must be translated into the top prevalent languages by rate region.

iv. The PIHP must provide the data obtained through these surveys to the Department upon request.

v. All efforts to solicit feedback from members and all gift offers must be approved by the Department and must be part of the PIHP's Quality Assessment/Performance Improvement (QAPI) plan.

vi. The value of incentives used to encourage survey participation may not exceed $25 per person. Incentives for the purposes of marketing and member communication are any form of financial compensation, including material

items, travel or transportation reimbursement, childcare services, etc., offered to members or potential members.

c. Raffles and Nominal Gifts

i. All raffle items, must be submitted to the Department for approval no later than 10 business days prior to the event and must include:

a) A description,

b) Declared amount, and

c) Number to be disbursed.

ii. The PIHP may provide promotional raffles valued at $100 or less at community health events.

iii. The PIHP may offer raffles or gifts valued at $100 or less for specific members-only initiatives, including participation in disease management programs. Only a few members may receive gifts of high value, subject to Department approval.

iv. The PIHP may provide nominal gifts for member participation in focus groups. The amount of the gifts must be reasonable give the amount of participation and must be approved by the Department.

d. The PIHP may use their logo and name on materials.

e. The PIHP may provide health messaging and other materials to improve health literacy.

f. Provide plan information to educate members and potential members.

g. The HMO must notify DHS of its participation in a community or health event using the Events Spreadsheet.

h. Participation in community events may be publicized via social media, HMO Program websites, direct communication with current membership, and/or via press releases.

i. The PIHP may use social media to provide general health messaging.

D. Sanctions

1. The PIHP agrees to engage only in member communication and outreach activities and distribute only those materials that are pre-approved in writing. The PIHP that fails to abide by these requirements may be subject to sanctions. In determining any sanctions, the Department will take into consideration any past unfair member communication, or marketing practices, the nature of the current problem, and the specific implications on the health and well-being of members. In the event that the PIHP's affiliated provider fails to abide by these

requirements, the Department will evaluate if it was reasonable for the PIHP to have had knowledge of the member communication or marketing issue and the PIHP's ability to adequately monitor ongoing future member communication or marketing activities of the subcontractors.

2. Any HMO that engages in marketing or that distributes materials without prior approval by the Department may be subject to:

    a. Immediate retraction of materials.

    b. Sanctions detailed in Article XIV, section D of the contract.

E. Reproduction/Distribution of Materials

The PIHP may reproduce and distribute (at their own expense) information or documents sent to the PIHP from the Department that contains information the PIHP-affiliated providers must have in order to fully implement the Contract.

F. PIHP Identification (ID) Cards

The PIHP may issue its own PIHP ID cards. The PIHP may not deny services to a member solely for failure to present the PIHP issued ID card. The ForwardHealth cards will always determine the PIHP enrollment, even where the PIHP issues PIHP ID cards.

G. Preferred Methods of Communication

The PIHP must have a policy describing the PIHP's process for assessing the preferred method of communication of each hearing-impaired member. The PIHP must offer each hearing-impaired or vision-impaired member the type of auxiliary aid(s) s/he prefers in order to access program services and benefits. Once the hearing-impaired or vision-impaired member identifies the type of auxiliary aid(s) s/he prefers, a less effective form of communication may not be used. For example, a person who can most effectively communicate in sign language may not be required to communicate using hand written notes. For members with visual impairment, the PIHP must include its policy on providing materials in Braille, larger fonts, or other alternatives.

H. Supplemental Contact Information and Email

1. Use of Phone Numbers

    a. The PIHP is allowed to use additional telephone numbers included on the Supplemental Demographic Information Report for members enrolled in the PIHP. All requirements regarding telephone communications included within this guide apply for all telephone numbers provided by the member.

    b. If provided, the PIHP should always use the member's preferred contact method, preferred contact time, and preferred contact telephone number when first attempting to reach the member by telephone. If the PIHP is unable to speak with the member but is able to leave a message, the PIHP must not seek to speak with the member directly by contacting multiple telephone numbers provided or leaving multiple messages on different

telephone lines. When leaving a message, personal health information (PHI) must not be included in the message.

c. The Supplemental Demographic Report is intended to provide additional information that is not currently on the Initial and Final Enrollment Rosters and support the PIHP in getting in contact with members. The Supplemental Demographic Report will be provided to the PIHP in the same manner in which they receive their Initial and Final Enrollment Roster. Information on this report should only be used to support communications to enrolled Medicaid members.

2. Email Communication

a. Personal Health Information (PHI) must not be included in email communication from the PIHP to a member. To protect the member's privacy and confidentiality, email communications that contain PHI require a secure portal log-in to view the information. To assure the member, the PIHP must inform the member that the PIHP will never request personally identifiable information via email. Rather, the PIHP will request members to log-in to a secure portal to update or provide personally identifiable information.

b. For example, a general health and wellness newsletter that is sent via email does not require a secure portal; however, any communication specific to an individual's diagnosis or health condition will require the member to access the information through a secure portal. This could include general information or survey targeting treatment or care for an individual's diagnosis or health condition.

c. The PIHP is prohibited from sending emails to members (or their authorized representative) that are not currently enrolled in their PIHP. Depending on who has provided an email address, there may be differences in the type of information the PIHP can communicate over email to an enrolled member.

3. Email Content

Within the email, the PIHP must use clear subject lines. Subject lines must accurately reflect the content of the message. The message must provide a valid physical postal address. The message must also provide a clear and conspicuous explanation of how the member can choose to stop receiving emails from the PIHP in the future. The PIHP cannot sell or transfer email addresses to a third party outside the terms of a subcontract or provider agreement, including in the form of a mailing list.

4. Subscribing to Emails

The PIHP can ask for the member's email address for purposes of subscribing to the PIHP's electronic communications for the PIHP's records. The PIHP must explicitly indicate the type of information that will be communicated electronically and how to unsubscribe to emails from the PIHP before requesting

a member's email address. The PIHP cannot require a member to sign up for email subscription in order to get information about the PIHP.

5. Text Message Notifications

   The PIHP must follow the standard DHS approval process for written communications to members prior to circulation of materials, including text messages. DHS approval indicates only that the content of the message is acceptable to DHS. The PIHP will need to work with their own legal counsel to confirm they have consent to text members and ensure that all materials are HIPAA and Telephone Consumer Protection Act (TCPA), if applicable, compliant.

6. Unsubscribing from Email Messages

   a. The PIHP must inform the members on how and where to unsubscribe from receiving email communication from the PIHP.

   b. Email address will continue to be shared with the PIHP until the member updates his or her information in ACCESS. In order to prevent the member's email address from being shared with the PIHP, the member must update their MyACCESS account or contact the IM agency. After creating or logging into their MyACCESS account, the member can choose to update or remove their email address and stop sharing their email address under the "Manage My Email" feature. Any changes made to email address should appear on the next Supplemental Demographic Report for the PIHP.

7. Automated Chat

   Use of an automated chat feature within the PIHP website does not need Department approval.

I. For CY2024 Only

Contact with former members who have recently lost Medicaid eligibility for limited purpose of providing enrollment and renewal information:

1. The PIHP may contact former members who have recently lost eligibility due to lack of renewal or late verification, for the limited purpose of providing former members with information about re-establishing Medicaid eligibility.

2. PIHPs may only contact former plan members if the former plan members are within their 90-day period to complete a renewal without. The Department will provide the PIHP with lists of former members who have lost eligibility and the timeframe in which the member must complete the renewal process.

3. The PIHP must follow the standard the Department approval process for communications to members prior to circulation materials to former members.

4. The PIHP may provide former members with information about enrollment, including renewals, in Medicaid programs. The PIHP may direct former members to do the following as applicable:

    a. Apply online at the ACCESS website: www.access.wisconsin.gov.

    b. Complete the online form at: www.dhs.wisconsin.gov/forms/F1/F10182.pdf;

    c. Call ForwardHealth Member Services at 1-800-362-3002;

    d. Call or go to their county IM agency or tribal agency to complete an application: www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm.

5. The PIHP is prohibited from completing the renewal process on behalf of a former member.

    a. The PIHP may provide a member with assistance in completing the renewal process.

    b. With the former member's permission, the PIHP may contact an IM agency on a former member's behalf in order to contain contact information or arrange for an initial appointment between IM staff and the former member.

VII. Member Rights and Responsibilities

A. Policies

The PIHP must have written policies guaranteeing each member's rights, and share those written policies with staff and affiliated providers to be considered when providing services to members. The PIHP must comply with any applicable Federal and State laws, including those identified in 42 CFR 438.100, that pertain to member rights. The PIHP must have written restraint policies guaranteeing each member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. As cited in 42 CFR 438.100, enrollees of PIHPs have the following rights:

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

B. Advocate Requirements

The PIHP must employ a WI FCMH PIHP Advocate(s) during the entire contract term. The PIHP Advocate(s) must work with both members and providers to facilitate the provision of benefits to members. The advocate is responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. The advocate position must be in an organizational location within the PIHP that provides the authority needed to carry out these tasks. The PIHP advocate may delegate the below tasks to appropriate plan staff as the PIHP advocate determines appropriate. The detailed requirements of the PIHP Advocate are listed below:

1. Functions of the WI FCMH PIHP Advocate(s)

a. Investigate and resolve access and cultural sensitivity issues identified by PIHP staff, State staff, providers, advocate organizations, and members.

b. Monitor grievances and appeals, along with the grievance and appeal personnel, for the purposes of identification of trends or specific problem areas of access and care delivery. The monitoring function includes ongoing participation in the PIHP grievance and appeal committee.

c. Attempt to resolve grievances and appeals without formal hearings or reviews whenever possible. Resolution of issues and concerns should happen through internal review, negotiation, or mediation, when possible.

d. Recommend policy and procedural changes to PIHP management including those needed to ensure and/or improve member access to and quality of care. The recommended changes can be for both internal administrative policies and subcontracted providers.

e. Act as the primary contact for member advocacy groups. Work with member advocacy groups on an ongoing basis to identify and correct member access barriers.

f. Act as the primary contact for local community based organizations (local governmental units, non-profit agencies, etc.). Work with local community based organizations on an ongoing basis to acquire knowledge and insight regarding the special health care needs of members.

g. Participate in working with DMS Managed Care staff assigned to the PIHP on issues of access to medical care, quality of medical care, and working with the enrollment specialist, ombudsmen, and the Department's approved external advocate on issues of access to medical care, quality of medical care, and enrollment and disenrollment.

h. Analyze on an ongoing basis internal PIHP system functions that affect member access to medical care and quality of medical care.

i. Attend, organize and provide ongoing training and educational materials for the PIHP staff and providers to enhance their understanding of the values and practices of all cultures with which the PIHP interacts.

j. Provide ongoing input to PIHP management on how changes in the PIHP provider network will affect member access to medical care and member quality and continuity of care. Initiate and participate in the development and coordination of plans to minimize any potential problems that could be caused by provider network changes.

k. Review and approve the PIHP's informing materials to be distributed to members to assess clarity and accuracy.

l. Assist members and their authorized representatives for the purpose of obtaining their medical records.

m. The lead advocate position is responsible for overall evaluation of the PIHP's internal advocacy plan and is required to monitor any contracts the PIHP may enter into for external advocacy with culturally diverse associations or agencies. The lead advocate is responsible for training the associations or agencies and ensuring their input into the PIHP's advocacy plan.

n. Be willing to travel, as needed, to be accessible to meet the needs of members in different areas of the state.

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

2. Staff Requirements and Authority of the WI FCMH PIHP Advocate

a. At a minimum, the PIHP must have one PIHP Advocate for BadgerCare Plus and at least two for Medicaid SSI depending on PIHP certification. The advocate(s) must be located in the organizational structure so that they have the authority to perform the functions and duties listed in Article VII.B.1.a-n.above.

b. Upon request from the Department, PIHPs are required to state the staffing levels to perform the functions and duties listed in Article VII.B. 1. a-n. above in terms of number of full and part time staff and total full time equivalents (FTEs) assigned to these tasks. The Department assumes that an PIHP acting as an Administrative Service Organization (ASO) for another PIHP will have at least one advocate or FTE position for each ASO contract as well as maintain their own internal advocate(s). The PIHP must consider and monitor current enrollment levels when evaluating the number of advocates necessary to meet the needs of members. The PIHP may employ less than the required FTE advocate position(s), but must justify to the satisfaction of the Department why less than one FTE position(s) will suffice for the PIHP's member population. The PIHP must also regularly evaluate the advocate position(s), work plan(s), and job duties and allocate an additional FTE advocate position or positions to meet the duties listed in Article VII.B.1.a-n above if there is significant increase in the PIHP's member population or in the PIHP service area. The Department reserves the right to require the PIHP to employ an FTE advocate position if the PIHP does not demonstrate the adequacy of a part-time advocate position.

c. In order to meet the requirement for the advocate position statewide, the Department encourages the PIHP to contract or have a formal memorandum of understanding for advocacy and/or translation services with associations or organizations that have culturally diverse populations within the PIHP service area. However, the overall or lead responsibility for the advocate position must be within each PIHP. The PIHP must

monitor the effectiveness of the associations and agencies under contract and may alter the Contract(s) with written notification to the Department.

d. The Medicaid SSI advocate must be knowledgeable and have experience working with people with disabilities and shall have adequate time to advocate for the target Medicaid SSI populations.

C. Advance Directives

The PIHP must maintain written policies and procedures related to advance directives. (Written information provided must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change.) An advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) and relating to the provision of such care when the individual is incapacitated. The PIHP must:

1. Provide written information at the time of PIHP enrollment to all adults receiving medical care through the PIHP. Per 42 CFR § 438.3(j), if a member is incapacitated at the time of initial enrollment and is unable to receive information or articulate whether or not they have executed an advance directive, the PIHP may give advance directive information to the member's family or authorized representative. The written information should be regarding:
   a. The individual's rights under Wisconsin law (whether statutory or recognized by the courts of Wisconsin) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives; and
   b. The individual's right to file a grievance with the Department of Health Services, Division of Quality Assurance, regarding noncompliance with advance directive requirements. If requested, assist the member in filing a grievance with the Division of Quality Assurance regarding noncompliance with advance directive requirements; and
   c. The PIHP's written policies respecting the implementation of such rights.
2. Per 42 CFR § 438.3(j), maintain written policies and procedures concerning advance directives which must, at a minimum, do the following:
   a. Clarify any differences between any PIHP conscientious objection and those that may be raised by individual physicians and identify the state legal authority permitting those objectives.
   b. Describe the range of medical conditions or procedures affected by the conscience objection.
   c. Document in the individual's medical record whether or not the individual has executed an advance directive.
   d. Not discriminate in the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an

advance directive. This provision shall not be construed as requiring the provision of care which conflicts with an advance directive.

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

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

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

The above provisions shall not be construed to prohibit the application of any Wisconsin law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

D. Primary Care Provider Selection and Designation

Per 42 CFR § 438.208(b)(1), the PIHP must ensure that every member has a primary care provider or a primary care clinic responsible for coordinating the services accessed by the member. The PIHP must have a process in place to link each BadgerCare Plus and Medicaid SSI member with a primary care provider, a primary care clinic, or a specialist when appropriate based on the preferences and health care needs of the member. The process shall include a defined method to notify the member of their primary care provider and how to contact the provider. The PIHP shall allow members an initial choice of primary care provider or primary care clinic prior to designation.

1. PIHP primary care provider or primary care clinic selection and designation strategy

   a. The strategy the PIHP uses to link members to a primary care provider or primary care clinic must take into account the preferences and health care needs of the member. In particular, for those members with chronic conditions including but not limited to those listed below, PIHPs are to take additional steps to ensure these members are linked to a primary care provider or primary care clinic that can appropriately address their condition, as well as ensure the member receives coordinated care to help manage the condition. Depending on the condition, the primary care provider may be a specialist. The specific chronic conditions include, but are not limited to:

      i. Diabetes

      ii. Asthma

      iii. COPD

      iv. Congestive heart failure

      v. Behavioral health

vi. Prenatal and post-partum care

b. PIHPs must ensure members are linked to a primary care provider or primary care clinic that provides culturally appropriate care. Specifically, the provider must be able to relate to the member and provide care with sensitivity, understanding, and respect for the member's culture.

c. As part of the primary care provider or primary care clinic selection and designation strategy, PIHPs must include the following:

i. A process for linking all members to an appropriate primary care provider or primary care clinic (or specialist for members identified with chronic conditions), including a step in which members are given the opportunity to choose their PCP. PIHPs shall ensure care is coordinated between the primary care provider, primary care clinic and/or specialists, which includes the development of a patient-centered and comprehensive treatment plan.

ii. Communication methods that notify members of their primary care provider, primary care clinic or specialist to ensure the member utilizes primary care and encourages members to keep their scheduled appointments.

iii. The PIHP will evaluate the effectiveness of their primary care provider selection and designation strategy to ensure quality of care.

2. Changing and lock-in PCP Selection

The PIHP must permit members to change primary providers at least twice in any year, and to change primary care providers more often than that for just cause. Just cause includes a lack of access to quality, culturally appropriate health care. The PIHP must treat a request for change in primary care provider due to just cause as a grievance, and adhere to the notification and timeframe requirements detailed in the Member Grievances and Appeals Guide.

3. Data sharing with PCP

The PIHP must have a process to share information on members to their primary care provider on a regular basis. The information must include, but is not limited to, utilization data and prescription drug data such as from the pharmacy extract provided by the Department.

E. Member Appointment Compliance

The PIHP must have a strategy in place to reduce the number of members who do not show up for scheduled appointments. This strategy must include outreach and education components for both members and providers. DHS may request additional information from PIHPs on member appointment compliance during the contract period.

F. Choice of Network Provider

The PIHP must offer each member covered under this Contract the opportunity to choose a primary care provider affiliated with the PIHP, to the extent possible and appropriate. If the PIHP designates a PCP to members, then the PIHP must notify members of the designation. If the PIHP has reason to lock in a member to one primary provider in cases of difficult case management, the PIHP must submit a written request in advance of such lock-in to the PIHP's managed care analyst. Culturally appropriate care in this section means care by a provider who can relate to the member and who can provide care with sensitivity, understanding, and respect for the member's culture.

G. Coordination and Continuation of Care

The PIHP must have a system in place to ensure well-managed patient care, including at a minimum:

1. Management and integration of health care through primary provider/gatekeeper/other means.
2. Systems to ensure referrals for medically necessary, specialty, secondary and tertiary care.
3. Systems to ensure provision of care in emergency situations, including an education process to ensure that members know where and how to obtain medically necessary care in emergency situations.
4. Systems that clearly specify referral requirements to providers and subcontractors. The PIHP must keep copies of referrals (approved and denied) in a central file or the patient's medical records.
5. Systems to ensure the provision of a clinical determination of the medical necessity and appropriateness of the member to continue with mental health and substance abuse providers who are not subcontracted with the PIHP. The determination must be made within 10 business days of the member's request. If the PIHP determines that the member does not need to continue with the non-contracted provider, it must ensure an orderly transition of care.
6. Systems to ensure referrals and coordination for mental health and substance abuse services between the health care manager, the DMCPS or county child welfare agency, the primary care physician and the mental health and substance abuse providers.
7. Systems to ensure coordination with existing programs for children with special health care needs through the Milwaukee Public Schools (MPS) and other school systems in its service area.
8. The PIHP must comply with the Department's transition of care policy to ensure that members transitioning to the PIHP from FFS Medicaid or transitioning from one Managed Care entity to another have continued access to services if the member, in the absence of continued services, would suffer or serious detriment to their health or be at risk of hospitalization or institutionalization. The

Department's transition of care policy can be found at: https://www.dhs.wisconsin.gov/publications/p02364.pdf.

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

10. The PIHP must ensure continuity of care for members receiving health care under FFS prior to their enrollment in the PIHP, and for newly enrolled members switching PIHP enrollment. The PIHP must:

    a. Ensure members receive continued access to previous services when the absence of continued services would pose serious health or hospitalization risks per 42 CFR § 438.62 (b). Members who meet this criteria are not subject to the 90-day access limitations escribed in Article VII.F.10.b.1-3.

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

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

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

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

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

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

11. Pursuant to Wis. Stat. §609.24:

    The PIHP shall, with respect to covered benefits, provide coverage to a member for the services of a provider, regardless of whether the provider is in-network at

the time the services are provided, if the PIHP represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the member during the most recent enrollment period.

a. Time Limitations

i. For primary care physicians: Coverage shall be provided by the PIHP until the end of the contract year for which it was represented that the provider was, or would be, a participating provider in the PIHP network.

ii. For a participating provider who is not a primary care physician and whose position with the plan terminates: for the remainder of the course of treatment or for 90 days after the provider's participation with the plan terminates, whichever is shorter except that the coverage is not required to extend beyond the end of the contract year for which it was represented that the provider was, or would be, a participating provider.

iii. If maternity care is the course of treatment and the member is a person who is in the 2nd or 3rd trimester of pregnancy when the provider's participation with the plan terminates, until the completion of postpartum care for member and infant.

iv. The coverage required under this section need not be provided or may be discontinued if any of the following applies:

a) The provider no longer practices in the PIHP's geographic service area.

b) The PIHP terminates or terminated the provider's contract for misconduct on the part of the provider.

b. Medical Necessity
This section does not preclude the application of any provisions related to medical necessity that are generally applicable under the plan.

c. Notice to Members
The PIHP shall notify all members of the provisions under this section whenever a participating provider's participation with the plan terminates, or shall, by contract, require a participating provider to notify all plan members of the provisions under this section if the participating provider's participation with the plan terminates.

H. Culturally and Linguistically Appropriate Services (CLAS) Standards

1. The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for

health and health care organizations to implement culturally and linguistically appropriate services. The National CLAS Standards include:

a. Principal Standard

    i. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

b. Governance, Leadership and Workforce

    i. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

    ii. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

    iii. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

c. Communication and Language Assistance

    i. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

    ii. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.

    iii. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

    iv. Provide easy-to-understand print and multimedia and signage in the languages commonly used by the populations in the service area.

d. Engagement, Continuous Improvement, and Accountability

    i. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.

    ii. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

iii. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

iv. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

v. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

vi. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

vii. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

2. The PIHP must incorporate the National CLAS standards into organizational practices and the delivery of services with a focus on care management services for members. The PIHP must:

   a. Develop and submit policies and procedures at certification demonstrating how all National CLAS standards have been incorporated into organizational practices and delivery of services.

   b. Describe and submit CLAS-related self-assessments, trainings, implementation plan(s), and evaluation plan(s) the PIHP has previously done or plans to complete in the upcoming calendar year at an organizational level including:

      i. a timeline with dates for initiation and completion of activities

      ii. assessment questions

      iii. aggregate level self-assessment and evaluative results

      iv. all documents referenced within the CLAS self-assessments, trainings, implementation plan(s), and evaluation plan(s).

   c. Submit an evaluation of CLAS standard based on data, including member experience and members' feedback, including::

      i. effectiveness of incorporated elements;

      ii. areas not effective; and

      iii. description of how to revise the approach.

3. The PIHP must incorporate in its policies, administration and service practice the following:

a. Recognizing members' beliefs,

b. Screening members for social risk factors and/or health related social needs,

c. Partnering with community based organizations to address members' unmet health related social needs

d. Addressing cultural and linguistic differences in a responsive manner, and

e. Fostering in its staff and providers behaviors that effectively address interpersonal communication styles that respect members' cultural backgrounds.

f. Permitting members to change provider's based on the provider's ability to provide culturally and linguistically appropriate services.

g. Requiring culturally and linguistically appropriate grievance and appeal protocols.

4. The PIHP must encourage and foster CLAS Standards among providers and increase diversity in the PIHP's network to respond appropriately to member's linguistic and cultural needs. The PIHP must permit members to choose providers from the PIHP's network based on linguistic and/or cultural needs. The PIHP must permit members to change primary care providers based on the provider's ability to provide services in a culturally and linguistically responsive manner.

I. Health Education and Disease Prevention

The PIHP must inform all members of ways they can maintain their own health and properly use health care services.

The PIHP must have a health education and disease prevention program that is readily accessible to its members. The program must be offered within the normal course of office visits, as well as by discrete programming. The programming must include:

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

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

3. Health-related education materials in the form of printed, audiovisual and/or personal communication.

   Health-related educational materials produced by the PIHP must be at a sixth grade reading comprehension level and reflect sensitivity to the diverse cultures served. Also, if the PIHP uses material produced by other entities, the PIHP must review these materials for grade level comprehension and sensitivity to the diverse cultures served. Finally, the PIHP must make all reasonable efforts to locate and use culturally appropriate health-related material.

4. Information on recommended checkups and screenings, and prevention and management of disease states that affect the general population. This includes specific information for persons who have or who are at risk of developing such

health problems as hypertension, diabetes, STD, asthma, breast and cervical cancer, osteoporosis and postpartum depression.

5. Health education and disease prevention programs, including injury control, family planning, teen pregnancy, sexually transmitted disease prevention, prenatal care, nutrition, childhood immunization, substance abuse prevention, child abuse prevention, parenting skills, stress control, postpartum depression, exercise, smoking cessation, weight gain and healthy birth, postpartum weight loss, and breast feeding promotion and support. (Note: Any education and prevention programs for family planning and substance abuse would supplement the required family planning and substance abuse health care services covered by WI FCMH.)

6. The PIHP should offer a discrete substance abuse screening and prevention program for members at risk of substance abuse disorder. Wisconsin Medicaid and BadgerCare Plus covers a screening, brief intervention, and referral to treatment benefit (SBIRT) for all members (see ForwardHealth online handbook, Topic #8297) and a similar benefit for pregnant members (see Topic #4442).

7. Promotion of the health education and disease prevention programs, including use of languages understood by the population served, and use of facilities accessible to the population served.

8. Information on and promotion of other available prevention services offered outside of the PIHP, including child nutrition programs, parenting classes, programs offered by local health departments and other programs.

9. Systematic referrals of potentially eligible women, infants, and children to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and relevant medical information to the WIC program. More information about the WIC program as well as list of the local WIC agencies can be found on the WIC website (http://www.dhs.wi.gov/wic/).

VIII. Provider Appeals

A. Provider Appeals to the Department

1. Process to appeal to the Department
    a. Providers may choose to pursue resolution directly with the Department through the provider appeal process after exhausting the PIHP appeal process.
    b. The provider has 60 calendar days from the PIHP's final appeal decision to submit all required information pertaining to the case(s) in question.
    c. The Department will seek rebuttal from the PIHP when it has determined that the provider's appeal necessitates further review.
    d. The Department may send an official Request for Additional Information notice to the PIHP. 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 PIHP fails to submit the requested information by the date required by the Department, the Department may overturn the original denial and compel the PIHP 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 date of receipt of all pertinent information to inform the provider and the PIHP of the final decision.
    b. If the Department's decision is in favor of the provider, the PIHP 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 a misrepresentation of facts.
    d. The Department will review the appeal documents and make a Final Decision based on the contract (both the DHS-PIHP contract and the PIHP-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 PIHP, including appeals related to:
        i. Clinical level of care (e.g. observation vs. inpatient) provided to the member, or the results of contractually agreed upon PIHP reviews of claims or medical records.

B. PIHP Responsibility

1. The PIHP 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 PIHP must provide information to network providers of any PIHP-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 PIHP (i.e. not limited to claim and appeal submission, policy resources, PIHP website). Electronic notification from the PIHP 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 PIHP 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 PIHP and to the Department.
3. The PIHP 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. PIHPs 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, or on the PIHP website. For non-contracted providers, clear process for claim dispute escalation, through written notification. In cases of denial of payment, written (or HIPAA 835 transaction) notification must occur on the date the payment was denied.
    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 of action being taken. A "resubmission of a claim" or "reconsideration of a claim" is not a formal appeal.
    b. The PIHP must provide an explanation of the process the provider should follow to appeal the PIHP's decision to the PIHP once all claim reconsideration action has been exhausted. This must include a statement regarding the provider's rights to appeal to the PIHP, including the timeline for the PIHP to complete the reconsideration process—which must be 60 days or less—and the name of the person and/or function at the PIHP to whom the provider appeal should be submitted.

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

5. The PIHP must adhere to the following timelines:

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

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

6. PIHP Provider Appeal notification requirements

   a. The PIHP must acknowledge the receipt of each formal written appeal received from providers within 10 calendar days.

   b. The PIHP 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, a EOP from the reprocessed claim is acceptable if it indicates the claim was reprocessed.

   e. If the appeal is upheld, in cases of denial of payment, written (or HIPAA 835 transaction) notification must occur on the date the payment was denied.

7. The PIHP 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. The provider appeal log must include any provider claim appeals processed by any subcontractor. The provider appeal log and data summary must be submitted to the Department the last business day of April, July, October and January for the prior quarter.

C. Provider Responsibility

The PIHP 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 PIHP (i.e. not limited to claim and appeal submission, policy resources, PIHP website). Electronic notification from the PIHP 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 insurance plans.

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

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

IX. Member Grievances and Appeals

A. General Requirements

1. Grievance and Appeal System

   The PIHP must have a grievance and appeal system in place for members. The grievance and appeal system must:

   a. Ensure that members have the option to appeal any adverse benefit determination or file a grievance expressing their dissatisfaction about any matter other than an adverse benefit determination, to the Board of Directors of the PIHP. The PIHP Board of Directors may delegate the authority to review grievances and appeals to the PIHP grievance appeal committee, but the delegation must be in writing.

      i. If a grievance and appeal committee is established, the member Advocate must be a member of the committee.

   b. Ensure that individuals with the authority to require corrective actions are involved in the grievance process.

   c. Have written policies and procedures that detail what the grievance and appeal system is and how it operates.

   d. Identify a contact person in the PIHP to receive grievances and appeals and be responsible for routing and processing.

   e. Inform members about the existence of the grievance and appeal processes and how to use them.

   f. Attempt to resolve issues and concerns without formal hearings or reviews whenever possible. When a member presents a grievance or appeal, the member Advocate must attempt to resolve the issue or concern through internal review, negotiation, or mediation, if possible.

2. Level of Appeals—The PIHP may have only one level of appeal for members.

3. Filing Requirements

   a. A member may file a grievance and request an appeal with the PIHP. A member may request a State fair hearing only after receiving notice that the adverse benefit determination has been upheld by the PIHP (see Article IX.D).

   b. If the PIHP fails to adhere to the notice and timing requirements in Article IX.D, the member is deemed to have exhausted the PIHP's appeals process, and the member may initiate a State fair hearing.

   c. A provider or an authorized representative may request an appeal, file a grievance, or request a State fair hearing on behalf of a member, provided there is documented consent from the member. For the purposes of this

Article, when the term "member" is used, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request the continuation of benefits as specified in Article IX.F.2.

4. Member Filing Timeframes

   a. Grievance: A member may file a grievance with the PIHP at any time.

   b. Appeal: A member has 60 calendar days from the date on the adverse benefit determination notice to file a request for an appeal to the PIHP.

5. Procedures

   a. Grievance: The member may file a grievance either orally or in writing. The member must file a grievance with the PIHP. The date of the PIHP's receipt of the member's oral or written grievance request is the start date of the acknowledgement and decision timeframes described under Article IX.D.2.a.

   b. Appeal: The member may request an appeal either orally or in writing. The date of the PIHP's receipt of the member's oral or written appeal request is the start date of the acknowledgement and decision timeframes described under Article IX.D.2.b.

B. Notice of Adverse Benefit Determinations

1. Notice of Adverse Benefit Determination Requirement

   a. The PIHP must give members timely and adequate notice of an adverse benefit determination in writing consistent with the requirements of Article IX.B.2 and in Article VI, "Marketing and Member Materials". This includes adverse benefit determinations made by the PIHP, providers, or its subcontractors. It also includes:

      i. Determinations on services that were authorized by the PIHP the member was previously enrolled in, as consistent with the requirements of 42 CFR § 438.62(a)-(b).

   b. Denial of a request for an item meeting the definition of durable medical equipment or appliances, or disposable medical supplies, shall be treated by the PIHP as an adverse benefit determination, regardless of whether the item is on the Forward Health Durable Medical Equipment Index or the Wisconsin Medicaid Index of Disposable Medical Supplies or other indices of coverable medical equipment and supplies used by the PIHP.

2. Content of Notice

   a. The PIHP must submit to the Department all notice language for approval prior to its use.

i. The Department has provided template letters and mandatory language to be included in member letters. This content can be found on ForwardHealth.

b. The initial notice must explain the following:

i. The adverse benefit determination the PIHP has made or intends to make.

ii. The reasons for the adverse benefit determination and the right of the member to be provided reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination free of charge. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

iii. The member's right to request an appeal of the HMO's adverse benefit determination, including information on exhausting the HMO's one level of appeal described in Article IX A.2.a and the right to request a State fair hearing consistent with Article IX A.3.a.

iv. The procedures for exercising the rights specified in Article IX.C.2.

v. The circumstances under which an appeal process can be expedited and how to request it, including the fact that an expedited timeframe requires a medical provider or the HMO to verify that delay can be a health risk.

vi. The member's right to have benefits continue while the appeal resolution is pending, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services (see Article IX.F.4.a.).

vii. The member's right to have a representative assist at any point in the grievance or appeal process including reviews or hearings, and how to request that assistance.

viii. The member's right to present "new" information before or during the grievance and appeal process including reviews or hearings.

ix. The fact that retaliatory action will not be taken against a member, a member's authorized representative or a provider who appeals the PIHP's decision.

x. The fact that the member can receive help filing a grievance or appeal by calling the member Advocate or the Ombuds.

xi. The address and telephone number of the member Advocate and Ombuds.

3. Timing of Notice

The PIHP must mail the notice within the following timeframes:

a. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified below (as found in 42 CFR §§ 431.211, 431.213, and 431.214).

i. The PIHP must send a notice at least 10 days before the date of action, (as defined in 42 CFR § 431.201) except as permitted under Article IX.B.3.a.ii and Article IX.B.3.a.iii.

ii. The PIHP may send a notice not later than the date of action if any of the following occur:

a) The PIHP has factual information confirming the death of a member.

b) The PIHP receives a clear written statement signed by a member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates understanding that this must be the result of supplying that information.

c) The member has been admitted to an institution and has become ineligible under the plan for further services.

d) The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address (See 42 CFR § 431.231 (d) for procedure if the beneficiary's whereabouts become known).

e) The PIHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.

f) A change in the level of medical care is prescribed by the member's physician.

g) The notice involves an adverse determination made with regard to the preadmission screening requirements of §1919(e)(7) of the Social Security Act.

iii. The PIHP must send notice as soon as practicable before a member will be transferred or discharged when:

a) The safety or health of individuals in the facility would be endangered.

b) The resident's health improves sufficiently to allow a more immediate transfer or discharge.

c) An immediate transfer or discharge is required by the resident's urgent medical needs.

d) A resident has not resided in the nursing facility for 30 days.

iv. The agency may shorten the period of advance notice to 5 days before the date of action if both of the following conditions are met:

a) The agency has facts indicating that action should be taken because of probable fraud by the member.

b) The facts have been verified, if possible, through secondary sources.

b. For denial of payment, at the time of any action affecting the claim.

c. The standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service.

i. One extension of up to 14 days may be allowed if either of the following conditions are met:

a) The member or provider requests an extension.

b) The PIHP justifies the need for additional information and how the extension is in the member's interest. Determinations must be made within the timeframe specified in Article IX.B.3.c and will be available to the Department upon request.

d. If the PIHP meets the criteria in Article IX.B.3.c.i.b for extending the timeframe for standard service authorization decisions it must do both of the following:

i. Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

ii. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

e. For expedited service authorization decisions, as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service.

i. The expedited timeframe may be extended by up to 14 calendar days if the criteria listed under Article IX.B.3.c are met.

f. Service authorization decisions not reached within the timeframes specified in Article IX.B.3.c. and Article IX.B.3.e. are considered an adverse benefit determination. In these situations, notice must be mailed no later than the date that the timeframes expire.

C. Handling of Grievances and Appeals

1. General Requirements

In handling grievances and appeals, the PIHP must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

2. Requirements for Adverse Benefit Determinations

The PIHP's process for handling member grievances and appeals for adverse benefit determinations must:

a. Acknowledge in writing receipt of each grievance and appeal. If being sent to a provider, written notices may be sent by mail or electronically via secure provider portal.

b. Ensure the individuals who make decisions on grievances and appeals are individuals:

i. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

ii. Who are health care professionals with appropriate clinical expertise, if deciding any of the following:

a) An appeal of a denial that is based on lack of medical necessity.

b) A grievance regarding denial of expedited resolution of an appeal.

c) A grievance or appeal that involves clinical issues.

iii. Who take into account all comments, documents, records, and other information submitted by the enrollee or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

c. Provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The

PIHP must inform the member orally of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in Article IX.D.2 and Article IX.D.3.

iv. If the member is presenting evidence in person, the PIHP must inform the member in writing of the time and place of the meeting at least seven days before the meeting. In expedited appeals, the PIHP must also notify the member orally.

d. Provide the member and if applicable, the member's representative, the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the PIHP (or at the direction of the PIHP) in connection with the appeal. This includes information or documentation generated by the PIHP's providers, and subcontractors.. The information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in Article IX.D.2 and Article IX D.3.

e. Include as parties to the appeal, the member and the member's representative, or the legal representative of a deceased member's estate.

D. Resolution and Notification

1. Basic Rule

The HMO must resolve and provide notice for each grievance and appeal as expeditiously as the member's health condition requires, and within the timeframes specified in this Article.

2. Acknowledgment and Resolution Timeframes

a. Standard Resolution of Grievances

For standard resolution of a grievance, the PIHP must send a written acknowledgement of receipt of the grievance to the member within 10 business days of receipt of the grievance (oral or written) and a final written decision resolving the grievance within 30 calendar days of receiving the grievance (oral or written). This includes member grievances that were resolved during the initial phone call to the PIHP.

b. Standard Resolution of Appeals

For standard resolution of an appeal, the PIHP must send a written acknowledgement of receipt of the appeal to the member within 10 business days of receipt of the appeal (oral or written) and a final written decision resolving the appeal within 30 calendar days of receiving the appeal (oral or written). This timeframe may be extended under the conditions outlined in Article IX.D.3.

c. Expedited Resolution of Appeals

For expedited resolution of an appeal, the PIHP must make reasonable effort to provide oral notice and issue a written disposition of an expedited hearing decision within 72 hours of receiving the verbal or written request for an expedited resolution. This timeframe may be extended under the conditions outlined in Article IX.D.3.

d. Grievances and Appeals Submitted by Individuals Purporting to be an Authorized Representative

If a grievance or appeal is submitted by an individual purporting to be the member's authorized representative and the HMO does not have the documented consent of the member for the individual to act as the member's representative on file, then the HMO must do the following:

i. Upon receipt of the grievance or appeal request, attempt to contact the member to confirm the member's desire for the grievance or appeal to proceed.

ii. If contact is made with the member and the member confirms, either verbally or in writing, that they desire the grievance or appeal to proceed, inform the member of the need to provide written consent for an individual to act as the member's authorized representative in the grievance or appeal and that, in the absence of such documented consent, the grievance or appeal will be processed as a request from the member.

iii. Initiate the appeal or grievance resolution process as of the date the member confirms that they wish to proceed with the appeal or grievance.

iv. Send the written acknowledgement letter to the member (and, if the member's documented consent is obtained prior to the acknowledgment letter being sent out, to the member's authorized representative) within the timeframes described under Article IX.D.2.a, b or c. The PIHP's receipt of the member's grievance or appeal with respect to these timeframes is the date of the member's confirmation that they wish to proceed with the grievance or appeal.

v. Complete the appeal or grievance resolution process and issue a written resolution decision within the timeframes described under Article IX.D.2.a, b or c. The PIHP's receipt of the member's grievance or appeal with respect to these timeframes is the date of the member's confirmation that they wish to proceed with the grievance or appeal.

a) If the PIHP does not receive documented consent from the member for the purported authorized representative to act as the member's representative prior to the appeal or

grievance resolution decision deadline, send the written decision resolving the grievance or appeal to the member.

b) If the PIHP receives documented consent from the member for the purported authorized representative to act as the member's representative prior to the appeal or grievance resolution decision deadline, send the written decision resolving the grievance or appeal to the representative and the member.

c) If contact is made with the member and the member does not wish to proceed with the grievance or appeal, dismiss the grievance or appeal and send a written notice to that effect to the member.

d) If no contact is made with the member within 30 calendar days of receipt of the grievance or appeal from the purported representative, dismiss the grievance or appeal and send a written notice to that effect to the member.

3. Extension of Timeframes

   a. The PIHP may extend the timeframes from Article IX.D.2 by up to 14 calendar days if any of the following occur:

      i. The member requests the extension.

      ii. The PIHP shows that there is need for additional information and how the delay is in the enrollee's interest. Documentation regarding this determination must be available to the Department upon request.

   b. The total timeline for the PIHP to finalize a formal grievance or appeal may not exceed 45 days from the date of the receipt.

4. Requirements Following Extension

   If the PIHP extends the timeframes not at the request of the member, it must complete all of the following:

   a. Make reasonable efforts to give the member prompt oral notice of the delay.

   b. Within 2 calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if they disagree with the decision.

5. Deemed Exhaustion of Appeals and Processes\

   If the PIHP fails to adhere to the notice and timing requirements in this Article, the member is deemed to have exhausted the PIHP's appeals process and the member may initiate a State fair hearing.

6. Format of Notices

a. Grievances

The PIHP must provide written notice of resolution of a grievance in a format and language that, at minimum, meets the standards described in Article VI.

b. Appeals

iii. For all appeals, the PIHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described in Article VI.

iv. The PIHP must issue a separate written notice of appeal resolution for each adverse benefit determination appealed by a member. For example, if two adverse benefit determinations are made by the PIHP at the same time, the PIHP must send out two separate adverse benefit determinations to the member. If the member appeals both adverse benefit determinations, the PIHP must issue two separate notices of appeal resolution.

v. For notice of an expedited resolution, the PIHP must also make reasonable efforts to provide oral notice.

7. Content of Notice for appeal Resolution

a. The PIHP must submit to the Department all notice language for approval prior to its use.

i. The Department has provided template letters and mandatory language to be included in member letters. This content can be found on ForwardHealth.

b. The written notice of the resolution must include the following:

ii. The results of the resolution process and the date it was completed.

iii. For appeals not resolved wholly in favor of the member:

a) The right to request a fair hearing with the Division of Hearing and Appeals (DHA), and how to do so.

b) The right to request and receive benefits while the hearing is pending, and how to make the request.

c) That the member maybe held liable for the cost of those benefits if the hearing decision upholds the HMO's adverse benefit determination (Article IX.F.4.a.).

8. Requirements for State Fair Hearings

a. A member may request a State fair hearing with the DHA only after receiving notice that the HMO is upholding the adverse benefit determination.

b. If the HMO fails to adhere to the notice and timing requirements in Article IX.D.2-5, the member is deemed to have exhausted the HMO's appeals process and the member may initiate a State fair hearing.

c. The member must request a State fair hearing no later than 90 calendar days from the date of receipt of the HMO's notice of resolution. Receipt of notice is presumed within 5 calendar days of the date the notice was mailed.

d. The parties to the State fair hearing include the Department, the HMO, and the member and the member's representative, or the representative of a deceased member's estate.

e. Upon request for information regarding a State fair hearing, the HMO must provide all relevant materials to appropriate parties (including the member, the member's appointed representative (if applicable), the Department, the state's fiscal agent, or DHA) within 5 business days, or sooner if possible. This includes:

    i. The HMO denial letter.

    ii. All pertinent medical or dental records.

    iii. Any other pertinent documentation, as determined by the Department.

f. Per 42 CFR § 431.244, State fair hearing decisions will be reached within the specified timeframes:

    i. Standard Resolution

    Within 90 calendar days of the date the member filed the appeal with the HMO, not including the number of days the enrollee took to subsequently file for a State fair hearing.

    ii. Expedited Resolution

    Within three (3) working days from Department receipt of a hearing request for a denial of a service that:

    a) Meets the criteria for an expedited appeal process but was not resolved using the HMO's appeal timeframes, or

    b) Was resolved wholly or partially adversely to the member using the HMO's expedited appeal timeframes.

E. Expedited Resolution of Appeals

1. General Rule

The PIHP must establish and maintain an expedited review process for appeals, when the PIHP determines (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously

jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

2. Punitive Action

The PIHP and its contracted providers must ensure that punitive action is not taken against anyone who requests an expedited resolution or supports a member's appeal, including but not limited to a member, authorized representative, or provider.

3. Action following denial of a request for expedited resolution

If the PHP denies a request for expedited resolution of an appeal, it must:

a. Transfer the appeal to the timeframe for standard resolution in accordance with Article IX.D.2.b.

b. Follow the requirements in Article IX.D.4.

F. Continuation of Benefits During the Appeal and State Fair Hearing Process

1. Definition of Timely Filing

As used in this Article:

Timely filing means the member as filed for continuation of benefits on or before the later of the following:

a. Within 10 calendar days of the PIHP sending the notice of adverse benefit determination.

b. Intended effective date of the PIHP's proposed adverse benefit determination.

2. Continuation of Benefits

The PIHP must continue the member's benefits if all the following occur:

a. The enrollee files that request for an appeal timely in accordance with Article IX.A 3.a-c and Article IX A.4.a-b.

b. The appeal involves the termination, suspension, or reduction of previously authorized services.

c. The services were ordered by an authorized provider.

d. The period covered by the original authorization has not expired.

e. The member or their authorized representative timely files for continuation of benefits. (Per Article IX.A.3.c providers cannot request that benefits be continued).

3. Duration of Continued or Reinstated Benefits

If, at the member's request, the PIHP continues or reinstates the enrollee's benefits while the appeal or state fair hearing is pending the benefits must be continued until one of the following occurs:

a. The member withdraws the appeal or request for state fair hearing.

b. The member fails to request a state fair hearing and continuation of benefits within 10 calendar days after the PIHP sends the notice of an adverse resolution to the member's appeal under Article IX.D.2.b.

c. The DHA issues a hearing decision adverse to the member.

4. Member Responsibility for Services Provided

If the DHA upholds the PIHP's adverse benefit determination, the PIHP may pursue reimbursement from the member for the cost of services provided to the member while the PIHP appeal and state fair hearing was pending, to the extent that they were provided solely because of the requirements of this Article.

G. Reversed Appeal Resolutions

1. Services not provided while the appeal is pending.

If the PIHP or the DHA reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the PIHP must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.

2. Services provided while the appeal is pending.

If the PIHP or the DHA reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the PIHP must pay for those services.

H. Recordkeeping Requirements

1. Recordkeeping System

a. The PIHP must maintain records of grievances and appeals and must submit them in accordance with requirements detailed in Article IX.H.2-3.

b. The recordkeeping system must include a copy of the original grievance or appeal, the response, and the resolution.

2. Record Information Requirements

a. Records must distinguish WI FCMH members from commercial members and members of other health plans, including those serving other Medicaid members.

b. The record of each grievance or appeal must contain, at a minimum, all of the following information:

i. A general description of the reason for the grievance or appeal.

ii. The date received.

iii. The date of each review or, if applicable, review meeting.

iv. Resolution at each level of the appeal or grievance, if applicable.

v. Date of resolution at each level, if applicable.

vi. Name of the covered person for whom the grievance was filed.

3. Record Maintenance

The record must be accurately maintained in a manner accessible to the Department available upon request to CMS.

I. Monitoring of Grievances and Appeals

1. Department Review of Timely Notification

Per 42 CFR § 438.228(b), the Department will conduct random reviews of the PIHP and its providers or subcontractors to ensure that they are adhering to the timely notice requirements detailed in Article IX.

2. Submission of Reports

a. The PIHP must submit quarterly reports to the Department of all grievances and appeals. The PIHP must forward all reports under Article IX.I.3 to the Department within 30 days of the end of the quarter in the format specified.

b. Failure on the part of the HMO to submit the quarterly grievance and appeal reports in the required format within five days of the due date may result in any or all sanctions available under the Contract.

c. The quarterly grievance and appeal report must include any member grievances and/or appeals processed by any subcontractors.

3. Member Grievance and Appeal Reporting Form

The HMO must submit to the Department each appeal and grievance received in the past quarter using the forms found at https://dhs.wisconsin.gov/library/collection/F-03112 and https://dhs.wisconsin.gov/library/collection/F-03112A .

4. Changes to Appeal and Grievance Reporting Requirements

The Department may revise elements to be included in the quarterly appeal report or grievance report and shall give the PIHP notice of new elements.

J. Information to Providers and Contractors

1. The PIHP must distribute to its, providers and subcontractors the Ombuds Brochure on member grievance and appeal rights at the time the contract is entered.

2. When a new Ombuds Brochure is available, the PIHP must distribute copies to its providers or subcontractors within three weeks of receipt of the new brochure.

3. The PIHP must ensure that its providers and subcontractors have written procedures for describing how members are informed of denied services. The PIHP will make copies of the providers' and subcontractors' appeals and grievance procedures available for review upon the Department's request

X. Quality Assessment Performance Improvement (QAPI)

A. QAPI Requirements

The PIHP Quality Assessment Performance Improvement (QAPI) program must conform to the requirements of 42 CFR Part 438, Medicaid Managed Care Requirements, Subpart E, Quality Measurement and Improvement. At a minimum, the program must comply with 42 CFR § 438.330 (b) which states that the PIHP must:

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

B. QAPI Program

The PIHP must have a comprehensive QAPI program that protects, maintains and improves the quality of care provided to BadgerCare Plus and Medicaid SSI program members.

1. The PIHP must evaluate the overall effectiveness of its QAPI program annually to determine whether the program has demonstrated improvement, where needed, in the quality of care and service provided to its BadgerCare Plus and Medicaid SSI population.
2. The PIHP must incorporate access for medical home practice sites to an information system that supports ongoing communication and follow-up of health care information, as well as the commitment of resources to monitor quality and outcomes, including periodic submission and analysis of clinical and administrative health care data for the purpose of utilization monitoring and continuous quality improvement.
3. The PIHP must document all aspects of the QAPI program and make it available to the Department for review upon request. The Department may perform off-site and on-site QAPI audits to ensure that the PIHP is in compliance with contract requirements. The review and audit may include:
    a. On-site visits;
    b. Staff and member interviews;
    c. Medical record reviews;
    d. Review of all QAPI procedures, reports, committee activities, including credentialing and re-credentialing activities;

e. Corrective actions and follow-up plans;

f.

g. Peer review process;

h. Review of the results of the member and provider satisfaction surveys; and

i. Review of staff and provider qualifications.

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

   a. Annual plan to meet its Pay-for-Performance (P4P) goals and submit NCQA audited P4P results to the Department on time;

   b. Annual Performance Improvement Projects (PIPs) topic selection, implementation, monitoring, and final report submission to the Department and to the Department's External Quality Review Organization (EQRO).

5. The PIHP governing body is ultimately accountable to the Department for the quality of care provided to PIHP members. Oversight responsibilities of the governing body include, at a minimum:

   a. Approval of the overall QAPI program;

   b. An annual QAPI plan, designating an accountable entity or entities within the

   c. Review of written reports from the designated entity on a periodic basis, which include a description of QAPI activities;

   d. Progress on objectives, and improvements made;

   e. Formal review on an annual basis of a written report on the QAPI program; and

   f. Directing modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the PIHP.

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

   a. Persons with expertise in the care of children with chronic conditions.

b. Persons who are knowledgeable and familiar with the needs of children in out-of-home placement.

c. A variety of health professions (e.g., physical therapy, nursing, etc.)

d. Qualified professionals specializing in mental health and substance abuse on a consulting basis.

e. Qualified professionals specializing in dental care on a consulting basis when an issue related to this area arises.

f. A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.)

g. An individual with specialized knowledge and experience with persons with disabilities.

h. PIHP management or governing body.

i. Child welfare professionals and other sector social workers.

j. Other persons who work with children in out-of-home placement in counties in the PIHP's service area.

7. Members of the PIHP, out-of-home care providers, and/or birth parents must be able to contribute input to the QAPI Committee. The PIHP must have a system to receive member input on quality improvement, document the input received, document the PIHP's response to the input, including a description of any changes or studies it implemented as the result of the input and document feedback to members in response to input received. The PIHP response must be timely.

8. The PIHP must demonstrate the capacity for reporting on enrollee satisfaction, including caregiver, provider and cross-sector level input/feedback where appropriate.

9. The committee must meet on a regular basis, but not less frequently than quarterly. The activities of the QAPI Committee must be documented in the form of minutes and reports. The QAPI Committee must be accountable to the governing body. Documentation of Committee minutes and activities must be available to the Department upon request.

10. QAPI activities of the PIHP's providers and subcontractors, if separate from PIHP QAPI activities, must be integrated into the overall PIHP/QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter data, are incorporated into all provider and subcontractor contracts and employment agreements. The PIHP QAPI program shall provide feedback to the providers and subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QAPI efforts. Other management activities (utilization management, risk management, customer service, grievances and appeals, etc.) must be integrated with QAPI program. Physicians and other health care practitioners and institutional providers must actively cooperate and participate in the PIHP's quality activities.

The PIHP remains accountable for all QAPI functions, even if certain functions are delegated to other entities. If the PIHP delegates any activities to contractors, the conditions listed in Article XIV.A "Delegations of Authority" must be met.

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

12. The PIHP must designate a medical director to oversee the FCMH quality improvement program. The designated individual shall be accountable for the QAPI activities of the PIHP's own providers, as well as the PIHP's subcontracted providers.

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

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

C. Monitoring and Evaluation

1. The PIHP In conjunction with DHS, DCF, DMCPS, county child welfare agencies in the PIHP's service area, and their designees, shall develop performance measures that meet the following objectives:

    a. Integrated and Comprehensive Health Services Delivery. The PIHP shall deliver coordinated, comprehensive health care including physical, behavioral and oral health care that is tailored to each FCMH member's individualized needs.

        The health system must have sufficient capacity and informatics to support and implement multi-directional communication and quality reporting at the provider, plan, and enrollee level, including clinically integrated community agencies and providers external to the health system where applicable.

    b. Timely Access. The PIHP will provide timely access to a full range of developmentally appropriate services. The needs of the individual child will be assessed by an out-of-home care health screen within 2 business days of entering out-of-home care (i.e. a child removed from the home at 4:00pm on Wednesday will receive an out-of-home care health screen by end of business day on Friday), followed by a comprehensive health assessment within 30

days of enrollment. Children will receive well child check-ups at the increased frequency for children in out-of-home care recommended by the American Academy of Pediatrics. All other identified medical, developmental, behavioral/mental health, and oral health needs fo the child will be met in an effective and timely manner.

c. High Quality and Flexibility of Care. The PIHP will coordinate, organize, and facilitate care in order to deliver services in an effective and efficient manner. The PIHP will be expected to utilize trauma-informed and evidence-informed practices. The PIHP will have the flexibility to deliver services to its members in the most effective manner, including in home settings.

d. Transitional Planning and Cross-System Coordination. Children in out-of-home placement will receive transitional planning and follow-up services necessary to assure continuity of health care after achieving permanency or aging out of out-of-home care. The PIHP will coordinate with other systems providing health and developmental services, including the local school system, the county-administered Birth to 3 and Children's Long-Term Support Waiver programs, and county-funded mental health services.

e. Well-Being Outcomes. The PIHP will support children to have better physical health, improved developmental, behavioral and mental health outcomes, positive permanency outcomes, and enhanced resiliency.

f. Psychotropic Medication Management. The PIHP will establish case management strategies to link psychotropic medication management at the medical home provider level to an individualized integrated physical and behavioral health care plan.

2. The PIHP must demonstrate capacity for tracking and reporting on:

a. Uniform and complete encounter data for all covered services as specified by the state, including case planning and care coordination information.

b. Health care data and outcomes at both eh individual child and aggregate systems levels.

c. Specific performance measurement data using standard metrics/performance measures required by the state.

d. Priority and non-clinical areas relevant to children in out-of-home care as specified by the state for quality improvement.

e. The rates and types of psychotropic medication usage among enrollees, as well as identification of non-standard and/or inappropriate prescribing practices based on analysis of state-level data regarding the characteristics of and variations in psychotropic prescribing patterns relative to integrated health system enrollees.

f. All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made, which must be reported all providers to the PIHP per 42 CFR s.438.6(f)(2)(ii).

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

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

5. Provider performance must be measured against practice guidelines and standards adopted by the QAPI Committee. Areas identified for improvement must be tracked and corrective actions taken when warranted. The effectiveness of corrective actions must be monitored until problem resolution occurs. Reevaluation must occur to ensure that the improvement is sustained.

6. The QAPI program must monitor and evaluate the quality of clinical care on an ongoing basis. Important aspects of care (i.e., acute, chronic conditions, high volume, high-risk preventive care and services) must be studied and prioritized for performance improvement and updating guidelines. Standardized quality indicators must be used to assess improvement, ensure achievement of minimum performance levels, monitor adherence to guidelines, and identify patterns of over and underutilization. The Department will use the latest available HEDIS specifications for measurement year (MY) and measures will be defined in annual PIHP Quality Guide.

7. The PIHP must use appropriate clinicians and persons with knowledge and experience working children in out-of-home placement to evaluate clinical data and serve on multi-disciplinary teams tasked with analyzing and addressing data issues.

8. PIHPs must mandate provider identification of provider preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR s. 434.6(a)(12) and 42 CFR s. 447.26. PIHPs must report all identified provider-preventable conditions through its encounter data.

   Health care acquired conditions for non-payment include hospital-acquired conditions as identified by Medicaid other than Deep Vein Thrombosis

(DVT)/Pulmonary Embolism (PE) with total knee replacement surgery in pediatric and obstetric patients.

Other provider-preventable conditions for non-payment are identified as:

a. Wrong surgical or other invasive procedure performed on a patient;

b. Surgical or other invasive procedure performed on the wrong body part;

c. Surgical or other invasive procedure performed on the wrong patient.

9. The PIHP must also monitor and evaluate care and services in certain priority clinical and non-clinical areas relevant to children in out-of-home placement specified by the Department, including incorporation of trauma-informed principles and treatment(s) into provider education, health system policies, and service delivery. Non-clinical areas of monitoring and evaluation must include member satisfaction.

10. The PIHP must make documentation available to the Department upon request regarding quality improvement and assessment studies on plan performance, which relate to the enrolled population. See reporting requirements in "Performance Improvement Priority Areas and Projects."

11. The PIHP must develop or adopt best practice guidelines in accordance with 42 CFR 438.236 (b) and meet the following requirements:

    a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.

    b. Consider the needs of the PIHP members.

    c. Are adopted in consultation with network providers.

    d. Are reviewed and updated periodically as appropriate.

    The PIHP must disseminate the guidelines to all providers and, upon request, to members and potential members.

    Decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply must be consistent with the guidelines.

12. Cooperating with Monitoring and Evaluation

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

    b. The WI FCMH must assist the Department and the external quality review organization (EQRO) in identifying and collecting information required to

carry out on-site or off-stie reviews and interviews with WI FCMH staff, providers, and members.

c. In the event that a review by the Department or the EQRO results in findings that the Department determines are unsatisfactory, the WI FCMH must cooperate in further investigation or remediation, which may include:

i. Corrective action within a time frame to be specified in the notice; and

ii. Additional review by the Department or by the WI FCMH to determine the extent and causes of the noted problems.

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

1. The PIHP must have written policies and procedures for provider selection and qualifications. For each practitioner, including each member of a contracting group that provides services to the PIHP's members, initial credentialing must be based on a written application, primary source verification of licensure, disciplinary status, eligibility for payment under WI FCMH, and Provider Number or National Provider Identifier. The PIHP's written policies and procedures must identify the circumstances in which site visits are appropriate in the credentialing process.

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

2. The Wis. Adm, Cod, 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.

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

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

5. The PIHP must periodically monitor (no less than every three years) the provider's documented qualifications to ensure that the provider still meets the

PIHP'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.

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

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

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

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

9. The PIHP must have a formal process of peer review of care delivered by providers and active participation of the PIHP's contracted providers in the peer review process. This process may include internal medical audits, medical evaluation studies, peer review committees, evaluation of outcomes of care, and systems for correcting deficiencies. The PIHP must supply documentation of its peer review process upon request.

10. The PIHP must have written policies that allow it to suspend or terminate any provider. The PIHP must have a written appeal process available to providers that conforms to the requirements of the HealthCare Quality Improvement Act of 1986 (42 USC 11101 etc. Seq.).

    a. The Department is responsible for monitoring and terminating providers from the Medicaid program for reasons listed under Wisconsin Admin. Code § DHS 106.06 as well as the reasons listed below in Article X.E.7.b and d. The Department will inform the PIHP when a provider is terminated from the Wisconsin Medicaid program for cause and the PIHP must terminate that provider from its network.

    b. The PIHP must terminate a provider for cause if the PIHP learns of the following provider misconduct:

       i. Criminal Conviction. The provider or 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 PIHP receives permission from the Department to not terminate the provider as identified in X.D.7.c.

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. This requirement applies unless the PIHP receives permission from the Department to not terminate the provider as identified in X.D.7.c.

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 fails to submit timely and accurate information. This requirement applies unless the PIHP receives permission from the Department to not terminate the provider as identify X.D.7.c.

v. Onsite Review. The provider fails to permit access to provider locations for any site visit. This requirement applies unless the PIHP receives permission from the Department to not terminate the provider as identified in X.D.7.c.

vi. Terminated or Revoked for Cause under Separate Medicaid or Medicare Enrollment. The provider's enrollment has been terminated or revoked "for cause" by Medicare or another state's Medicaid program.

vii. Provider Conduct. The provider or any owner, or managing employee, of the provider is excluded from the Medicare or Medicaid programs.

c. The PIHP must terminate a provider due to a reason in Article X.D.7.b.i and iii-v, unless the PIHP obtains approval from the Department to not terminate the provider. This process is not available for an PIHP when a provider must be terminated due to a reason in Article X.D.7.b.ii or vi. The PIHP must contact its Managed Care Analyst to request permission to not terminate the provider. The Managed Care Analyst shall alert the DHS OIG of the request. The DHS OIG will determine whether the termination can be waived.

d. The PIHP 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. Improper Prescribing Practices. The PIHP determines that a provider has a pattern of practice of prescribing drugs that is abusive, as defined in 42 C.F.R.§ 455.2, or represents a threat to the health and safety of members.

iv. 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.

v. 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.

vi. 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.

11. The PIHP must notify DHS OIG and the Child and Family Program Specialist when it terminates a provider for cause. See Article XII.M.7 for reporting requirements. The PIHP must report to other entities as required by law (42 USC 11101 et. Seq.).

12. The PIHP must determine and verify at specified intervals that:

a. Each provider, other than an individual practitioner is licensed to operate in the state, if licensure is required, and in compliance with any other applicable state or federal requirements; and

b. The PIHP verifies if the provider claims accreditation, or is determined by the PIHP to meet standards established by the PIHP itself.

13. These standards do not apply to:

a. Providers who practice only under the direct supervision of a physician or other provider, and

b. Hospital-based providers such as emergency room physicians, anesthesiologists, and other providers who provide services only incident to hospital services.

These exceptions do not apply if the provider contracts independently with the PIHP.

E. Member Feedback on Quality Improvement

1. The PIHP must have a process to maintain a relationship with its members that promotes two-way communications and contributes to quality of care and service. The PIHP must treat members with respect and dignity.
2. The PIHP must demonstrate monitoring of member satisfaction as an input to improving quality of care and service.
3. The PIHP is encouraged to find additional ways to involve members in quality improvement initiatives and in soliciting member feedback in quality of care and services the PIHP provides. Other ways to bring members into the PIHP's efforts to improve the health care delivery system include but are not limited to focus groups, member advisory councils, member participation on the governing board, the QAPI committees or other committees, or task forces related to evaluating services. All efforts to solicit feedback from members must be approved by the Department.

F. Medical Records

1. Per 42 CFR § 438.208(b)(5), the PIHP must have written policies and procedures for participating provider health records content and documentation that have been communicated to providers and a process for evaluating its providers' medical records based on the PIHP's policies. The PIHP should encourage use of Certified Electronic Health Record Technology (CEHRT) by clinicians for documenting and sharing clinical information as well as use of the Office of National Coordinator's (ONC) Interoperability Standards Advisory best available standards to share information electronically across the continuum of care. These policies must also address patient confidentiality, data organization and completeness, tracking, and important aspects of documentation such as accuracy, legibility, and safeguards against loss, destruction, or unauthorized use. The PIHP must also have confidentiality policies and procedures that are applicable to administrative functions that are concerned with confidential patient information. Those policies must include information with respect to disclosure of member-identifiable medical record and/or enrollment information and specifically provide:

   a. That members may review and obtain copies of medical records information that pertains to them.

b. That members have the right to request and receive a copy of their medical records, and to request that they be amended or corrected (Wis. Stat. s. 146.83).

c. That policies above must be made available to members upon request.

2. Patient medical records must be maintained in an organized manner (by the PIHP, and/or by the PIHP's subcontractors) that permits effective patient care, reflect all aspects of patient care and be readily available for patient encounters, administrative purposes, and Department review.

3. Because the PIHP is considered a contractor of the state and therefore (only for the limited purpose of obtaining medical records of its members) entitled to obtain medical records according to Wis. Adm. Code, DHS 104.01(3), the Department requires WI FCMH enrolled providers to release relevant records to the PIHP to assist in compliance with this section. The PIHP that has not specifically addressed photocopying expenses in their provider contracts or other arrangements, are liable for charges for copying records only to the extent that the Department would reimburse on a FFS basis.

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

5. The PIHP must have written quality standards and performance goals for participating provider medical record documentation and be able to demonstrate, upon request of the Department, that the standards and goals have been communicated to providers. The PIHP must actively monitor compliance with established standards and provide documentation of monitoring for compliance with the standards and goals upon request of the Department.

6. Health records must be readily available for PIHP-wide Quality Assessment/Performance Improvement (QAPI) and Utilization Management (UM) activities.

   For health records and any other health and enrollment information that identifies a particular member, the PIHP uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.

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

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

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

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

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

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

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

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

The Department requires PIHP participation in Wisconsin Statewide Health Information Network (WISHIN), the state-designated entity for health information exchange, to facilitate exchange of medical records between health plans and providers. The Department considers PIHPs compliant with the medical record requirements in Article X.F. by participating in WISHIN. All PIHPs must participate in WISHIN, specifically including subscribing to the WISHIN Pulse community health record, submitting a member roster as specified by WISHIN, and subscribing to the WISHIN Patient Activity Report (PAR) or other event-notification service offered by or through WISHIN.

8. The PIHP shall use its best efforts to assist members and their authorized representatives in obtaining complete records, including progress notes, within 10 working days of the record request.

9. Minimum medical record documentation per chart entry or encounter must conform to the Wis. Adm. Code, Chapter DHS 106.02(9)(b) medical record content.

G. Utilization Management (UM)

1. The PIHP and its subcontractors must have documented policies and procedures for all UM activities that involve determining medical necessity and processing requests for initial and continuing authorization of services (42 CFR § 438.210(b)(1)).

The PIHP must communicate to providers the criteria used to determine medical necessity and appropriateness. The criteria for determining medical necessity may not be more stringent than what is used in the State Medicaid program, as set forth in Wis. Adm. Code § DHS 101.03(96m), including any quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the

State Plan, and other published State policy and procedures. Documentation of denial of services must be available to the Department upon request.

Pursuant to 42 CFR § 438.210(b)(2), the PIHP must:

a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

b. Consult with the requesting provider for medical services when appropriate.

When reviewing requests for authorization of services, qualified medical professionals must be involved in any decision-making that requires clinical judgment. The decision to deny, reduce or authorize a service that is less than requested must be made by a health professional with appropriate clinical expertise in treating the affected member's condition(s). The PIHP may not deny coverage, penalize providers, or give incentives or payments to providers or members that are intended to reward inappropriate restrictions on care or results in the under-utilization of services.

2. If the PIHP delegates any part of the UM program to a third party, the delegation must meet the requirements in this Contract.

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

4. The PIHP's policies must specify time frames for responding to requests for initial and continued service authorizations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited responses to requests for authorization of urgently needed services. In addition, the PIHP must have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (interrater reliability).

   a. Within the time frames specified, the PIHP must give the member and the requesting provider written notice of:

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

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

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

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

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

i. Within 14 days of the receipt of the request, or

ii. Within 72 hours if the provider indicates, or the PIHP determines, that following the ordinary time frame could jeopardize the member's health or ability to attain, maintain, or regain maximum function.

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

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

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

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

7. Postpartum discharge policy for mothers and infants must be based on medical necessity determinations. This policy must include all follow-up tests and treatments consistent with currently accepted medical practice and applicable federal law. The policy must allow at least a 48-hour hospital stay for normal spontaneous vaginal delivery, and 96 hours for a cesarean section delivery, unless a shorter stay is agreed to by both the physician and the member. The PIHP may not deny coverage, penalize providers, or give incentives or payments to providers or members. Post hospitalization follow-up care must be based on the medical needs and circumstances of the mother and infant. The Department may request documentation demonstrating compliance with this requirement.

H. Accreditation

Per 42 CFR § 438.332, the PIHP must report to the Department if it is accredited by a private independent accrediting agency. PIHPs that have received accreditation by a private independent accrediting agency (AAAHC, NCQA, and URAC) must provide the state with a copy of its most recent accreditation review, as part of the PIHP certification application process. This copy must contain:

a. PIHP accreditation status;

b. Name of the CMS-recognized accreditation entity;

c. The effective start and end dates of accreditation;

d. The lines of business / specific member population for which the accreditation was achieved (e.g., commercial and/or Medicaid, etc.);

e. The specific accreditation status of the PIHP, including survey type and level (as applicable); and

f. Accreditation results from the accreditation entity, including recommended actions or improvements, correction action plans and summaries of findings.

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

I. Performance Improvement Priority Areas and Projects

Per 42 CFR § 438.330, the PIHP must have an ongoing program of performance improvement projects (PIPs) to address the specific needs of its members. The PIPs must address one clinical and one non-clinical performance areas that are expected to have a favorable effect on health outcomes and member satisfaction.

The Department will permit the development of collaborative relationships among the PIHPs, local health departments, community-based behavioral health treatment agencies (both public and private), and other community health organizations to achieve improved services in priority areas. The Measurement Year (MY) starts on January 1 and ends on December 31 of the applicable contract year.

1. The PIHP is required to submit two PIPs each year.
   a. One clinical and one non-clinical.
   b. The Racial Disparity PIP referenced in Article X.K of this contract may constitute the non-clinical.
2. The State has the authority to select a particular topic for the PIPs. Additionally, CMS, in consultation with the State and stakeholders, may specify performance measures and topics for performance improvement projects. The performance improvement topic must take into account the prevalence of a condition among, or need for a specific service by, the FCMH members served under this Contract; enrollee demographic characteristics and health risks; and the interest of consumers or purchasers in the aspect of care or services to be addressed.
3. The PIHP should use quality-of-care measures for children, including assessments of structure, process, health, and/or functional outcomes.

   Clinical priority areas include but are not limited to:

   a. Incorporation of trauma-informed competence and services into FCMH practice and service delivery;
   b. Utilization of evidence=based, trauma-informed behavioral health substance/abuse services;
   c. Quality of outpatient behavioral and mental health services;
   d. Behavioral health joint care planning and accountability;
   e. Evaluation of the need for specialty services;
   f. Children with special health care needs identification and services;

g. High volume/high-risk services identified by the PIHP (e.g., psychotropic medication management, asthma);

h. Prevention and care of acute and chronic conditions;

i. Comprehensive/complex care coordination;

j. Care coordination and health/mental health promotion;

k. Transitional care across settings;

l. Appropriate monitoring and management of medication by a qualified provider.

Non-clinical priority areas include, but are not limited to:

a. Wait times for an appointment to see a primary care provider or medical specialist or to receive a specialized service or piece of equipment;

b. Access to specialized transportation services;

c. Adequacy of the behavioral and mental health network with regard to geographic accessibility to its members;

d. Monitoring of complaints, grievances and appeals (e.g., are the PIHP's complaint mechanisms easy to use?);

e. Mechanisms to collect information from pediatric providers on how well the FCMH's system works for their patients;

f. Mechanisms to involve consumer/family participation in the PIHP's policy development;

g. Using a member satisfaction survey targeted to specific pediatric populations (e.g., with chronic conditions);

h. Use of health information technology.

4. Health plans should submit PIPs which use objective quality indicators to measure the effectiveness of the interventions. Per 42 CFR § 438.330(d)(2), PIHPs should submit PIPs which include the planning and initiation of activities for sustaining or continuing PIP improvement over time. Plans should not submit baseline studies which are designed to evaluate whether a problem exists.

5. The PIHP must submit a preliminary PIP proposal summary that meets the PIP guidelines issued by the EQRO as described in the PIHP Quality Guide for the applicable MY, and state the proposed topic, the study question/project aims with a measurable goal, study indicators, study population, sampling methods if applicable, data collection procedures, improvement strategies, sustained improvement plan, and the prospective data analysis plan. The preliminary PIP proposal must be submitted to the Department by email to the EQRO by the first business Day of November.

a. The Department and the EQRO will review the preliminary PIP proposals and meet with the PIHP to give feedback to the PIHP on the PIP proposal. The Department will determine if the PIP proposals are approved. Suggestions arising from the EQRO and PIHP dialogue should be given consideration as the PIHP proceeds with the PIP implementation.

b. If the proposal is rejected by the Department, the PIHP must re-submit a new or revised PIP proposal within the timeframe specified by the Department. Re-submission will be reviewed again by the Department and the EQRO.

6. After receiving the State's approval, the PIHP may communicate with the EQRO throughout the implementation of the project if questions arise.

7. The PIHP should perform ongoing monitoring of the project throughout the year to evaluate the effectiveness of its interventions.

8. After implementing the PIP over one calendar year, the PIHP must submit to the FCMH Contract Monitor, or the EQRO their completed PIP reports utilizing the format provided by the Department by the first business day of July of the following year.

9. The EQRO will schedule a conference call with the PIHP to review the EQRO feedback on the final PIP report.

10. Per 438.330(e)(1), if an PIHP submits a multi-year PIP, it must submit annual proposals and final reports, which the EQRO will review and report on results trended over multiple years.

11. The EQRO may recommend a PIHP's PIP for inclusion in Wisconsin's Best Practices Seminars in which all the PIHPs will participate.

12. The Department will consider that the plan failed to comply with PIP requirements if:

    a. The plan submits a final PIP on a topic that was not approved by the Department and the EQRO.

    b. The EQRO finds that the PIP does not meet federal requirements:

        i. The PIP does not define a measurable goal using clear and objective quality indicators.

        ii. The PIP does not include the implementation of systemic interventions to improve quality of care.

        iii. The PIP does not evaluate systematically the effectiveness of the interventions.

        iv. The PIP does not reflect the adoption of continuous cycles of improvement through which the PIHP can sustain quality improvement.

c. The PIHP does not submit the final PIP by its due date of the first business day of July of the year in which it's due. The Department may grant extensions of this deadline, if requested prior to the due date.

d. Failure to comply with PIP requirements may result in the application of sanctions described in Article XIV.D.

13. Ten Steps to a Successful PIP

Step 1: Describe the project/study topic.

Step 2: Describe the study questions/project measurable goals.

Step 3: Describe the selected study indicators/project measures and baseline data.

Step 4: Describe the identified population for which the study or project is aimed at.

Step 5: Describe the sampling methods used (if any).

Step 6: Describe the organization's data collection procedures.

Step 7: Describe the organization's interventions and improvement strategies.

Step 8: Describe the organization's data analysis plan and the interpretation of results from data collection.

Step 9: Describe the likelihood that the reported improvement is real improvement.

Step 10: Identify lessons learned and assess the sustainability of its documented improvement.

J. Public Reporting

The Department will publicly report various quality and other performance metrics for PIHPs via a website and other media, per 42 CFR § 438.608 Requirement 42 CFR § 438.340.

K. Health Disparity Plan

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

As part of the Performance Improvement Projects, the PIHP has developed a health disparities reduction plan and must continue to make progress in identifying and addressing health disparities within its membership as part of its ongoing QAPI workplan.

L. FCMH Quality Measures

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. Time Frame. 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 FCMH. 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 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 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 aged 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 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 specification 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 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 antipsychotic 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, how well doctors communicate, health plan customer service, and how people ate the health plan. The Department will use the latest AHRQ specifications available.

XI. PIHP Administration

A. Compliance with Applicable Law

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

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

The Department may incorporate into the Contract any change in covered services mandated by federal or state law effective the date the law goes into effect, if it adjusts the capitation rate accordingly. The Department will give the PIHP at least 30 days' notice before the intended effective date of any such change that reflects service increases, and the PIHP may elect to accept or reject the service increases for the remainder of that contract year. The Department will give the PIHP 60 days' notice of any such change that reflects service decreases, with a right of the PIHP to dispute the amount of the decrease within 60 days. The PIHP has the right to accept or reject service decreases for the remainder of the Contract year. The date of implementation of the change in coverage will coincide with the effective date of the increased or decreased funding. This section does not limit the Department's ability to modify this Contract due to changes in the state budget.

The PIHP is not endorsed by the federal or state government, CMS, or similar entity.

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

B. Organizational Responsibilities and Duties

1. Ineligible Organizations

   Upon obtaining information or receiving information from the Department or from another verifiable source, the PIHP must exclude from participation in the PIHP all organizations that could be included in any of the categories defined in Article XI.B.1.a.(references to the Act in this section refer to the Social Security Act).

a. Entities that could be excluded under Section 1128(b)(8) of the Social Security Act are entities in which a person who is an officer, director, agent or managing employee of the entity, or a person who has direct or indirect ownerships or control interest of 5% or more in the entity has:

i. Been convicted of the following crimes:

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

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

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

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

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

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

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

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

i. The administration, management, or provision of medical services.

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

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

c. Entities that employ, contract with, or contract through any individual or entity that is excluded from participation in Medicaid under Section 1128 or 1128A, for the provision (directly or indirectly) of health care, utilization review, medical social work or administrative services. For the services listed, the PIHP must refrain from contracting with any entity that employs, contracts with, or contracts through an entity that has been debarred or excluded from participation in Medicaid by the Secretary of Health and Human Services under the authority of Section 1128 or 1128A of the Act.

d. Foreign Entities

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

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

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

2. Contract Representative

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

3. Attestation

The PIHP's Chief Executive Officer (CEO), the Chief Financial Officer (CFO) or designee must attest to the best of their knowledge to the truthfulness, accuracy, and completeness of all data submitted to the Department. This includes encounter data, ventilator dependent member data, provider and facility network submissions, comprehensive exam reports and health data indicators and any other data regarding claims the PIHP paid.

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

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

Certain Recipients and Vendors must also comply with Wis. Stats., s.16.765, and Administrative Code (ADM) 50, which require the filing of an Affirmative Action Plan (AA Plan). The Affirmative Action Plan is NOT part of the CRC Plan.

a. Affirmative Action Plan

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

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

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

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

Compliance with the requirements of the AA Plan will be monitored by the DHS, Office of Affirmative Action and Civil Rights Compliance.

b. Civil Rights Compliance (CRC) Plan

i. The PIHP receiving federal and/or state funding to administer programs, services and activities through DHS must file a Civil Rights Compliance Letter of Assurance (CRC LOA). All PIHPs

with fifty (50) or more employees AND who receive over $50,000 in funding must complete a Civil Rights Compliance Plan (CRC Plan). The CRC Plan is to be kept on file and made available upon request to any representative of the Department. The instructions and template to complete the requirements for the CRC Plan are found at http://dhs.wisconsin.gov/civilrights/Index.HTM.

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

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

ii. PIHPs subcontracting federal or state funding to other entities must obtain a CRC LOA from their subcontractors. The CRC LOA must be kept on file and produced upon request or at the time that an on-site monitoring visit is conducted. Subcontractors with fifty (50) or more employees AND who receive over $50,000 in funding must complete a CRC Plan. The CRC Plan is to be kept on file and produced upon request by the DHS AA/CRC Office, a representative of the DHS or at the time the PIHP conducts an on-site monitoring visit.

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

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

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

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

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

5. Non-Discrimination in Employment

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

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

employment, notices to be provided by the contracting officer setting forth the provisions of the non-discrimination clause.

Contractor further agrees not to subject qualified persons to discrimination in employment in any manner or term or condition of employment on the basis of arrest record, conviction record, genetic testing, honesty testing, marital status, military service, pregnancy or childbirth, or use of legal products during non-work hours outside of the employer's premises, except as otherwise authorized by applicable statutes.

All PIHP employees are expected to support goals and programmatic activities relating to non-discrimination and non-retaliation in employment.

With respect to provider participation, reimbursement, or indemnification, the PIHP will not discriminate against any provider who is acting with the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification. This shall not be construed to require the PIHP to contract with providers beyond the number necessary to meet the needs of the WI FCMH population. This shall not be construed to prohibit the PIHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or from establishing any measure designed to maintain quality and control cost consistent with these responsibilities. If the PIHP declines to include an individual or group of providers in its network, it must give the affected providers written notice of the reason for its decision.

6. Provision of Services to the PIHP Members

The PIHP must provide contract services to WI FCMH members under this Contract in the same manner as those services are provided to other members of the PIHP.

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

Per 42 CFR § 438.210(a)(3), the PIHP:

a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished to members in Medicaid fee for service.

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

c. May place appropriate limits on a services on the basis of criteria applied under the State Plan, such as medical necessity; or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

7. PIHP Staffing Level to Support Providers

At the time of contract renewal and at service area expansion request, the PIHP must have appropriate staffing levels for the entire service area to support contracted provider participation and timely claim payment, per Art. XIV, D, 2.

The PIHP must:

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

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

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

8. Access to Premises

The PIHP must allow duly authorized agents or representatives of the state or federal government access to the PIHP's or PIHP subcontractor's premises during normal business hours to inspect, audit, monitor or otherwise evaluate the performance of the PIHP's or subcontractor's contractual activities and shall produce all records requested as part of such review or audit within a reasonable time, but not more than 10 business days. Upon request for such right of access, the PIHP or subcontractor must provide staff to assist in the audit or inspection effort, and adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort. All inspections or audits must be conducted in a manner as will not unduly interfere with the performance of PIHP's or subcontractor's activities. The PIHP will have 30 business days to respond to any findings of an audit before the Department finalizes it. All information obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations.

9. Liability for the Provision of Care

Remain liable for provision of care for that period for which capitation payment has been made in cases where medical status code changes occur subsequent to capitation payment.

10. Subcontracts

The PIHP must ensure that all subcontracts are in writing, comply with the provisions of this Contract that are appropriate to the service or activity, and

ensure that all subcontracts do not terminate legal liability of the PIHP under this Contract. The PIHP may subcontract for any function covered by this Contract, subject to the requirements of Article XIV, B.

11. Coordination with Community-Based Health Organizations, Local Health Departments, Division of Milwaukee Child Protective Services, Prenatal Care Coordination Agencies, School-Based Services Providers, Targeted Case Management Agencies, School-based Mental Health Services, Birth to Three Program Providers, and Healthy Wisconsin

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

    a. Community-Based Health Organizations

        The Department encourages the PIHP to contract with community-based health organizations for the provision of care to WI FCMH members in order to ensure continuity and culturally appropriate care and services. Community-based organizations can provide HealthCheck outreach and screening, immunizations, family planning services, and other types of services.

        The Department encourages the PIHP to work closely with community-based health organizations. Community-based health organizations may also provide services, such as WIC services, that the PIHP is required by federal law to coordinate with and refer to, as appropriate.

    b. Federally Qualified Health Centers (FQHC)

        PIHPs must make at least two good faith written and documented efforts to contract at a reasonable market rate with FQHCs located within their service area for the provision of care to WI FCMH members.

    c. Local Health Departments

        The Department encourages the PIHP to contract with local health departments for the provision of care to WI FCMH members in order to ensure continuity and culturally appropriate care and services. Local health departments can provide HealthCheck outreach and screening, immunizations, blood lead screening services, and services to targeted populations within the community for the prevention, investigation, and control of communicable diseases (e.g., tuberculosis, HIV/AIDS, sexually transmitted diseases, hepatitis and others).

        The Department encourages the PIHP to work closely with local health departments. Local health departments have a wide variety of resources that could be coordinated with the PIHP to produce more efficient and cost-effective care for the PIHP members. Examples of such resources are ongoing medical services programs, materials on health education, prevention, and disease states, expertise on outreaching specific sub-

populations, communication networks with varieties of medical providers, advocates, community-based health organizations, and social service agencies, and access to ongoing studies of health status and disease trends and patterns.

d. Child Welfare Coordination

PIHPs must designate at least one staff member to serve as a contact with county child welfare agencies and the Division of Milwaukee Child Protective Services (DMCPS), in the Wisconsin Department of Children and Families. If the PIHP chooses to designate more than one contact person the PIHP should identify the service area for which each contact person is responsible. The Department encourages PIHPs to designate a staff member with at least two years of experience working in a child welfare agency, or who has attended child welfare training through the Wisconsin Child Welfare Training Partnership.

In Milwaukee County, PIHPs must provide all WI FCMH covered mental health and substance abuse services to individuals identified as clients of DMCPS. Disputes regarding the medical necessity of services identified in the Family Treatment Plan will be adjudicated using the dispute process, except that the PIHP must provide court-ordered services.

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

e. Prenatal Care Coordination (PNCC) Agencies

The PIHP must coordinate services with a MA certified PNCC agency providing MA services to PIHP-enrolled members. To ensure coordination, the PIHP shall:

i. Sign a memorandum of understanding (MOU) with all PNCC agencies in the PIHP service area. The Department provides a template MOU that can be found at ForwardHealth Online Wisconsin Managed Care and Medicaid Handbook Topic #16917. The PIHP may require a PNCC agency to demonstrate to the PIHP that all other criteria under Administrative Rule DHS 105.52(4) have been met prior to signing the MOU.

ii. Assign an PIHP representative to coordinate member services and care with the PNCC agency.

f. School-Based Services (SBS) Providers

The PIHP must use its best effort and document attempts to sign a MOU with all SBS providers in the PIHP service area to ensure continuity of care and to avoid duplication of services. School based services are paid FFS when provided by a BadgerCare Plus enrolled SBS provider. However, in situations where a member's course of treatment is

interrupted due to school breaks, after school hours or during the summer months, the PIHP is responsible for providing and paying for all BadgerCare Plus covered services. The PIHP must not consider SBS (e.g. physical, occupational, and speech and language therapy services) as automatically duplicative when it is considering the medical necessity of a requested community based service.

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

g. Targeted Case Management (TCM) Agencies

The PIHP must interface with the case manager from the TCM agency to identify what WI FCMH covered services or social services are to be provided to a member. The PIHP is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the PIHP.

h. School-based Mental Health Services

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

i. Birth to 3 Program Providers

PIHPs are 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 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.

PIHPs reimburse 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 Service Plan (IFSP), and the provider is employed by or under contract with a Birth to 3 Program Agency. PIHPs 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.

PIHPs must authorize PT, OT, or SLP services that are provided with an initial evaluation and assessment and that are identified in and requested at the same frequency, intensity, and duration listed in the member's IFSP. PIHPs should not impose additional medical necessity criteria for Birth to 3 Program services. PIHPs are 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 PIHP.

To approve non-Birth to 3 prior authorization requests for therapeutic services, PIHPs should verify that the provider request includes confirmation that the child has been referred to the Birth to 3 Program. Such confirmation includes caregiver discussion regarding the availability of the Birth to 3 Program, review of member medical records with confirmed referral in the record, or direct referral by the therapy provider to the Birth to 3 Program. PIHPs may also accept the IFSP or Child Enrollment Status Regarding Birth to 3 Program form from PTs, OTs or SLPs as a method of confirmation.

Generally, the State or Birth to 3 Program must obtain parental consent before the State or Birth to 3 Program can disclose a child's personally identifiable information to the Department. As allowed by federal regulations, parents or guardians may refuse consent to bill their commercial health insurance for services received through the Birth to 3 Program. Birth to 3 Program services are an exception to Medicaid being the payor of last resort.

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. A child's natural environment includes settings that are natural and normal for the child's age peers who have no disability as defined in 34 FCR 303 and Wis. Admin. Code. § DHS 90.03(25). Natural environments may include the child's home, natural environments may include family childcare, community settings (e.g., YMCA), early childhood education settings, inclusive childcare centers, or other settings where most of the children do not have disabilities. Natural environments do not include medical facilities such as therapy clinics, physician clinics, rehabilitation agencies, outpatient hospitals, or other center-based settings where most of the participating children have disabilities. PIHPs are encouraged to develop MOUs with county Birth to 3 Program agencies in their service area.

PIHPs are 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. PIHPs may impose their standard medical necessity criteria

when authorizing therapy services outside the Birth to 3 Program for a child under 3.

PIHPs can find a list of county contacts for Birth to Three programs on the Department website.

j. Healthy Wisconsin

The Department encourages PIHPs to serve as partners in Healthy Wisconsin, the state's health assessment and health improvement plan. This includes the PIHP working towards objectives that influence the health of the public and long-term goals for the decade. More information on Healthy Wisconsin can be found at:

https://healthy.wisconsin.gov/content/about-us

k. Local WIC Agencies

The PIHP is encouraged to use the DMS/DPH agreement template as a guide and enter into an agreement with Local WIC Agencies within the PIHP's service area for the purpose of collaboration of care and to ensure referrals between the parties are made. The PIHP is required to refer all WIC categorically eligible PIHP members to the Local WIC Agency. The WIC Program provides nutrition services, supplemental foods, breast feeding promotion and support, and immunization screening. Some Local WIC Agencies are WI Medicaid enrolled as HealthCheck – Other Services providers and may contract with PIHPs for blood lead poisoning screenings performed during the WIC appointment as a Medicaid-billable service.

l. Prenatal Care Coordination (PNCC) Agencies

The PIHP must coordinate services with a MA certified PNCC agency providing MA services to PIHP-enrolled members. To ensure coordination the PIHP shall:

i. Sign a memorandum of understanding (MOU) with any PNCC providers in the PIHP service area upon request of the PNCC provider. The Department provides a template MOU that can be found at ForwardHealth Online Wisconsin Managed Care and Medicaid Handbook Topic #16917. The WI FCMH may require a PNCC agency to demonstrate to the PIHP that all other criteria under Administrative Rule 105.52(4) have been met prior to signing the MOU.

ii. Assign a PIHP representative to coordinate member services and care with the PNCC agency.

12. Clinical Laboratory Improvement Amendments (CLIA)

The PIHP must use only laboratories that have a valid CLIA certificate along with a CLIA identification number, and comply with federal CLIA regulations as specified by 42 CFR Part 493. Those laboratories with certificates must provide only the types of tests permitted under the terms of 42 CFR Part 493.

13. PIHP Responsibilities in the Event of a Federal or State Declared Emergency:

PIHPs are required to submit an annual plan, to maintain business operations in the event of a state or federal declaration of disaster or State of Emergency by June 30th. The PIHP must cooperate with DHS' efforts to ensure minimal disruption to the ForwardHealth program and the members served.

a. Continuity of Operations

i. Business Continuity Plan

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

a) A description of how the health plan will organize and assign the urgency with which activities and processes will need to be resumed in the event of a disruption including:

1) Member's access to services. The health plan must:

A) Establish provisions to ensure that members are able to see Out-of-Network Providers if the member has a permanent address in the federal or state declared disaster areas and are unable to access In-Network providers.

B) Establish provisions to ensure that members are able to use telehealth services if the member has a permanent address in the federal or state declared disaster areas.

C) Provide detailed plans it will use to ensure that prior authorizations are extended and transferred without burden to new providers if directed by DHS, and the means by which the health plan will identify the location of members who have been displaced.

D) Report status of members and issues regarding member access to covered services as directed by DHS.

b) Claims Payment

1) A description of how the health plan will address the following activities:

A) Timely provider claims processing and payment consistent with DHS contract requirements and health plan-provider contract policies.

B) Establishing provider contract language that addresses relaxed health plan timely filing requirements for provider service claims provided in good faith with reasonable submission delay due to a Federal or State declared disaster or emergency and submit to DHS for review.

C) Honoring unauthorized provider claims consistent with ongoing treatment due to demonstrated patient need or urgent patient need occurring during a Federal or State declared disaster or emergency period where heath plan authorization communications and processes were delayed or failed.

D) Providing a communication and interim plan for approval by DHS should they experience a disruption that risks the ability to meet the claims processing/payment timeline requirements.

c) Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a disruption to determine at what point in time the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.

d) Inclusion of a risk assessment that reviews the probability and impact of various threats to the health plan's operations. This involves stress testing the health plan's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the health plan in refining its business impact analysis and in developing a business continuity strategy.

e) Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.

1) Health Plans must ensure that proper training is provided for each role under this provision.

f) Criteria for executing the business continuity plan, including escalation procedures.

1) A detailed communication plan with members, employees, providers, the Department, and other stakeholders including: Coordinating with DHS or any other local, state, or federal agencies as needed during the disaster or emergency response. This coordination may vary based on type of situation; however, anticipated coordination includes, but is not limited to:

A) Designating a Point of Contact (POC) for continuity of operations specifically related to disaster preparedness in order to communicate the health plan's response to the DHS emergency preparedness POC.

B) Designating a POC to support members residing in Tribal Lands where applicable.

C) Participating in meetings with DHS or other agencies

D) Assisting with impacted member or provider communications

E) Facilitate effective communication with members, providers and staff regarding the impact of the disaster as well as a process by which inquiries may be submitted and addressed.

F) Implementing policy, process, or system changes at the direction of DHS, keeping DHS informed on the progress of the implementation

G) Additional communication and/or reporting requirements through the duration of the emergency

H) The health plan must notify DHS of any contract flexibilities or extensions needed during the course of the emergency or

disaster. DHS will maintain a health plan emergency/disaster response guide to document any such approved flexibilities or revised deadlines, outside the contract amendment process.

I) Permission from DHS, contingent on approval of content, to do one-time member outreach via text message to those who have not opted into text messaging, to inform members about the disaster or emergency, offer PIHP resources or contact information, and instructions on how to opt into text messaging.

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

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

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

h) Recovery time for each major business function, based on priority.

i) Business workflow and workaround procedures, including alternate processing methods and performance metrics.

j) Recording and updating business events information, files, and data, once business processes have been restored.

k) Documentation of security procedures for protection of data through web-based cloud application.

l) Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.

m) A description of an annual testing and evaluation plan.

n) A description of the health plan familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The health plan will negotiate the role of the health plan and the county roles in emergency response.

1) Health plans must ensure annually the readiness of the plan by conducting exercises carrying out the plan's provisions, evaluate its performance and make necessary updates. The health plan must coordinate with local emergency management departments, local agencies and DHS prior to an event to understand local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

o) A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.

1) Care Coordination

A) The health plan must ensure that care coordination for all members are compliant with the health plan's emergency recovery plan. In particular, care coordination for members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if covered service are disrupted or interrupted.

p) Emergency Recovery Plan

1) The Emergency Recovery Plan shall address, at a minimum, the following recovery aspects related to the management information system and where appropriate, use web-based cloud applications:

A) Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.

B) Communication plan for critical personnel, key stakeholders and business partners involved in the health plan's management information system.

iii) Including the health plan's ability to provide continuous services to members and maintain critical operations in the even employees are unavailable to work remotely for extended periods of time.

C) Periodic back-up which is adequate and secure for all computer software and

operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).

D) Full and complete back-up copies of all data and software.

E) Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.

F) Policies and procedures for purging outdated backup data.

G) Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.

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

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

The PIHP shall implement requirements from the CMS "Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers" final rule (85 FR 25510). The PIHP shall implement these interoperability requirements in accordance with the applicable specifications of the Office of the National Coordinator's (ONC's) "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program" companion final rule (85 FR 25642).

The PIHP shall implement:

a. Patient Access Application Programming Interface (API): The PIHP shall provide members with the ability to access their own personal health information, including structured claims and encounter information, costs, and a defined sub-set of their clinical information as outlined at 42 CFR § 422.119, 42 CFR § 431.60, 42 CFR § 457.730, and 45 CFR § 156.221, specifically for the Patient Access API, and current version of the United States Core Data for Interoperability (USCDI) dataset. The PIHP will be responsible for the Patient Access API, including all applicable technology standards, supporting technology infrastructure, and security protocols required to conform with the CMS final rule. This information shall be

provided via an HL7 FHIR compliant standards-based API available to third-party applications of the member's choice.

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

c. Payer-to-Payer Data Exchange: The PIHP shall provide members with the ability to exchange certain patient clinical data (specifically the current version of the U.S. Core Data for Interoperability (USCDI) data set). Members shall have the ability to request the transfer of all clinical data from an assigned payer to a future payer to enable health data portability. The PIHP is required to conform with 42 CFR 438.62(b)(1)(vi) & (vii) for Medicaid managed care plans (and by extension under § 457.1216 CHIP managed care entities) and implement a process for this data exchange beginning January 1, 2022.

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

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

PIHPs must make documentation related to implementation of these requirements as required in the CMS final rule (85 FR 25510) available to Wisconsin Division of Medicaid Services upon request.

C. Confidentiality of Records and HIPAA Requirements

The parties agree that all information, records, and data collected in connection with this Contract will be protected from unauthorized disclosure as provided in Chapter 49, Subchapter IV, Wis. Stats., DHS 108.01, Wis. Adm. Code, 42 CFR Part 431 Subpart F, 42 CFR Part 438 Subpart F and 45 CFR Parts 160, 162, and 164 and any other confidentiality law to the extent that these requirements apply. Except as otherwise

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

1. Duty of Non-Disclosure and Security Precautions

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

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

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

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

2. Limitations on Obligations

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

   a. is part of the public domain without any breach of this Agreement by PIHP;

   b. is or becomes generally known on a non-confidential basis, through no wrongful act of PIHP;

   c. was known by PIHP prior to disclosure hereunder without any obligation to keep it confidential;

   d. was disclosed to it by a third party which, to the best of PIHP's knowledge, is not required to maintain its confidentiality;

   e. was independently developed by PIHP; or

f. is the subject of a written agreement whereby the State consents to the disclosure of such Confidential Information by PIHP on a non-confidential basis.

3. Legal Disclosure

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

4. Unauthorized Use, Disclosure, or Loss

If PIHP 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, PIHP shall notify the State's (Contract Manager/Contact Liaison/Privacy Officer) within the same business day the PIHP becomes aware of such use, disclosure, or loss. Such notice shall include, to the best of the PIHP's knowledge at that time, the persons affected, their identities, and the Confidential Information disclosed.

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

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

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

i. Notify consumer reporting agencies of the unauthorized release.

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

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

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

5. Trading partner requirements under HIPAA

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

a. Trading Partner Obligations

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

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

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

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

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

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

c. Trading Partners or Trading Partner's Business Associate have responsibilities to adequately test business rules appropriate to their types and specialties.

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

e. Trading Partner or Trading Partner's Business Associate understands that from time-to-time HHS may modify and set compliance dates for the HHS Transaction Standards. Trading Partner or Trading Partner's Business

associate must incorporate by reference any such modifications or changes (45 CFR § 160.104).

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

g. Privacy

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

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

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

h. Security

i. The Department and the Trading Partner or Trading Partner's Business Associate must maintain reasonable security procedures to prevent unauthorized access to data, data transmissions, security access codes, envelope, backup files, and source documents. Each party will immediately notify the other party of any unauthorized attempt to obtain access to or otherwise tamper with data, data transmissions security access codes, envelope, backup files, source documents other party's operating system when the attempt may have an impact on the other party.

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

6. Indemnification

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

7. Equitable Relief

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

8. Liquidated Damages

The PIHP agrees that an unauthorized use or disclosure of Confidential Information may result in damage to the State's reputation and ability to serve the public interest in its administration of programs affected by this Agreement. Such amounts of damages which will be sustained are not calculable with any degree of certainty and thus shall be the amounts set forth herein. Assessment under this provision is in addition to other remedies under this Agreement and as provided in law or equity. The State shall assess damages as appropriate and notify the PIHP in writing of the assessment. The PIHP shall automatically deduct the damage assessments from the next appropriate monthly invoice, itemizing the assessment deductions on the invoice.

Liquidated Damages shall be as follows:

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

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

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

9. Compliance Reviews

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

10. Survival

    This Section shall survive the termination of the Agreement.

11. Party in Interest

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

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

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

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

D. Declaration of National or State Emergencies/Disasters:

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

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

XII. Reports and Data

A. Required Use of the Secure ForwardHealth Portal

1. Secure ForwardHealth Portal

    a. The PIHP must request a secure ForwardHealth Portal account to access data and reports, maintain information, conduct financial transactions and other business with DHS. When the PIHP requests an account, the designated PIHP contact will receive a PIN via their email address. The PIN is used to access specific PIHP information on the secure ForwardHealth Portal.

    b. The PIHP must assign users roles/permissions within the secure ForwardHealth Portal account to ensure only authorized users have access to data and functions provided. The PIHP must ensure all users understand and comply with he terms and conditions found in Article XI.C, Confidentiality of Records and HIPAA Requirements, of this contract.

    Detailed information for how to grant roles and permissions can be found at: https://www.forwardhealth.wi.gov/WIPortal/Account/Setup/tabId/111/Default.aspx.

2. Secure File Transfer Protocol

    a. The PIHP must request a secure file transfer protocol account (SFTP) directory (Host Name: ftpb.forwardhealth.wi.gov; Port 22) to submit encounter data, including data related to ventilator payments, and other reports specified by the Department.

    b. The PIHP must designate a single person as the security administrator for the SFTP directory and inform the Department of this person's name, telephone number, and email address. The PIHP must also designate a back-up person for the security administrator and inform the Department of the backup's name, telephone number, and email address. The role of the security administrator is to add and delete user accounts accessing the PIHP's SFTP directory.

    c. The PIHP must ensure user accounts are purged from the SFTP upon the termination of a covered employee or business associate, whether the termination is voluntary or involuntary, and when a current covered employee or business associate no longer has a business need to saccess the SFTP.

    d. The PIHP must ensure all users understand and comply with the terms and conditions found in Article XI.C, Confidentiality of Records and HIPAA Requirements, of this contract.

B. Access to and/or Disclosure of Financial Records

The PIHP and any subcontractors must make available to the Department, the Department's authorized agents, and appropriate representatives of the U.S. Department of Health and Human Services any financial records of the PIHP or subcontractors that relate to the PIHP's capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this Contract. The PIHP must comply with applicable record keeping requirements specified in Wis. Adm. Code ss. DHS 105.02(1)-(7) as amended.

C. Access to and Audit of Contract Records

Throughout the duration of this Contract, and for a period of ten years after termination of this Contract, the PIHP must provide duly authorized representatives of the state (including the Office of the Inspector General) or federal government access to all records and material relating to the PIHP's provision of and reimbursement for activities contemplated under the Contract. Such access shall include the right to inspect, audit and reproduce all such records and material, including but not limited to computer records system, invoices, and to verify reports furnished in compliance with the provisions of this Contract. All information so obtained will be accorded confidential treatment as provided under applicable laws, rules or regulations. Refusal to provide required materials during an audit may subject the PIHP to sanctions in Article XIV.D.

D. Encounter Data and Reporting Requirements

The PIHP is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. PIHP staff will participate with the Department in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA and T-MSIS requirements applicable to the PIHP. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual PIHP meetings with the Department to address changes in requirements, local applications or databases. The PIHP must cooperate with the Department on data submission protocol and testing. The Department or its designee reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract and anytime thereafter. Per 42 CFR § 438.602(e), the Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each PIHP no less frequently than once every three years.

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

    a. The PIHP must participate in PIHP encounter technical workgroup meetings scheduled by the Department.

    b. The PIHP must capture and maintain a claim record of each service or item provided to members, using CMS 1500, UB-04, HIPAA transaction code sets, or other claim, or claim formats that are adequate to meet all reporting requirements of this Contact. The original claim submitted by

the provider must be stored and retrievable upon request by either the Department or CMS.

c. The database must be a complete and accurate representation of all services the PIHP provided during the Contract period.

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

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

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

g. The PIHP must submit adjudicated clean claims as encounters no later than 120 days after the date the PIHP adjudicates the claim. If an PIHP paid encounter is denied within the Department's Medicaid Management Information System (MMIS), the PIHP has 90 days to resolve the encounter to priced status within the system. PIHPs are not subject to the penalty under Article XII.E.6. for failure to submit encounter within 120 days after the date the PIHP adjudicates the claim.

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

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

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

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

3. Testing and Certification Requirements: The electronic test encounter data files are subject to Department review and approval before production data is accepted

by the Department. Production encounters or other documented encounter data must be used for the test data files.

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

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

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

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

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

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

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

5. Encounter Data Certification Requirements:

a. The PIHP must submit accurate, complete, and truthful encounter data that the Department can use for rate-setting, Federal Reporting, special programs and any other purpose deemed necessary by the Department.

b. During the rate development process, upon receiving encounter data summaries from the Department or its actuarial accounting firm, the PIHP must review the encounter data and encounter cata extracts for accuracy and immediately report inaccuracies or discrepancies to the Department and the Department's actuarial accounting firm prior to agreeing to new rates.

c. The requirements for certifying encounter data apply only to the encounter data in files uploaded to a PIHP's encounter reporting SFTP directory.

d. Pursuant to § 438.606, the PIHP must attest that, based on the information, knowledge, and belief, the data, documentation, and information reported

to the Department is accurate, complete, and truthful. The attestation must be made by the Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

iii. The PIHP must assign the person attesting and back upper person the role of "Encounter Data Certifier" available in the Managed Care Organization Portal Page.

iv. Within ten business days of the end of a month, the person attesting must log into the Encounter Data Certifier account and perform the functions in the Portal Page to certify the encounter data uploaded to the Department via SFTP. Per 42 CFR § 438.606(c), this action must be performed each month, and a month's files must be certified separately from the files of anay other month.

v. The certification statement presented by the secure ForwardHealth Portal to the Attesting Officer Reads, "I attest that, based on best information, knowledge, and belief, the data documentation, and information reported to the Department via SFTP for [MONTH][YEAR] is accurate, complete, and truthful."

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

E. Coordination of Benefits (COB), Encounter Record, Member Grievances and Appeals, and Birth Cost Reporting Requirements

The PIHP agrees to furnish to the Department and to its authorized agents, within the Department's time frame and format, information that the Department requires to administer this Contract, including but not limited to the following:

1. Encounter Record for Each Member Service

   An encounter record for each service provided to members covered under this Contract. The encounter data set must include at least those data elements specified in the Encounter User Guide or elements required by the national standards.

2. Member Grievances and Appeals to the PIHP

Copies of all member grievances and appeals and documentation of actions taken on each grievance and appeal.

F. Records Retention

The PIHP must retain, preserve, and make available upon request all records relating to the performance of its obligations under the Contract, including paper and electronic claim forms, for a period of not less than ten years from the date of termination of this Contract. Records involving matters that are the subject of litigation or audit shall be retained for a period of not less than ten years following the termination of litigation or audit. Copies of the documents contemplated herein may be substituted for the originals with the prior written consent of the Department, if the Department approves the microfilming procedures as reliable and supported by an effective retrieval system.

G. Reporting of Corporate and Other Changes

The PIHP must report to the Department through their Managed Care Analyst any change in corporate structure or any other change in information previously reported, such as through the application for certification process. The PIHP must report the change upon submission of the Application of Change in Domestic Company Status with the Office of the Commissioner of Insurance. .

1. Any change in information relevant to ineligible organizations.
2. Any change in information relevant to ownership and business transactions of the PIHP.

H. Provider and Facility Network Data Submission

1. The PIHP that contracts with the Department to provide WI FCMH services must submit a detailed provider network and facility file weekly and when the PIHP experiences significant change with respect to network adequacy (as defined in Article V.D.), to the State's SFTP. The file must be submitted using the format specified in the ForwardHealth Encounters and Reporting Provider Network Universe.
2. The provider network and facility file shall include only Medicaid-enrolled providers who are contracted with the PIHP to provide contract services to SSI members.
3. PIHP must submit complete and accurate provider network and facility data. The Department will provide the PIHP with the required file format layout and data fields. The Department retains the right to conduct audits of provider and facility data for completeness and accuracy during the contract period. Incomplete or inaccurate provider and/or facility data may subject the PIHP to administrative sanctions outlined in Article XIV.D..

I. Financial Template

1. Annual Reporting

a. The PIHP is required to submit financial templates per the schedule and instructions provided in the financial template.

b. As instructed in the Annual PIHP Financial Audit Guide, the PIHP is required to submit a Medicaid supplemental schedule along with the financial template. The Medicaid supplemental schedule will specifically segregate the financial results for the BadgerCare Plus and Medicaid SSI contract from other lines of business for the required audit period and be reported on a GAAP basis. The supplemental schedule must provide assurance that the financial template information submitted to DHS by the PIHP is verifiable, complete and ties to the other audited financial statements, and must be submitted in accordance with the instructions stated in the PIHP Annual Financial Audit Guide.

c. The internal audit and subsequent Medicaid supplemental schedule must be certified by an independent auditor.

d. Additionally, the PIHP must provide the department all work papers used to verify that the financial template was accurate per the CMS Citation 438.3(m).

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

f. The letter and work papers must be submitted to the Department at both DHSDMSBRS@dhs.wisconsin.gov and DHSOIGManagedCare@dhs.wisconsin.gov.

g. The Financial Template can be found on the ForwardHealth Portal.

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

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

2. Quarterly Reporting

The PIHP is required to submit financial information on a quarterly basis to help identify emerging trends in service delivery. A quarterly template will be distributed to the PIHP and is to be completed 45 days after the end of each quarter. The PIHP will be notified and provided with updated versions as necessary. The PIHP is required to submit the quarterly financial report per the schedule and instruction provided in the most recent version of the quarterly financial report template provided by DHS.

3. Financial and Encounter Independent Audit

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

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

The following costs are excluded from rate setting:

a. Advertising and Marketing, unless permissible as part of the PIHP and PIHP Communication, Outreach, and Marketing Guide

b. Lobbying

c. Charitable Contributions and Donations

d. Regulatory Fines and Penalties

e. Travel Costs beyond those necessary to provide member healthcare services or economical administration of the Wisconsin Medicaid program

f. Entertainment

Unallowable costs must be reported in the identified section of the financial reporting template. The department reserves the right to make adjustments to financial submissions for costs deemed unallowable based on Department or auditor review.

J. Contract Specified Reports and Due Dates

The WI FCMH must meet timely submission deadlines for the reports required in this contract as well as additional reports or responses requested by the Department. Failure to meet specified submission deadlines without an approved extension could lead to corrective action, as described in Article XIV.D., at the discretion of the Department.

Weekly REPORTS		
PIHP Provider Network	List of all providers in the PIHP network, Submit via the SFTP. *(See the File Submission Specification Guide)*	Article V, F
Monthly REPORTS		
Supplier Diversity Report	Send monthly reports regarding the PIHPs subcontract with DOA certified MBEs and DVBs	Article XII, N
QUARTERLY REPORTS		
1ST QUARTER: (Jan-March); 2ND QUARTER: (April – June); 3RD QUARTER: (July – Sept); 4TH QUARTER: (Oct – Dec)		
Attestation Form	Send quarterly attestation form to the **BRS.** Email report to: DHSDMSBRS@dhs.wisconsin.gov Due date schedule is:	Article II D5 Forms are located in ForwardHealth.

	1st Quarter – April 30 2nd Quarter – July 30 3rd Quarter – Oct 30 4th Quarter – Jan 30	
Grievance and PIHP Appeal Summary Report	Send quarterly summary grievance and appeal reports to **BCS** by either hardcopy or password protected attached email. Report includes PHI. Due date is within 30 days of end of quarter.	Addendum V, C Use form in Grievance and Appeal Guide.
Access Payments	Send DMS BRS a summary of access payments for services incurred during the previous calendar year. Due date is the end of each quarter. Email report to: DHSDMSBRS@dhs.wisconsin.gov	Article XV, A.3
Detail Claims Report	Send DMS BRS a detail claims report identifying member services incurred during the previous calendar year. Due date is the end of each quarter. Email report to: DHSDMSBRS@dhs.wisconsin.gov	Article XV, A.3
ANNUAL REPORTS		
Performance Improvement Project (PIP) Final Project	Send to your **BCS** Care4Kids contract monitor and EQRO contact by password protected email attachment. Report due on the 1st business day of July.	Article X I
Annual PIHP Financial Reconciliation Report	PIHP certification of the encounter data for reconciliation due no earlier than twelve months after the end of the calendar year.	Article XVI A.3
Initial Performance Improvement Project (PIP) (PIP Proposal)	Send to your **BCS** managed care contract monitor and EQRO contact by password protected email attachment. Topic Selection on first business day of November.	Article X I
Financial Template	Report due to DMS BRS. Due date is no earlier than twelve months after the end of the Calendar Year. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI(A)3(b)2
Audited Financial Template	Report due to DMS BRS. Due date is no earlier than twelve months after the end of the Calendar Year. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI(A)3(b)2
Most recent complete year of encounter records	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI

Reconciliation of financials	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Alternate/Previous Medicaid IDs for enrolled members	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Access payments for prior year	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Statement of operations for the most recent complete year	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Vision Sub-payments for the most recent complete year	Report due to DHMS BRS. Due date is no earlier than June 15th. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
Upcoming Rate Year Budget Projection	Report due to DHMS BRS. Due date is November 1st. Email report to: DHSDMSBRS@dhs.wisconsin.gov.	XVI
QAPI Plan, QAPI Staff, QAPI Committee, etc.	Submit to DHS annually by April 1st.	Article X, section A
OTHER REPORTS		
Affirmative Action Plan Submit every **3 years**	**AA/CRC Office** in the format specified on Vendor Net. Send to dhscontractcompliance@dhs.wisconsin.gov	Article XI C 4
Civil Rights Compliance Letter of Assurance and Plan	**AA/CRC Office** in the format specified in Article III, C.4.b. Send to AA/CRC Coordinator dhscontractcompliance@dhs.wisconsin.gov	Article I C 4 b
Encounter Data File in	**Send to Fiscal agent** on SFTP	Article XII E

(**837I, 837P, 837D**) format.		
Court Ordered Birth Cost Report.	Send report to your **BCS**, managed care contract monitor by password protected email attachment. This report contains PHI. **Submit on an as needed basis.**	Addendum IV B
Communicable Disease Reporting (by providers).	PIHP providers must send report to the **local health department**. Report of human immunodeficiency virus (HIV) will be made directly to the **State Epidemiologist. Providers should** submit **on an as needed basis.**	Article XII J
Fraud, Waste and Abuse Investigations.	The PIHP must report allegations of fraud, waste and abuse (both provider and member) to the Department within 15 days of the suspected activity coming to the attention of the PIHP. Submit **on an as needed basis.**	Article XII L 2
Abortions, Hysterectomies and Sterilizations.	The PIHP must comply with state and federal compliance requirements for abortions, hysterectomies and sterilizations. Submit form with signatures **on an as needed basis.**	
Privacy and Security Incidents	Send information to your **BCS** managed care contract monitor the same day an incident occurs. Submit **on an as needed basis.**	Article XI, D
CMS Drug Utilization Review Report	PIHPs are required to submit timely responses to report and survey requests as required by federal and/or state law or program policy.	Article XI, A
Daily EVV Authorization File	PIHPs are required to submit a daily file for authorizations for personal care services.	Article IV(1)(15)
Daily EVV Visit File	PIHPs are required to utilize a daily file that contains all verified provider network EVV visits.	Article IV(1)(15)
COVID-19 Vaccination Reporting	Submit timely responses to report and survey requests as needed to your BCS managed care contract monitor.	

Any reports that are due on a weekend or holiday are due the following business day. The Department electronically produces multiple reports and resources for use by BadgerCare Plus and Medicaid SSI PIHPs, which are listed at the following website:

https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/reports_data/PIHPmatrix.htm.spage.

K. Communicable Disease Reporting

As required by Wis. Stats. 252.05, mandated providers affiliated with a WI FCMH PIHP shall report the appearance, suspicion or diagnosis of a communicable disease or death resulting from a communicable disease to the local health department for any member treated or visited by the provider. Reports of human immunodeficiency virus (HIV) infection shall be made directly to the State Epidemiologist. Such reports shall include the name, sex, age, residence, communicable disease, and any other facts required by the local health department and Wisconsin Division of Public Health. Such reporting shall be made within 24 hours of learning about the communicable disease or death or as specified in Wis. Adm. Code DHS 145. Charts and reporting forms on communicable diseases are available from the local health department. Each laboratory subcontracted or otherwise affiliated with the PIHP shall report to the local health department the identification or suspected identification of any communicable disease listed in Wis. Adm. Code DHS 145. Reports of HIV infections shall be made directly to the State Epidemiologist.

L. Program Integrity

1. Administrative Management Arrangements

The PIHP 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 PIHP must cooperate with the Department on fraud, waste and abuse investigations.

a. Administrative Management Arrangements:

The PIHP's 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.

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

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

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

b) The PIHP must submit to DHS OIG the PIHP Program Integrity Staff Assignment Form by January 31 via the 'General Documents' section of the DHS OIG SharePoint

site. The form will identify the person or vendor assigned and the percent of FTE associated with identified tasks.

2. Written Procedures

The PIHP written procedures must include:

a. Written policies, procedures, and standards of conduct that articulate the PIHP'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 PIHP's senior management, and the PIHP'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 PIHP's employees.

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

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;

a) Post-payment program integrity strategies must include network provider audits of medical records for verification of actual provision of services.

ii. The PIHP may use network provider audits to evaluate the efficacy of other internal PIHP functions, such as prior authorization. The PIHP may not seek recoupment for findings that are rooted in performance errors of PIHP employees.

iii. The PIHP's contract with its network providers must explain the audit process including authority used by the PIHP for audit citations as well as the authority to recoup overpayments, extrapolate audit findings, or take other actions.

iv. If the PIHP uses extrapolation as a program integrity tool, the sampling and extrapolation methodologies must be compliant with Wis. Admin. Code DHS § 105.01 (3)(f).

v. The Department is not a party to complaints, lawsuits, or other actions taken due to action taken by the PIHP, because the contract between the PIHP and the network provider is between two private entities.

vi. Cost avoidance or prepay strategies must include a method of quantifying, documenting, and reporting savings to the PIHP and/or the Department. Cost avoidance strategies should be properly reported on the Cost Avoidance Log of the quarterly program integrity report.

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

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

ix. Prompt and thorough correction of such issues to reduce the potential for recurrence.

x. Ongoing compliance with the requirements under the contract.

f. If the PIHP makes or receives annual payments under the contract of at least $5,000,000, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about 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 may make a report through the hotline (877-865-3432) or through the online portal: (https://www.reportfraud.wisconsin.gov/rptfrd/default.aspx).

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

iii. Policies and Procedures to implement all payment suspensions imposed by DHS OIG.

3. Compliance Plan

a. The PIHP must submit their compliance plan annually. The PIHP's compliance plan, at minimum, covers the requirements in Article XII.M.1. and M.2. of this contract and was previously submitted as part of the certification application process. This is separate from the Fraud, Waste, and Abuse Strategic Plan.

i. The PIHP 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.

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

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

a. The PIHP 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 PIHP 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 and either approve the plan or return it to the PIHP for changes.

iii. If changes are necessary, the PIHP 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.D.

d. The PIHP 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 PIHP must implement their first annual FWA strategic plan on January 1, 2023 and will implement a new plan annually thereafter.

f. The Department will audit the PIHPs' compliance with their FWA strategic plans during the following year.

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

h. PIHPs 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 the Department. The Department will provide technical assistance through a variety of means including but not limited to monthly and written documentation.

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

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

5. FWA Strategic Plan Annual Audit

a. The Department will audit, on an annual basis, the PIHP's compliance with their FWA strategic plan in the year following the end of the contract year's strategic plan.

b. The Department will audit the FWA Strategic Plan for compliance with the plan's reported data analytics activities, program integrity initiatives, prepayment activities, post payment activities, and verification services.

c. The PIHP must comply with all requests from the Department for documents necessary to complete the FWA Strategic Plan Annual Audit. The Department may request documents including but not limited to:

    i. Analytics reports.

    ii. Recoupment reports.

    iii. Prepayment and post payment summary reports.

    iv. Summary reports for individual program integrity initiatives.

    v. Network provider audit reports.

    vi. Fraud, waste, and abuse investigation reports.

d. The Department will use the following process:

    i. The Department requests documentation specific to the PIHP's FWA strategic plan.

    ii. The Department reviews the submitted documentation.

    iii. The Department provides the PIHP with feedback including any findings and instructions for submitting rebuttal including a due date.

    iv. PIHP provides rebuttal within the specified timeframe. If the rebuttal is not received within the specified timeframe, the Department issues the final audit report.

    v. The Department reviews additional information submitted by the PIHP.

    vi. The Department issues a final audit report including any mitigation strategies which may include but are not limited to technical assistance, prescribed activities in the next plan, enhanced monitoring, or corrective action plan or other sanction administered by DMS.

    vii. The Department may issue financial sanctions when:

    a) The PIHP has refused to engage in technical assistance provided by the Department OIG in response to a determination that the PIHP is out of compliance with their FWA strategic plan; or

    b) The PIHP has refused to engage in the audit process.

6. Reporting Potential Fraud, Waste and Abuse

Investigations of suspected or substantiated fraud, waste, and abuse develop when a provider is suspected of having received Medicaid reimbursement for which they are not entitled or causing the unnecessary expenditure of Medicaid funds through unnecessary utilization or other means. All cases of suspected or substantiated fraud, waste, or abuse must be reported to DHS OIG.

The PIHP must cooperate with the Department on investigations of fraud, waste and abuse investigations. Failure on the part of the PIHP to report fraud, waste or abuse may result in DHS enforcing applicable sanctions under Article XIV.D. in this contract. Pursuant to 42 CFR § 455.23, the authority of determining credible allegations of fraud rests with the Department.

a. Reporting Suspected Fraud, Waste and Abuse

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

ii. All cases of suspected fraud, waste, and abuse must be reported to DHS OIG via the hotline (877-865-3432) or online portal (https:www.reportfraud.wisconsin.gov/RptFrd) 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.

a) Subject matter for complaints includes 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.

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

c) Reports of potential and substantiated fraud from an PIHP must not be made anonymously.

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

e) Documentation of preliminary investigations must be retained in accordance with Article XII.M.12 of this contract.

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

a) Date the suspected fraud, waste, and abuse was identified or reported to the PIHP.

b) A detailed summary of the actions taken to investigate the issue.

c) A determination of whether the fraud, waste, and abuse issue is substantiated or unsubstantiated.

d) A detailed explanation of the facts supporting the determination.

e) An explanation of whether a full investigation will be conducted.

f) A detailed explanation of the facts supporting whether a full investigation will or will not be conducted.

g) Planned next steps.

iv. All complaints made via the hotline or portal, whether substantiated or unsubstantiated, must be reported on the PIHP'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 if the preliminary investigation substantiates fraud.

vi. The PIHP must conduct a full investigation if the preliminary investigation determines the alleged fraud is substantiated.

a) The full investigation is an in-depth review of the alleged fraud which seeks to collect facts and supporting documentation needed for referral to the Wisconsin Department of Justice (DOJ)—Medicaid Fraud Control and Elder Abuse Unit (MFCEAU).

b) At a minimum, for every full investigation the PIHP shall document the occurrence, or non-applicability, of the following actions, including dates and detailed case notes.

1) The information from the original complain.

2) Description of the focus of the investigation.

3) Data Reviewed.

4) Sample requested.

5) Date medical records requested.

6) Date medical received, not received, or received incomplete.

7) Date medical review initiated,

8) Date medical review completed.

9) Interviews with members, providers, or other relevant individuals.

10) On-site visits or audits.

11) Overpayment calculated.

12) Extrapolation calculated.

13) Communication (written or verbal) with members, providers, or other relevant individuals.

c) The PIHP must continue to report the investigation on the QPIR and indicate whether the case is ongoing or complete.

d) The PIHP has 270 days from the date the preliminary investigation was reported to complete the full investigation of the alleged fraud, waste, and abuse, and etiehr determine a referral will be submitted to the DHS OIG or close the case and take other administrative action as appropriate.

e) The PIHP shall notify their OIG representative via email and proved an explanation why any full investigation will not be completed within the required 270 days. OIG may grant an extension for extenuating circumstances.

b. Reporting Substantiated Fraud

i. Fraud is considered substantiated if the allegation has been verified and the allegation has indicia of reliability. The PIHP must report all cases of substantiated fraud 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 PIHP 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 PIHP 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 .

iv. Following the submission of the credible allegation of fraud referral, the PIHP 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 PIHP must collaborate with its DHS OIG representative or MFCEAU investigator to provide any additional information or documentation that may be requested for the case.

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

vii. The PIHP must demonstrate effort through conducting audits and investigations to try to achieve the benchmarks for submitted credible allegation of fraud referrals prescribed in the chart on the DHS OIG SharePoint site. The assigned number of referrals is commensurate to the number of members served by the plan.

a) The PIHP referrals presented by DHS OIG to DHS OIG management and legal counsel, or are submitted to MFCEAU by OIG on the abbreviated credible allegation of fraud spreadsheet, count towards the benchmark.

b) Compliance with this requirement will be measured through applied effort, as determined by the Department, to meet or exceed the target number of referrals, This will be measured on an ongoing basis through the monthly meetings with the DHS OIG Auditor and monitoring of the plan's QPIRS and fraud, waste, and abuse strategic plans.

c. Reporting Substantiated Waste and Abuse

i. In accordance with Article XII.M.5.a.ii. the PIHP 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 PIHP must also report all substantiated and unsubstantiated complaints on the plan's QPIR.

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

iv. The PIHP should also indicate on the QPIR what action will be taken to mitigate the risk. Examples include: educating the provider, or recouping the overpayment, etc.)

7. Suspension of Provider Payments

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

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

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

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

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

    ii. PIHPs must also record these payment suspensions on the Terminations/Sanctions/Suspensions tab of the Quarterly Program Integrity Report (F-02250).

8. Termination or Exclusion of Network Providers

The PIHP must report providers terminated for cause by the PIHP, as well as providers the PIHP identifies as excluded, to DHS OIG.

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

b. The PIHP 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/exclusion, reason for termination/exclusion and the date the appeal window closes.

c. 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.

9. Treatment of Recoveries – Overpayments Made to Network Providers by the PIHP

Pursuant to 42 CFR s 438.608(d), the PIHP must attempt to recover all overpayments made to network providers, including those overpayments attributed to fraud, waste, and abuse, identified by the PIHP.

a. The PIHP recovers the overpayments and retains the funds for all overpayments identified by the PIHP, 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 PIHP is responsible for determining the actual overpayment amount.

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

i. The PIHP must share the documented process with all providers in the PIHP's network.

ii. The PIHP must require the network providers to return overpayments within 60 days of the provider receiving written notification of the overpayment or, if self-identified by the provider, within 60 days of the provider's discovery of the overpayment.

iii. The PIHP must require the provider to notify the PIHP of the reason for the overpayment.

iv. The PIHP must appropriately reflect the recovery of all overpayments in the PIHP's encounter data and on Tab 3 of the Quarterly Program Integrity Report.

v. Provider agreement language must require network providers to follow the same requirements when they self-identify an overpayment they have received.

10. Treatment of Recoveries – Overpayments Made to the PIHP by the State

a. The FCMH is responsible for monitoring ForwardHealth interChange enrollment and capitation payment reports for discrepancies in members the PIHP considers enrolled. Any discrepancies which resulted in an overpayment to the PIHP from the State must be reported to OIG. Examples of capitation discrepancies include but are not limited to:

    i. Incorrect health plan.

    ii. Member has passed away.

    iii. Member is incarcerated.

    iv. Incorrect rate region.

    v. Incorrect age.

    vi. Issues related to enrollment or termination dates.

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

    i. The PIHP's name;

    ii. The member's Medicaid number;

    iii. The member's name;

    iv. The month or number of days if partial month;

    v. The rate paid;

    vi. The correct rate;

    vii. The reason for the overpayment, if known;

    viii. The original date the overpayment report to DHS; and

    ix. The action taken by the PIHP, if any.

11. Network Provider Audits

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

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

    i. DHS OIG will notify the PIHP by email and upload a deconfliction spreadsheet to the PIHP SharePoint for each network provider audit. The deconfliction spreadsheet will contain the scope and sample information pertaining to the potential audit.

ii. The PIHP 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 PIHP should continue with their investigation as planned.

iii. The PIHP has 10 business days to review and respond to the deconfliction spreadsheet. The PIHP must upload their response to the PIHP 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 plan 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. D.

vi. Or other means by which the audit findings can be addressed;

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

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

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

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

a) The provider may appeal to DHS OIG identified overpayments to the PIHP;

b) The provider may appeal to the Department, following the process outlined in in Article VIII of this contract, if the provider disagrees with the PIHP decision to uphold the overpayment recovery.

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

g. Ensuring that provider agreements require the PIHP's network providers to collaborate with DHS OIG and DHS OIG's 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.

12. Corrective Action Plans and Sanctions

DHS will issue any formal corrective action plans or sanctions related to non-compliance with this Article in accordance with Article XIV.D. The PIHP is required to respond to any corrective action or performance improvement activities within the timeframes specified.

13. Quarterly Program Integrity Reporting

The PIHP must submit the Quarterly Program Integrity Report (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 Report consists of the following five separate reporting categories:

i. Program Integrity Log: Captures complaints regarding fraud, waste, and abuse received by the PIHP 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. PIHPs 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 PIHP that impact Medicaid network providers.

v. Subcontractor Log must include the following information:

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

vi. 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 §§ 455.104 and 438.602(c).

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

i. DHS OIG will evaluate the submitted reports and may follow up with the PIHP 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.

14. Quarterly Meetings

OIG facilitates meetings with the PIHPs, 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 PIHP's Compliance Officer or representative must be in attendance to represent their respective PIHP.

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

ii. The Compliance Officer or PIHP 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 an PIHP 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.

15. Records Retention

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

M. Non-Disclosure of Trade Secrets and Confidential Competitive Information

1. To the extent that encounter records, medical-loss ratio reports, or other submissions/reports include or have the capacity to reveal amount(s) paid by the PIHP to provider(s), the PIHP and the Department agree that those records, reports or submissions constitute trade secrets under the Wisconsin Uniform Trade Secrets Act, Wis. Stats., s. 134.90(1)(c), and must remain confidential to protect the competitive market position of the PIHP. The Department agrees such records, reports or submissions are thus exempt from disclosure under s. 19.36(5), Wis. Stats. regardless of whether said information is specifically, separately designated as such by the PIHP at the time of submission or reporting to the Department.

2. If the Department receives an open records request, subpoena, or similar request involving the information described in Paragraph 1, the Department shall notify the PIHP of the request without unreasonable delay. Upon such request, the Department shall take all reasonable steps to prevent the disclosure of such information. In the event that disclosure of information is compelled pursuant to a writ of mandamus or other court order, the Department agrees to redact any otherwise proprietary, confidential, or trade secret information prior to said disclosure, subject to the terms of the order.

3. In the event the designation of the confidentiality of this information is challenged, the PIHP agrees to provide legal counsel or other necessary assistance to defend the designation of records, reports, or submissions as a trade secret. The Department shall, without charge to the PIHP, reasonably cooperate with such defense, to include providing legal counsel, testimony, and attestations regarding the protection of confidential and proprietary information that qualifies as a trade

secret. Notwithstanding the foregoing, the PIHP shall have the sole right and discretion to direct the defense to settle, compromise, or otherwise resolve such defense. Should any order or judgment be issued against the Department, the PIHP will hold the Department harmless and indemnify the Department for costs and damages assessed against the Department as a result of designating records, reports, or submissions as trade secret(s).

N. Annual Financial Report

The PIHP must submit its audited financial reports on an annual basis, starting with the PIHP's 2019 fiscal year. The audit must be conducted in accordance with generally accepted account principles (GAAP) and generally accepted auditing standards. The PIHP should include a Medicaid supplemental schedule along with the annual audited financial report. The Medicaid supplemental schedule will specifically segregate from other lines of business for the required audit period and be reported on a GAAP basis. The audited Medicaid supplemental schedule will be provided to the Department in the for of a "Statement of Operations and Changes in Net Assets" exclusive to the PIHP's Foster Care Medical Home contract. The statement must separately identify revenue and expenses covered by this Medicaid contract, other Medicaid contracts, and other non-Medicaid lines of business as applicable for the financial report.

The following example is a minimum requirement for the "state of Operations and Changes in Net Assets". The PIHP may provide an expanded statement with additional account categories at its discretion.

PIHP
State of operations and Changes in Net Assets
For the ear ended December 31, 20xx

	FCMH Medicaid Contract	All other Medicaid Contracts	Other Non-Medicaid	Total
REVENUE				
Premium Revenue				
Other Revenue				
Total Revenue				
EXPENSES				
Medical Expenses				
Claims adjustment expenses				
General administrative expenses				
Total Expenses				
NET INCOME/(LOSS)				

The PIHP will also submit its financial data for the Foster Care Medical Home Medicaid Contract on an annual basis on a Financial Template in order to restate medical expenses for paid claims and revenue for enrollment retroactively. The payment period will align with the encounters reported for the final reconciliation and will include a reconciliation of the Foster Care Medical Home Contract reported on the audited Medicaid supplemental schedule. The PIHP shall report financial data that exclusively includes allowable services under this contract for eligible members. The Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the financial data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

The following costs are excluded from rate setting:

a. Advertising and Marketing, unless permissible as identified in Article VI.
b. Lobbying.
c. Charitable Contributions and Donations.
d. Regulatory Fines and Penalties.
e. Travel Costs beyond those necessary to provide member healthcare services or economical administration of operation in the Wisconsin Medicaid program.
f. Entertainment.

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

O. Supplier Diversity Reporting

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

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

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

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

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

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

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

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

P. Out-of-Network Utilization Report

PIHPs shall submit to the Department an Out-of-Network Utilization Report. The log with summary will include information as stated in the Out of Network Quarterly report data dictionary. The log must include any out-of-network claims processed by any subcontractors.

Q. Reports: As needed

The PIHP agrees to furnish reports which may be required to administer this contract, to the Department and the Department's authorized agents. Such reports include but are not limited to corporate restructuring or any other change affecting the continuing accuracy of information the PIHP previously reported to the Department.

XIII. Functions and Duties of the Department

A. Utilization Review and Control

The Department will waive, to the extent allowed by law, any present Department requirements for prior authorization, second opinions, or other WI FCMH restrictions for the provision of contract services provided by the PIHP to members, except as may be required by the terms of this contract.

B. Department Audit Schedule

The PIHP will be notified approximately 30 days prior to regularly scheduled, routine audits being conducted via a letter from the Department.

C. PIHP Review of Study or Audit Results

The Department will provide PIHPs a 30 calendar day review period, for PIHP audits, PIHP report cards, PIHP Member Satisfaction Reports, or any other PIHP studies the Department releases to the public that identifies the PIHP by name. The PIHP may request an extension and the Department will exercise reasonable discretion in making the determination to waive the 30 business day review/comment requirement.

D. Vaccines for Children

The Department will assure that PIHP providers participate in the Vaccines for Children (VFC) program for administration of immunizations to BadgerCare Plus PIHP members according to the policies and procedures in the Wisconsin Health Care Programs Online Handbook. The Department will reimburse the PIHP for the cost of new vaccines that are newly approved during the contract year and not yet part of the Vaccine for Children program. The reimbursement of the vaccine shall be the same as the Department reimburses FFS providers during the period of VFC availability. The PIHP retains liability for the cost of administering the vaccines.

E. Provision of Data to the PIHP

The Department will provide to the PIHP immunization information from the Wisconsin Immunization Registry, to the extent available.

F. Conflict of Interest

The Department will maintain state employee conflict of interest safeguards at least equal to federal safeguards (41 USC 423).

XIV. Contractual Relationship

A. Delegations of Authority

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

1. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the subcontractor and provides for revocation of the delegation or imposition of other sanctions if the subcontractor's performance is inadequate, or out of compliance with HIPAA privacy or security requirements.
2. Before any delegation, the PIHP shall evaluate the prospective subcontractor's ability to perform the activities to be delegated.
3. The PIHP shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review at least once per contract period.
4. If the PIHP identifies deficiencies or areas for improvement, the PIHP and the subcontractor shall take corrective action.
5. If the PIHP delegates selection of providers to another entity, the PIHP retains the right to approve, suspend, or terminate any provider selected by that entity.
6. If the WI FCMH delegates processing of appeals, grievances, and/or claims processing to another entity,t he WI FCMH must coordinate with the subcontractor to obtain the data needed to meet the WI FCMH's reporting requirements.

B. Subcontracts

This Article does not apply to subcontracts between the Department and the PIHP. The Department shall have sole authority to determine the conditions and terms of such subcontracts. Subcontractor (hereinafter identified as subcontractor) agrees to abide by all applicable provisions of the PIHP's contract with the Department, hereinafter referred to as the BadgerCare Plus and Medicaid SSI PIHP Contract. Subcontract compliance with the BadgerCare Plus and Medicaid SSI PIHP Contract specifically includes but is not limited to the requirements specified below.

1. Subcontract Standard Language

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

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

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

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

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

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

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

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

h. Any PIHP or its subcontractor that enters into a contract with an entity outside the U.S. must clearly indicate Wisconsin law as jurisdiction for any breach of contract and ensure compliance with state and federal laws allowing for such contracts.

i. Per 42 CFR 438.230, subcontractor agrees to provide representatives of the PIHP, as well as duly authorized agents or representatives of the Department (including the Office of the Inspector General) and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the PIHP and the subcontractor), and administrative records. If the State (including the Office of the Inspector General), CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. Refusal will result in sanctions or penalties in Article XIV.D. against the PIHP for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

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

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

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

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

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

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

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

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

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

r. Subcontractor agrees to abide by the PIHP's restraint policy, which must be provided by the PIHP. Members have the right to be free from any

form of restraint or seclusion used as a means of force, control, ease or reprisal.

s. PIHPs shall not prohibit providers outside the parent healthcare system from contracting with another PIHP entity.

t. Subcontractor agrees to utilize the Department's EVV system or a certified alternat EVV system.

2. Subcontract Submission Requirements

a. Changes in Established Subcontracts

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

a) Technical changes do not have to be approved.

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

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

b. New Subcontracts

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

3. Review and Approval of Subcontracts

The Department may approve, approve with modification, or deny subcontracts under this Contract at its sole discretion. The Department may, at its sole discretion and without the need to demonstrate cause, impose such conditions or limitations on its approval of a subcontract as it deems appropriate. The Department may consider such factors as it deems appropriate to protect the interests of the state and WI FCMH members, including but not limited to the proposed subcontractor's past performance. The Department will:

a. Give the PIHP:

i. 120 days to implement a change that requires the PIHP to find a new subcontractor, and

ii. 60 days to implement any other change required by the Department.

b. Acknowledge the approval or disapproval of a subcontract within 15 business days after its receipt from the PIHP.

c. Review and approve or disapprove each new subcontract before the Contract takes effect. Any disapproval of subcontracts may result in the application by the Department of remedies pursuant to this Contract.

d. Ensure that the PIHP has included the standard subcontract language as specified in Article XIV.B.1. (except for specific provisions that are inapplicable in specific PIHP management subcontract).

4. Transition Plan

The PIHP may be required to submit transition plans when a primary care provider(s), mental health provider(s), gatekeeper or dental clinic terminates their contractual relationship with the PIHP. The transition plan will address continuity of care issues, member notification and any other information required by the Department to ensure adequate member access. The Department will approve, deny, or modify the transition plan within 15 business days of receipt or prior to the effective date of the subcontract change.

5. Notification Requirements Regarding Subcontract Additions or Terminations

The PIHP must:

a. Notify the Department of Additions or Terminations

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

i. A clinic or group of physicians, mental health providers, or dentists,

ii. An individual physician,

iii. An individual mental health provider and/or clinic,

iv. An individual dental provider and/or clinic.

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

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

The PIHP must notify the Department within 7 days of any notice by the PIHP to a subcontractor, or any notice to the PIHP from a subcontractor, of a subcontract termination, a pending subcontract termination, or a pending modification in subcontract terms, that could substantially reduce member access to care. This Department notification must be to both the PIHP's Contract Monitor and through the submission of an updated provider network to the SFTP server.

If the Department determines that a pending subcontract termination or pending modification in subcontract terms will jeopardize member access to care, then the Department may invoke the remedies pursuant to this

Contract. These remedies include contract termination (notice to the PIHP and opportunity to correct are provided for), suspension of new enrollment, and giving members an opportunity to enroll in a different PIHP.

In addition to the monthly submission, the PIHP must submit an updated provider and facility file when there has been a significant change with respect to network adequacy, as defined by the Department, in the PIHP's operations that would affect adequate capacity and services.

c. Notify Members of Provider Terminations

i. The WI FCMH must make good faith effort to give written notice of termination of a network provider to each member who received primary care from, or was seen on a regular basis by, the terminated provider.

ii. The WI FCMH must provide the member notice by the later of 30 calendar days prior to the effective date of the termination of fifteen (15) calendar days after receipt or issuance of the termination notice.

iii. The PIHP must use a template letter for this notification and obtain the Department's approval of the template before it is sent to members. Any subsequent proposed changes to the template must be approved by the Department.

6. Management Subcontracts

The Department will review PIHP management subcontracts to ensure that:

a. Rates are reasonable.

b. They clearly describe the services to be provided and the compensation to be paid.

c. Any potential bonus, profit-sharing, or other compensation, not directly related to the cost of providing goods and services to the PIHP, is identified and clearly defined in terms of potential magnitude and expected magnitude during this Contract period. Any such bonus or profit-sharing must be reasonable compared to the services performed. The PIHP must document reasonableness. A maximum dollar amount for such bonus or profit-sharing shall be specified for the Contract period.

The requirements addressed in Article XV.B.6.a-c are not required for non-WI FCMH members if the PIHP wishes to have separate arrangements for the non-members.

C. Memorandum of Understanding/Agreement

PIHPs are required to enter into or make every attempt to enter into an MOU with certain entities. PIHPs may include a provision within the MOU that will automatically renew MOUs with these entities. The MOU must include an opt out provision from the automatic renewal.

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

1. Section 1903(m)(5)(B)(ii) of the Social Security Act (42 U.S.C. § 1396b) vests the Secretary of the Department of Health and Human Services with the authority to deny WI FCMH payments to the PIHP for members who enroll after the date on which the PIHP has been found to have committed one of the violations identified in the federal law. State payment for members of the contracting organization is automatically denied whenever, and for as long as, federal payment for such members has been denied as a result of the commission of such violations. The state may impose sanctions if the PIHP has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.
2. In addition, the Department may pursue all sanctions and remedial actions with the PIHP that is taken with FFS providers if it determines, based on findings from onsite surveys, enrollee or other complaints, financial status, or any other source, that an PIHP acts or fails to act as follows pursuant to 42 CFR § 438.700:
    a. Fails substantially to provide medically necessary services that the PIHP is required to provide, under law or under this contract, to an enrollee covered under the contract.
    b. Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program
    c. Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to enroll a member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
    d. Misrepresents or falsifies information that it furnishes to CMS or to the Department.
    e. Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
    f. Fails to comply with the requirements for physician incentive plans.
    g. Distributes directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Department or that contain false or materially misleading information.

h. Violates any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act, or any implementing regulations.

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

3. Corrective Action Plan

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

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

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

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

4. Financial Penalties

The Department may pursue all financial penalties with the PIHP that are taken with FFS providers including any civil monetary penalties in the following specified amounts:

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

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

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

d. A maximum of $25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The state must deduct

from the penalty the amount of overcharge and return it to the affected member(s).

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

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

5. Suspension and Reduction of Enrollment

a. Suspension of New Enrollment

Whenever the Department determines that the PIHP is out of compliance with this Contract, the Department may suspend the PIHP's right to receive new enrollment under this Contract. When exercising this option, the Department, must notify the PIHP in writing of its intent to suspend new enrollment at least 30 days prior to the beginning of the suspension period. The suspension will take effect if the non-compliance remains uncorrected at the end of this period. The Department may suspend new enrollment sooner than the time period specified in this paragraph if the Department finds that the member's health or welfare is jeopardized. The suspension period may be for any length of time specified by the Department, or may be indefinite. The suspension period may extend up to the expiration of the Contract. The Department may also notify members of the PIHP's non-compliance and provide an opportunity to enroll in another PIHP.

b. Department-Initiated Enrollment Reductions

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

c. Other Enrollment Reductions

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

6. Withholding of Capitation Payments and Orders to Provide Services

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

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

a. Medically Necessary Covered Services

Whenever the Department determines that the PIHP has failed to provide one or more of the medically necessary covered services required under the Contract, the Department may either order the PIHP to provide such service, or withhold a portion of the PIHP's capitation payments for the following month or subsequent months, such portion withheld to be equal to the amount of money the Department must pay to provide such services.

If the Department orders the PIHP to provide services under this section and the PIHP fails to provide the services within the timeline specified by the Department, the Department may withhold from the PIHP's capitation payments an amount up to 150% of the Fee for Service amount for such services.

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

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

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

ii. If the Department ordered the PIHP to provide services under this section, it will pay the PIHP the actual documented cost of providing the services.

b. Payment Denials for New Members

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

Specifically, the State may recommend that CMS impose the denial of payment for new members to an PIHP that has a contract to provide WI FCMH services if the State determines that the PIHP acts or fails to act pursuant to 42 CFR § 438.700. The State's determination becomes CMS' determination for purposes of Section 1903(m)(5)(A) of the Act unless

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

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

c. Required Reports and Data Submissions

i. Encounter Data

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

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

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

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

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

   At a minimum, PIHPs must submit a consistent volume of encounters each month based on a calendar year average.

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

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

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

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

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

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

ii. Provider and Facility Network Data Submission

Incomplete or inaccurate provider and/or facility data will subject the PIHP to sanctions outlined in Article XIV.D.

iii. Dental Claims

Per Article IV.E.6.c., the Department will conduct validity and completeness audits of dental claims. Upon request, the PIHP must submit paid claims to the Department along with any other records the Department deems necessary for the completion of the audit. Payment of incomplete or inaccurate claims will subject the PIHP to sanctions.

d. Procedures for Withholding Capitation Payments

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

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

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

iii. If the PIHP submits encounter data late but submits it within five business days from the deadline, the Department will rescind liquidated damages if the data can be processed according to the criteria published in the PIHP Encounter Data User Manual. The Department will not edit the data until the process period in the subsequent month.

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

v. If the PIHP repeatedly fails to submit required data or reports, or submits data that cannot be processed, the Department will require the PIHP to develop a CAP to comply with the Contract requirements that must meet Department approval.

vi. After the corrective action plan has been implemented, if the PIHP continues to submit data beyond the deadline, or continues to submit data that cannot be processed, the Department will invoke the remedies under Article XIV.D.5.a. (Suspension of New Enrollment), or under Article XIV.D.5.b. (Department-Initiated Enrollment Reductions) of this Article, or both, in addition to liquidated damages that may have been imposed for a current violation.

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

e. Inappropriate Payment Denials

The PIHP that inappropriately fails to provide or deny payments for services may be subject to suspension of new enrollments, withholding, in full or in part, of capitation payments, contract termination, or refusal to contract in a future time period, as determined by the Department. The Department will select among these sanctions based upon the nature of the services in question, whether the failure of denial was an isolated instance or a repeated pattern or practice, and whether the health of a member was injured, threatened or jeopardized by the failure or denial. These sanctions

apply not only to cases where the Department has ordered payment after appeal, but also to cases where no appeal was made (i.e., the Department knows about the documented abuse from other sources).

f. Temporary Management

The state will impose temporary management, as provided in 42 CFR § 438.706, when there is continued egregious behavior by the PIHP, including, but not limited to behavior that is described in 42 CFR § 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or

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

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

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

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

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

g. PIHP Subcontractors

Per Article XIV.B.1.i., subcontractor agrees to provide representatives of the PIHP, as well as duly authorized agents or representatives of the Department and the federal Department of Health and Human Services, access to its premises and its contracts, medical records, billing (including contractual rates agreed upon between the PIHP and the subcontractor), and administrative records. Refusal will result in sanctions and/or financial penalties in Article XIV.D. against the PIHP for failure of its subcontractor to permit access to a Department or federal DHHS representative. Subcontractor agrees otherwise to preserve the full confidentiality of medical records in accordance with this Contract.

E. Modification and Termination of Contract

1. Modification

a. Mutual Consent:

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

b. Unilateral Modification by the Department:

This contract will be modified by the Department if changes in federal or state laws, rules, regulations or amendments to Wisconsin's CMS approved waivers or the state plan require modification to the contract. In the event of such change, the Department will notify the PIHP in writing. If the change materially affects the PIHP's rights or responsibilities under the contract and the PIHP does not agree to the modification, the PIHP may provide the Department with written notice of termination at least ninety (90) days prior to the proposed date of termination. (See Article XIV.E.2.e.ii).

2. Termination

a. Mutual Consent:

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

b. Unilateral Modification by Department:

i. Authority to Terminate Contract

The Department has the authority to terminate an PIHP's contract and enroll that entity's members in other PIHPs of the member's choosing, or provide their Medicaid benefits through other options included in the State plan, if the Department determines that the PIHP has failed to do either of the following:

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

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

ii. Notice and Pre-Termination Hearing:

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

iii. Member Disenrollment During Termination Hearing Process:

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

a) The PIHP shall provide assistance to any member electing to terminate their enrollment, by making appropriate

referrals and providing the individual's member record to new providers and/or a member's new PIHP.

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

iv. Post-Hearing Notice:

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

c. Foreign Entity:

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

d. Unilateral Termination by the PIHP

i. Changes to Capitation Rates:

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

ii. Changes in Reporting Requirements:

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

e. Terminated by either:

i. For Cause

Either party may terminate this Contract at any time if it determines that the other party has substantially failed to perform any of its functions or duties under this Contract. The party exercising this option must notify the other party in writing of its intent to terminate this Contract and give the other party 30 days to correct the identified violation, breach or non-performance of Contract. If such violation, breach or non-performance of Contract is not satisfactorily addressed within this time period, the exercising party may terminate this Contract. The termination date shall always be the last day of a month. The Contract may be terminated by the Department sooner than the time period specified in this paragraph if the Department finds that member health or welfare is jeopardized by continued enrollment in the PIHP.

ii. Changes Mandated by Federal or State Law:

Either party may terminate this Contract at any time, due to modifications to the contract mandated by changes in federal or state laws, rules or regulations that materially affect either party's rights or responsibilities under this Contract (see Article XIV.E.1.b). At least 90 days prior to the proposed date of termination, the party initiating the termination must notify the other party in writing of its intent to terminate this Contract.

iii. Loss of Federal or State Funding:

a) Permanent Loss of Funding

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

b) Temporary Loss of Funding

In the event funding will become temporarily suspended or unavailable, the Department or the PIHP may suspend performance of any or all of the PIHP's obligations under this Contract if the suspension or unavailability of funding will preclude reimbursement for performance of those obligations. The Department or PIHP shall attempt to give notice of suspension of performance of any or all of the

PIHP's obligations by 60 days prior to said suspension, if this is possible; otherwise, such notice of suspension should be made as soon as possible. Once the funding is reinstated, the PIHP will resume the suspended services within 30 days from the date the funds are reinstated. The contract will not terminate under a temporary loss of funding.

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

i. Transition Plan:

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

a) Submission of the Transition Plan

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

b) Management of the Transition

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

c) Continuation of Services

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

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

d) Costs of Transition Plan

The PIHP will be responsible for all expenses related to the transition plan, including, but not limited to costs associated with the Department's enrollment of the PIHP's members into other PIHPs or the provision of MA benefits to the PIHP's members through other options in the event of a unilateral termination by the Department under Article XIV.E.2.b.

ii. Notice to Members and Providers

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

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

c) Costs of Notice to Members and Providers

The PIHP will be responsible for all expenses related to notifications under Article XV.E.ii.a) and b).

iii. Pay for Performance Withhold Reconciliation:

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

a) Applying the PIHP's previous measurement year's P4P results to the termination year's performance benchmarks; or

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

iv. Return of Advanced Payments:

a) Any payments advanced to the PIHP for coverage of members for periods after the date of termination will be returned to the Department within the period of time specified by the Department.

b) Transfer of Information: The PIHP will supply all information necessary for the reimbursement of any outstanding WI FCMH claims within the period of time specified by the Department.

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

3. If the WI FCMH requests decertification

F. Interpretation of Contract Language

When disputes arise, the Department has the right to final interpretation and/or application of the Contract language. The PIHP will abide by the interpretation and/or application

XV. Fiscal Components/Provisions

A. Billing Members

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

However, if a member agrees in advance in writing to pay for a service not covered by WI FCMH, then the PIHP, PIHP provider, or PIHP subcontractor may bill the member. The standard release form signed by the member at the time of services does not relieve the PIHP and its providers and subcontractors from the prohibition against billing a member in the absence of a knowing assumption of liability for a non-WI FCMH covered service. The form or other type of acknowledgment relevant to a member's liability must specifically state the admissions, services, or procedures that are not covered by WI FCMH.

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

Except in emergency situation, the PIHP must use only Medicaid enrolled providers for the provision of covered services. The Department reserves the right to withhold from the capitation development the cost related to services provided by non-enrolled providers, at the FFS rate for those services, unless the PIHP can demonstrate that it reasonably believe, based on the information provided by the Department, that the provider was Medicaid enrolled at the time the PIHP reimbursed the provider for the service provision.

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

B. Physician Incentive Plans

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

The PIHP shall fully comply with the physician incentive plan requirements specified in 42 CFR s. 417.479(d) through (g) and the requirements relating to subcontracts set forth in 42 CFR s. 417.479(i), as those provisions may be amended from time to time. PIHP contracts must provide for compliance with the requirements set forth in s. 422.208 and s. 422.210.

The PIHP may operate a physician incentive plan only if no specific payment can be made directly or indirectly under such a plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If physician/group put at substantial financial risk for services not provided by physician/group, the PIHP must ensure adequate stop-loss protection to individual physicians and conduct annual enrollee surveys.

The PIHP must provide adequate and timely information on its physician incentive plan to any member upon request.

If required to conduct a member survey, survey results must be disclosed to the State and, upon request, disclosed to members.

The disclosure to the State includes the following, and will be reported in a format determined by the Department:

1. The PIHP must report whether services not furnished by a physician/group are covered by incentive plan. No further disclosure required if the PIP does not cover services not furnished by physician/group.
2. The PIHP must report type of incentive arrangement, e.g. withhold, bonus, capitation.
3. The PIHP must report percent of withhold or bonus (if applicable).
4. The PIHP must report panel size, and if patients are pooled, the approved method used.

If the physician/group is at substantial financial risk, the PIHP must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

C. Payment Requirements/Procedures

The PIHP is responsible for the payment of all contract services provided to members listed as ADDs or CONTINUEs on either the Initial or Final Enrollment Rosters generated for the coverage period.

The PIHP is also responsible for the provision, or authorizing the provision of, services to members with valid ForwardHealth ID cards indicating PIHP enrollment (via Electronic Voice Response or WiCall), without regard to disputes about enrollment status and without regard to any other identification requirements. Any discrepancies between the

cards and the enrollment rosters must be reported to VEDSPIHPSupport@wisconsin.gov for resolution.

The PIHP must continue to provide and authorize provision of all contract services until the discrepancy is resolved, including members who were PENDING on the Initial Roster and held a valid ForwardHealth ID card indicating PIHP enrollment for the coverage period (via Electronic Voice Response or WiCall), but did not appear as a CONTINUE on the Final Roster.

If a member shows on the Initial enrollment roster as PENDING and later shows on the Final roster as a DISENROLL, the PIHP will not be liable for services after the date the disenrollment is effective.

1. Claims Retrieval

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

2. Thirty Day Payment Requirement

   a. The PIHP must pay at least 95% of adjudicated clean claims from providers for covered medically necessary services within 30 days of receipt of a clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent providers have agreed to later payment. PIHP agrees not to delay payment to a subcontractor/provider pending provider collection of third party liability unless the PIHP has an agreement with the provider to collect third party liability.

   b. If the PIHP is currently experiencing a delay or anticipates a delay with timely claims processing and payment to providers, or discovers an error within the PIHP's claims processing system that delays claims processing longer than 30 days, the PIHP must notify the Department via an email to DHSDMSBRS@dhs.wisconsin.gov and the PIHP's managed care analyst. The PIHP must submit a plan to remedy the claims processing error including how the PIHP will ensure providers are paid without unnecessary delay. The PIHP cannot categorize claims processing errors due to system error in reconsideration or appeal.

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

   The PIHP must pay for covered services provided by a non-PIHP contracted provider to a disabled member less than three years of age, or to any member

pursuant to a court order (for treatment), effective with the receipt of a written request for referral from the non-PIHP contracted provider, and extending until the PIHP issues a written denial or referral. This requirement does not apply if the PIHP issues a written denial of referral within seven days of receiving the request for referral.

4. Payment of PIHP Referrals to Non-Affiliated Providers

   For PIHP approved referrals to non-affiliated providers, the PIHP must either establish payment arrangements in advance, or the PIHP is liable for payment only to the extent that WI FCMH pays, including Medicare deductibles, or would pay, its FFS providers for services excluding Hospital Access Payments, Hospital P4P Withhold, and Ambulatory Surgery Center Access Payments. Refer to Article VIII for policy on Provider Appeals.

   a. For Non-Affiliated Providers, the Department will adjudicate Provider Appeals according to FFS benefit policy and reimbursement, including PA requirements, emergency and post stabilization definition and other contract provisions. Refer to Article VIII, Provider Appeals.

   b. Should there be an appeal resolution determined by the Department to be in the Provider's favor, the PIHP must waive standard timely filing guidelines and allow the provider 60 days to rebill for services.

5. Health Professional Shortage Area (HPSA) Payment Provision

   Primary care and emergency care services provided to a member living in a Health Professional Shortage Area (HPSA) or by a provider practicing in a HPSA must be paid at least the PIHP established rate plus the standard enhancement reimbursement as specified in ForwardHealth Topic #648 for the procedure codes that qualify for HPSA enhanced reimbursement.

   The PIHP is not required to pay more than the enhanced FFS rate. The PIHP shall ensure that the money for HPSA payments is paid to the provider and is not used to supplant funds that previously were used for payment to the provider. The PIHP must develop written policies and procedures to ensure compliance with this provision. These policies must be available for review by the Department, upon request.

6. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

   If the PIHP contracts with a Medicaid enrolled FQHC or RHC for the provision of services to its members, the PIHP must pay at a minimum the Medicaid FFS rate or the equivalent aggregate FFS rate by provider. The PIHP must retain records demonstrating that they are meeting this requirement. The records must be available within 30 days of the Department's request for information and be made available to CMS upon request.

   The PIHP must pay at least 90% of adjudicated clean claims from FQHC or RHC providers for covered medically necessary services within 30 days of receipt of a

clean claim, 99% within 90 days and 100% within 180 days of receipt, except to the extent that providers have agreed to later payment.

7. Hospitalization at the Time of Enrollment or Disenrollment

   a. Hospitalization in this section is defined as an inpatient stay at a Medicaid-enrolled hospital as defined in Wis. Adm. Code DHS 101.03(76), including covered outpatient hospital observation days if the member was subsequently admitted as an inpatient.

   b. Discharge from one hospital and admission to another within 24 hours for continued treatment shall not be considered a discharge under this section. Discharge is defined here as it is in the UB-04 Manual.

   c. Hospitalization at the time of enrollment

      i. The PIHP will not assume financial responsibility for members who are hospitalized at the time of enrollment in the PIHP (effective date of coverage) until date of the hospital discharge.

      a) The Department is responsible for paying on a FFS basis all WI FCMH covered services for such hospitalized members during hospitalization.

   The PIHP is not financially responsible for hospital claims for members after the date of disenrollment. When the PIHP receives hospital claims that span dates of PIHP enrollment and after the date of disenrollment, the PIHP shall contact VEDS for special handling of the claim.

8. Members Living in a Public Institution (BadgerCare Plus, and Medicaid SSI Plans)

   The PIHP is liable for the cost of providing all medically necessary services to members who are living in a public institution during the month in which they first enter the public institution. Members who remain in public institution after the last day of the month are no longer eligible for BadgerCare Plus or Medicaid SSI and the PIHP is not liable for providing care after the end of the first month.

   Members who are living in a public institution and go directly from the public institution to a medical facility, court ordered or voluntarily, are no longer living in a public institution and remain eligible for BadgerCare Plus or Medicaid SSI. The PIHP shall be liable for the provision of medically necessary treatment if treatment is at the PIHP's contracted facilities, or if unable to itself provide for such treatment.

9. Payment to Provider Pending Credentialing Approval

   The PIHP must pay a Medicaid-enrolled provider for services provided to a member of the PIHP while the provider's complete application for credentialing is pending approval by the PIHP. If the provider's application is ultimately denied

by the PIHP, the PIHP is not liable for the services provided. This provision does not apply to PIHPs who are NCQA-accredited.

10. Calculation of Non-listed Max Fee Rate

When a rate is not listed on the FFS max fee schedule, the PIHP may determine their own payment methodology for determining the rate for affiliated and non-affiliated providers. The Department may request documentation of methodology if a provider appeal is submitted based on this derived payment amount.

11. The PIHP is prohibited from making payment to a provider for provider-preventable conditions (42 CFR 438.6(f)(2)(i)).

All provider-preventable conditions associated with claims for payment or member treatments for which payment would otherwise be made must be reported by all providers to the PIHP per 42 CFR 438.6(f)(2)(ii).

Refer to Article X.C.3 for a comprehensive listing of provider-preventable conditions.

12. 2022 American Rescue Plan Rate Increase

a. For purposes of this section, "ARPA eligible service provider" are providers of:

i. alcohol and other drug abuse (AODA) services,

ii. AODA Day Treatment,

iii. home health services,

iv. housing counseling,

v. mental health day treatment,

vi. mental health services,

vii. nursing provided in the home,

viii. occupational therapy provided in the home,

ix. personal care,

x. physical therapy provided in the home,

xi. respiratory care,

xii. respite,

xiii. skilled nursing services (RN/LPN) ,

xiv. speech and language pathology services provided in the home, and

xv. transportation as defined in Wis. Admin. Code DHS § 107.23, excluding ambulance.

b. Providers of services not listed, including but not limited to retail providers, nursing homes and common carrier transportation providers are

not ARPA eligible service providers under this section. PIHPs are also not eligible service providers.

c. PIHPs are required to provide a unit rate increase to all eligible providers equal to 5% of each eligible provider's rates for the services identified in Article XV.C.12.a.

13. Payments to providers for dental services provided under deep sedation

PIHPs must pay no less than the state plan approved rate for specified level I oral and maxillofacial procedures provided to members under deep sedation (EAPG 367; Procedure code: 41899, modifier U2). The state plan approved rate is available on FowardHealth Hospital Rates and Weights for the relevant procedure code and modifier. PIHPs must follow ForwardHealth policy that procedure code 41899 with modifier U2 denotes that the outpatient hospital service included deep sedation of the member.

XVI. Payments to the PIHP

A. Actuarial Basis

Reimbursement for the FCMH Program will be done under the authority of 42 CFR 438.2. This is a non-risk contract between the State of Wisconsin and the PIHP providing a Foster Care Medical Home to children in out-of-home care.

B. Reimbursement Method

The Department will develop a monthly non-risk prepayment rate based on historical spending for the Medicaid out-of-home placement population and/or PIHP's program history. Additional adjustments may be made based on the PIHP's service delivery requirements included in this contract. The PIHP will receive a monthly per member per month non-risk repayment for each enrolled individual. After the end of each calendar year, the Department will reconcile payments made to the PIHP with the cost of those services provided repriced against the Medicaid fee schedule and will either recoup from or make additional reimbursements to the PIHP based on the results of the reconciliation. In addition, the Department will provide administrative funding.

1. Non-risk Prepayment Rates
   In consideration of full compliance by the PIHP with contract requirements, the Department agrees to make monthly non-risk prepayments to the PIHP based on the non-risk prepayments include adjustments for care coordination costs and adjustments for approved "in-lieu of" service costs. It does not include services that are not covered under the State Plan.

   The Department will make payments for members enrolled for a partial month based on a daily rate. The daily rate is calculated by multiplying the monthly prepayment rate by 12 months and dividing that amount by 365 days (366 for leap years). This is the daily rate that will be sued for midmonth enrollments.

2. Annually Review of Non-risk Prepayment Rates
   The monthly non-risk prepayment rates set forth in this article are recalculated on an annual basis.

   a. DHS will incorporate CY2025 capitation rates into this contract via an amendment. The CY2024 capitation rates will remain in effect until the CY2025 are implemented.

   b. The PIHP will have 30 days from the date of the written notification to accept the new payment rates in writing or to initiate termination or non-renewal of the contract.

   c. A non-response after 30 days constitutes acceptance of the rates.

   d. The payment rates are not subject o renegotiation by the PIHP once they have been accepted.

e. The Department may elect to renegotiate rates as required by changes in federal or state laws, rules or regulations.

f. The Department may adjust payment rates to reflect the implementation of material provider rate changes. The rate adjustment would be certified as actuarially sound and approved by CMS in the form of a contract amendment.

3. Reconciliation & Quarterly Final Review

a. Quarterly Financial Review
The Department will perform a quarterly financial review to determine the adequacy of the non-risk prepayment rates. Within 45 days of the end of the quarter the PIHP will submit a financial statement to the Department for the PIHP program. If the PIHP program sustains an operating loss of more than 10% for two consecutive quarters, the Department will provide an additional payment to the PIHP in the amount of the year-to-date operating loss. Email financial statements to DHSDMSBRS@dhs.wisconsin.gov.

b. Final Reconciliation
Final reconciliation for each calendar year period will be initiated twelve months after the end of the calendar year period and completed no later than three months thereafter. This process will not be initiated earlier than twelve months after the end of the calendar year period in order to allow a sufficient claims run out of time.

i. Quarterly Detail Claims and Access Payment Reports—The PIHP must submit a quarterly detail claims report to the Department identifying member services incurred during the pervious calendar year. These data files must include unique member identifier, unique claim number identifiers, service codes, dates of service, and paid amounts. These files will be supplemental to encounter submissions and used by the Department to track the completeness of encounter reporting.

The PIHP must also submit a quarterly report to the Department identifying access payments for services incurred during the previous calendar year. These reports should be in the same format specified in Article XV, B.3.b.4.

ii. Service Costs—The reconciliation amounts will be calculated by comparing the amounts paid to providers against the service reported in the encounter system re-priced at the Medicaid fee-for-service paid amount. Encounters submitted and repriced in the encounter system by the end of the thirteenth (i.e. January 31st) month after the calendar year will be included in the final reconciliation. The Department will send all service year encounters in the MMIS to the PIHP by the middle of the 14th month (i.e. February 15th). The final reconciliation amount will include a missing data adjustment up to two percent of the total allowable costs to account for missing encounters that were submitted but not accepted by MMIS.

This adjustment will be developed based on a comparison of the total PIHP paid amounts in the encounter data and the total member service costs reported in the PIHP's audited financial data. The total member service costs reported in the PIHP's audited financial data will be divided by the total PIHP paid amounts in the encounter data. A factor of one (1) will be subtracted from this percentage. This final percentage will be multiplied by the total repriced paid amounts in the encounter data to determine the missing data adjustment dollar amount.

The missing data adjustment will not exceed the lesser of either two percent of total allowable costs or the missing data adjustment dollar amount derived from dividing the total member service costs reported in the PIHP's audited financial data by the total PIHP paid amounts in the encounter data, subtracting one (1) and multiplying by the total repriced paid amounts in the encounter data.

Examples of Missing Data Adjustment Calculation:

	a	b	c (a/b)-1	d	e c*d	f 2%*a	g Lesser of e or f
	Total allowable member service costs reported in the PIHP's audited financial data.	Total PIHP paid amounts in the encounter data.	Missing data adjustment formula.	Total repriced paid amounts in the encounter data.	Missing data adjustment amount.	Two percent of total allowable costs.	Lesser of missing data adjustment or two percent of total allowable costs.
Example 1	$1,000,000	$950,000	5.263%	$930,000	$48,947.37	$20,000	$20,000
Example 2	$1,000,000	$950,000	1.010%	$970,000	$9,797.98	$20,000	$9,797.48

The resulting total service costs for allowable service provided to the eligible enrollees will be compared to the non-risk prepayment rates, less the administrative component, paid to the PIHP for the same period of time. If, in aggregate, the amount spent as reported in this manner is greater than the amount paid in non-risk prepayment rates by the Department, an additional payment will be made to the contracting provider. If, instead, the amount reported is less than the Department provided in non-risk prepayments, a recoupment will be processed. The PIHP will submit the Financial Template and signed encounter attestation by the end of the fifteenth month (i.e. March 31st). The corrected amount calculated will be provided or recouped by the Department, by the end of the seventeenth month (May 31st) after the end of the calendar year period in question.

iii. PIHP Certification—A letter from the PIHP certifying the encounter data reflects actual utilization shall be submitted to the Department no later than the fourteenth month after the end of the calendar year. This

letter shall be submitted to CMS by the Department as part of the required CMS reconciliation documentation. The letter shall be signed by an officer or director the PIHP and shall contain:

1) Contract year being certified.
2) Total dollar mounts of claims paid for dates of service within the contract year. The dollar amount shall include billable care management. The contract year will be determined by the from date on the claim.
3) Total count of unique claim numbers for paid claims with the from date of service occurring within the contract year being certified. This include claims where the liability of the PIHP may be zero due to payments made by other health insurance.
4) Total access payments paid for contract year.
    a) Inpatient Hospital—Total access payments paid for claims with an admit date during the contract year being certified.
    b) Outpatient Hospital—Total access payments for claims with a from date of service during the contract year being certified.
5) Statement attesting to the accuracy and completeness of the data.

Email annual certification and access payment detail to DHSDMSBRS@dhs.wisconsin.gov.

iv. Access Payment Costs—Included with the PIHP certification, the PIHP shall submit detailed information for access payments for the certification year.

1) Inpatient hospital admissions and outpatient visits—The detail shall include the following fields for hospital inpatient admissions and outpatient visits:
    a) MA ID of provider.
    b) NPI of provider.
    c) Hospital name.
    d) Number of qualifying inpatient admissions paid to the individual hospital for admissions with a from date of service within the contract year being certified.
    e) Access payment rate per inpatient discharge.
    f) Total access payment to the hospital for inpatient discharges.

g) Total number of outpatient visits paid to the hospital for visits with a from date of service within the contract year being certified.

h) Access payment rate per outpatient visit.

i) Total payment to hospital for outpatient discharges.

v. Administrative Cost—Administrative Costs will not be reconciled.

c. Interim Payments for High-Cost Members
The non-risk prepayment rate will be established to reflect the anticipated benefit cost of the WI FCMH population. However, due to the distribution of these costs over the annual period and the small number of members, benefit costs may vary if there are unanticipated high costs members. The PIHP may request an interim payment from the Department. The PIPH may make a request to the Department for an interim financial payment no more than once every 30 days. The PIHP must submit a claim to the Department in accordance to current billing standards and include a statement or explanation of benefits (EOB) showing the amount of reimbursement paid. In the case of extended hospitalization, the PIHP may submit interim payment requests to the Department if the interim payments were made to the hospital.

The PIHP is still required to submit all claims in accordance with the encounter reporting requirements. Any additional payments made to the PIHP will be accounted for in the reconciliation process. All interim financial payments to cover on-going high-cost member expenses will be subject to approval.

C. Recoupments

The Department will recoup the PIHP payments as described below:

1. The Department will recoup PIHP's non-risk prepayment for the following situations where a member's PIHP status has changed for which a non-risk prepayment has been made:
    a. Member moves out of the PIHP's service area.
    b. Member enters an ineligible setting including residential care centers and secure facilities.
    c. Member dies.
    d. Member voluntarily disenrolls.
2. The Department will recoup the PIHP capitation payments for the following situations where the Department initiates a change in a member's PIHP status on a retroactive basis, reflecting the fact that the PIHP was not able to provide services. In these situations, recoupments for multiple months' capitation payments are more likely.

a. Correction of a computer or human error, where the person was never really enrolled in the PIHP.

b. Disenrollments of members for continuity of care reasons, or as specified in Article II.B.

3. If a PIHP member moves out of the PIHP's service area, the member will be disenrolled from the PIHP on the day they moved as verified by the eligibility worker. Any non-risk prepayments made for periods of time after disenrollment will be recouped.

4. The effective date of a voluntary disenrollment may be any day of the month. Payments for members who disenroll mid-month or lose program eligibility (e.g., by transferring to an ineligible setting such as a residential care center) will be appropriately recouped based on a daily rate in a subsequent financial cycle.

D. Coordination of Benefits (COB) and Third Party Liability (TPL)

To maintain the confidentiality of children in out-of-home care and consistent with Medicaid policy, the PIHP is not required to coordinate benefits.

For purposes of the COB and TPL, and pursuant to the Federal Deficit Reduction Act (P.L. 109-171, sec. 6035), the PIHP shall use cost avoidance when possible, except as otherwise permitted herein. Specifically, the PIHP is prohibited from referring members to publicly supported health care resources to avoid costs. While the PIHP cannot recoup payment pending third party liability recovery, it may request additional information from a provider or member prior to payment.

E. Hospital Access Payments

The non-risk prepayment rates paid to the PIHP Include funds for access payments. Consistent with reconciling after benefit costs to the Medicaid fee schedule these payments made to the PIHP as part of the non-risk prepayment rates will be reconciled to the Medicaid fee for service payment rates after the end of the contract year.

The PIHP shall make payments to Acute Care Hospitals or Critical Access Hospitals (CAH) based on the number of qualifying inpatient discharges and outpatient claims in the previous month. To ensure consistency with the reconciliation, the PIHP should pay the previous month's access payments at the FFS access payment amount for the appropriate dates of service. FFS access payment information can be found on the Department's website. The PIHP shall make payments to the hospitals no later than 15th of the following month.

These payments are in addition to any amount the PIHP is required by agreement to pay the hospital for provision of services to PIHP members. An "acute care hospital" means a Wisconsin hospital that is not a critical access hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital.

An “eligible CAH” means a Medicaid enrolled Wisconsin CAH that is not an acute care hospital, an institution for mental disease, or a general psychiatric hospital for which the Department has issued a certificate of approval that applies only to the psychiatric hospital and that is not a satellite of an acute care hospital.

A list of qualifying hospitals is available from the Department upon request.

“Qualifying discharges and outpatient claims” are inpatient discharges and outpatient claims for which the PIHP made payments to eligible providers in the preceding month, for services to the PIHP’s members, other than members who are eligible for both Medicaid and Medicare or Childless Adult (CLA) plan members. The PIHP shall exclude all members who are dually-eligible and all dual-eligible claims and members of CLA plans. If a third party pays the claim in full, and the PIHP does not make a payment, the claim shall not count as a qualifying claim for the hospital access payment. If the PIHP pays any part of the claim, even if there is a third party payer, the claim will be counted as a qualifying claim for hospital access payments.

1. Quarterly reporting requirements
   At the end of each quarter, the PIHP must submit the report in Addendum V, D to the Department. The spreadsheet shall contain the information identified in Article XV, Section A.3.b(4).
2. Noncompliance
   The Department shall have the right to audit any records of the PIHP to determine if the PIHP has complied with the requirements in this section. If at any time the Department determines that the PIHP has not complied with any requirement in this section, the Department will issue an order to the PIHP that it comply and the PIHP shall comply within 15 calendar days after the Department’s determination of noncompliance. If the PIHP fails to comply after an order, the Department may terminate the contract as provided under Article XIV, D.

   Upon request, the PIHP must submit a list of paid inpatient and outpatient claims to the Department and any other records the Department deems necessary to determine compliance.

   If the PIHP fails to send payment to the hospital within the payment timeframe, the PIHP will pay a fine to the Department equal to three percent of the delayed payment.
3. Payment disputes
   If the PIHP or a hospital dispute the monthly amount that the PIHP is required to pay the hospital, either party may request that the Department determine the amount of the payment if the request is filed within six months after the first day of the month in which the payment is due. The Department will determine the amount of the payment within 60 days after the request for a determination is made. The PIHP or hospital may request a contested case hearing under Ch. 227 on the Department’s determination.

4. Resolution of Reporting Errors
   The PIHP shall adjust prior hospital access payments that were based on an inaccurate counting of qualifying inpatient discharges or outpatient claims.

F. Unauthorized Programs or Activities

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

G. Payment Method

All payments, recoupments, and debit adjustments for payments made in error, distributed by the Department to the PIHP, will be made via Electronic Funds Transfer (EFT) via enrollment through the secure ForwardHealth Portal account.

PIHPs are responsible for maintaining complete and accurate EFT information in order to receive payment. If a PIHP fails to maintain complete and accurate information and DHS makes a payment to an incorrect account, the Department will be held harmless and will not reissue a payment.

All arrangements between the financial institution specified for EFT and the PIHP must be in compliance with all applicable federal and Automated Clearing House (ACH) regulations and instructions.

EFT information provided by the PIHPs via their secure ForwardHealth Portal account constitute a statement or representation of a material fact knowingly and willfully made or caused to be made for use in determining rights to payment within the meaning of s.49.49(1) and (4m), Wis. Stats., and if any such information is false, criminal or other penalties may be imposed under these laws.

The requirements and obligations for EFT are in addition to any and all other requirements and obligations applicable to PIHP in connection with their contract and their participation in any program that is part of ForwardHealth, including but not limited to requirements and obligations set forth in federal and state statutes and rules and applicable handbooks and updates.

H. Interpreter Services

1. PIHP expenses for employing interpreters may be included in the development of the administrative component of the PIHP payment.
2. PIHP may not claim interpreter services, reimbursed via encounter-based payments, as an administrative expense.

XVII. PIHP Specific Contract Terms

A. Documents Constituting Contract

1. Current Documents

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

2. Future Documents

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

B. Disclosure Statement(s) of Ownership or Controlling Interest in an PIHP and Business Transactions

1. Ownership or Controlling Interest Disclosure Statement(s)

   a. Pursuant to 42 CFR § 455.104 PIHP's, and subcontracted disclosing entities and fiscal agents, must provide the following disclosures to the Department:

      i. The name and address of any person (individual or corporation) with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box.

      ii. Date of birth and Social Security number (in the case of an individual).

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

Calculation of 5% Ownership or Control is as follows:

a) The percentage of direct ownership or control is the percentage interest in the capital, stock or profits.

b) The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization. Thus, if a person owns 10% of the stock in a corporation that owns 80% of the stock of the PIHP, the person owns 8% of the PIHP.

c) The percentage of ownership or control through an interest in a mortgage, deed or trust, note or other obligation is calculated by multiplying the percent of interest that a person owns in that obligation by the percent of the PIHP's assets used to secure the obligation. Thus, if a person owns 10% of a note secured by 60% of the PIHP's assets, the person owns 6% of the PIHP.

iv. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity is related to another person with ownership or control interest in the disclosing entity is a spouse, parent, child, or sibling; or whether the person with an ownership or control interest in any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

v. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

vi. The name, address, date of birth, and Social Security number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

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

i. Upon the provider or disclosing entity submitting the provider application.

ii. Upon the provider or disclosing entity executing the provider agreement.

iii. Upon request of the department during the re-validation of the enrollment process.

iv. Within 35 days after any changes in ownership of the disclosing entity.

c. Disclosure from fiscal agents are due at any of the following times:

i. Upon the fiscal agent executing the contract with the Department.

ii. Upon renewal or extension of the contract.

iii. Within 35 days after any changes in ownership of the fiscal agent.

d. Disclosure from PIHP's are due at any of the following times:

i. Upon the PIHP executing the contract with the Department.

ii. Upon renewal or extension of the contract.

iii. Within 35 days after any change in ownership of the managed care entity.

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

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

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

g. If the Department finds that the PIHP has a prohibited relationship with a person or entity who is debarred, suspended, or excluded from participation in federal healthcare programs, the Department:

i. Must notify the Secretary of noncompliance.

ii. May continue an existing agreement with the PIHP unless the Secretary directs otherwise.

iii. May not renew or otherwise extend the duration of an existing agreement with the PIHP unless the Secretary

provides to the Department and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

2. Business Transaction Disclosures

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

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

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

If the BadgerCare Plus and Medicaid SSI PIHP Contract is being renewed or extended, the PIHP must disclose information on those business transactions that occurred during the prior contract period. If the Contract is an initial contract with WI FCMH, but the PIHP has operated previously in the commercial or Medicare markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed. The business transactions which must be reported are not limited to transactions related to serving WI FCMH enrollment. All of these PIHP business transactions must be reported.

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

In accordance with 42 CFR § 455.106:

a. The PIHP must disclose to the Department the identity of any person who:

i. Has ownership or control interest in the provider, or is an agent or managing employee of the provider, and

ii. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or title XX service program since the inception of those programs.

b. The PIHP shall report to the Department within 20 working days of receipt of the following:

i. Any information regarding excluded or convicted individuals or entities, including those in Article XVII.B.3.a.ii.above;

ii. Any occurrence of an excluded, convicted, or unlicensed entity or individual who applies to participate as a provider.

c. Denial or termination or provider participation

i. The Department may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the title XX service Program.

ii. The Department may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under Article XVII.B.3.a.ii. above.

C. Miscellaneous

1. Indemnification

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

a. Any failure, inability, or refusal of the PIHP or any of its subcontractors to provide contract services.

b. The negligent provision of contract services by the PIHP or any of its subcontractors.

c. Any failure, inability or refusal of the PIHP to pay any of its subcontractors for contract services.

2. Independent Capacity of Contractor

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

3. Omissions

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

4. Choice of Law

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

5. Waiver

No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract will impair that right or power or be construed as a waiver

thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other will not be construed as a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement contained herein.

6. Severability

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

7. Survival

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

8. Force Majeure

   Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including but not limited to an act of war, and excluding labor disputes.

9. Headings

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

10. Assignability

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

11. Right to Publish

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

12. Media Contacts

    The PIHP agrees to forward to the Department all media contacts regarding WI FCMH programs or members.

D. PIHP Specific Contract Terms

1. Initial Contract Period

   The respective rights and obligations of the parties as set forth in this Contract shall commence on January 1, 2024, and unless earlier terminated, shall remain in full force effective through December 31, 2025. The specific terms for

enrollment, rates, risk-sharing, dental and chiropractic coverage are as specified in the Contract.

2. Renewals

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

3. Specific Terms of the Contract

   a. The specific terms in the PIHP's completed application for certification are incorporated into this Contract, including whether dental services and chiropractic services will be provided by the PIHP.

   b. For each rate period in this Contract, the PIHP agrees, at minimum, to maintain the service area that was in effect at the time the PIHP accepted the rates. This provision does not prevent the PIHP from expanding to new service areas as approved by the Department.

   c. The PIHP's service area are specified in its certification application.

   d. Rates are determined for county(ies) in which enrollment is accepted.

   e. Adjusted rates - Rates may be changed to reflect legislative changes in WI FCMH reimbursement or changes in approved services. Rate changes may occur during the rate year or in rare instances, retroactively.

   f. The Department shall calculate chronicity or risk adjustment scores as part of the rate development methodology depending on the availability of data. The risk adjustment scores will be applied prospectively to the rate schedule in the rate exhibits provided by the Department. The Department may adjust the PIHP prospective risk score if a significant variance in chronicity occurs from the risk adjustment score that was used to adjust the base rates. Any such adjustment will take effect no sooner than 45 days after calculating the variance. Any risk score changes applied to a given PIHP will also impact other PIHP risk scores due to budget neutrality requirements.

   g. An annual risk adjustment reconciliation will be calculated based on actual enrollment. This may result in additional payments to or recoupments from the PIHP. The adjustments will be budget neutral to the Department.

E. Noncompliance

The Department shall have the right to audit any records of the PIHP and to request any information to determine if the PIHP has complied with the requirements in this section. If at any time the Department determines that the PIHP has not complied with any requirement in this article, the Department will issue an order to the PIHP to comply. The PIHP shall comply within 15 calendar days after receipt of the order. If the PIHP fails to

comply after an order, the Department may pursue action against the PIHP as provided under Article XIV.D. Additionally, the PIHP may be required to forfeit the reimbursement.

F. Payment Disputes

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

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

G. Resolution of Reporting Errors

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

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

In WITNESS WHEREOF, the State of Wisconsin has executed this agreement:

PIHP Name	**State of Wisconsin**
Official Signature	Official Signature
Printed Name	Printed Name
Title	Title
Date	Date

ADDENDUM

I. PIHP Standard Member Handbook

The PIHP Standard Member Handbook is located on ForwardHealth.

ADDENDUM

I. Comprehensive Initial Assessment Requirements

Each child shall have a Comprehensive Initial Health Assessment within 30 days of enrollment in the PIHP. Ideally, the pediatric nurse practitioner or a primary care physician who performs the comprehensive initial health assessment continues to follow the child throughout his/her stay in foster care. The child/adolescent, out-of-home care provider(s), Division of Milwaukee Child Protective Services (DMCPS) or county child welfare professional, health care coordinator and birth parent(s) should be encouraged to attend the comprehensive initial health assessment whenever possible.

A. Proposed components of the Comprehensive Initial Assessment

1. A review of the child's available medical, behavioral, developmental, and social history (including results from the Child and Adolescent Needs and Strengths, if available) to guide provision of health care services.
2. A standard medical review of systems.
3. Complete unclothed physical examination (including genital examination) in compliance with the enhanced HealthCheck (Wisconsin's Early Periodic Screening, Diagnosis and Treatment) scheduled in Article III, L of the contract.
4. Close inspection for and documentation of any signs of child abuse, neglect, or maltreatment. Those primary care practitioners with limited experience this area should refer to the child protective center as necessary if a physical or sexual abuse exam is indicated.
5. Growth and nutritional assessment including measurement of height, weight, BMI, and head circumference for children <3 years old).
6. Immunization review.
7. Hearing/vision review with referral as indicated.
8. Dental/oral inspection with referral as indicated.
9. Adolescent survey (discussion with adolescents) to include at a minimum:
    a. Family relationships (foster and birth).
    b. Alcohol/drug/tobacco use.
    c. Sexual activity/sexual orientation.
    d. Pelvic examination and family planning counseling services for sexually active females as soon as possible.
    e. Prevention of sextually transmitted infections (STIs) and birth control.
    f. School performance.
    g. Educational/career plans.
    h. Physical activity/exercise/hobbies.
10. Screening lab tests based on the age and condition of the child (e.g., CBC, lead level, U/A, HIV testing if positive risk assessment and consent obtained).

11. Anticipatory guidance including education and counseling on topics specific to out-of-home care:
    a. General adjustments to new home, grief and loss issues.
    b. Behavioral problems that may have surfaced (adjustment re3actions, opposition behavior, depression, anger, attention or impulse control problems, etc.).
    c. Sleep problems.
    d. Appetite/unusual eating habits.
    e. Enuresis/encopresis.
    f. School problems behavioral/academic.
    g. Interaction with other children in the home.
    h. Contact with birth family including difficulties around visits.
12. Referrals to dental, mental health, Birth to Three, or other medical services as appropriate.
13. Assess "goodness of fit" between the child and the out-of- home care family.
14. Review of all current medications with distinct identification and documentation of any psychotropic medications, including clear identification of antipsychotic medications.

B. Developmental screen for younger children (those ≤5 years of age).

Measurement tools are not specified because they will vary depending up on the child's age and developmental stage. However, a developmental screening should include measurement of the following domains using whatever standardized tool the practitioner deems most appropriate.

a. Gross motor skills.
b. Fine motor skills.
c. Cognition.
d. Expressive and receptive language skills.
e. Social interactions.
f. Activities of daily living (ADL) skills.

A developmental assessment by a pediatric therapist(s) (physical, occupational, speech) should occur as soon as possible if problems are suspected. Children under three years of age can be referred to the Birth to 3 Early Intervention Program for evaluation.

Ongoing developmental surveillance should be incorporated at every well-child preventive visit to identify developmental concerns that may have surfaced since the child entered foster care. In addition, it I strongly recommended that a valid developmental screening test be administered regularly at the 9-, 18-, and 30-month visits.

C. Behavioral/Mental Health Screen for children over 5 years of age and adolescents.

MH Screening tools are not specified because they will vary on the child's age.

Note: The Child and Adolescent Needs and Strengths (CANS) will be administered by the child welfare professional to all children within 30 days of entering out of home care. If available at the time of the comprehensive initial health assessment, the results from the CANS should be reviewed. The review should include any requests for consideration of further behavioral health evaluation, treatment or therapy based on either the results of the CANS, or on identified behavioral/mental health concerns of the child welfare agency, child, family, or foster caregiver**.**

ADDENDUM

II. Coordination of Developmental and Mental/Behavioral Health Services

Coordination of developmental and mental/behavioral health services is critical to ensure appropriate and timely service delivery and to communicate service specific information to the Division of Milwaukee Child Protective Services (DMCPS) or the county child welfare agency, out-of-home care family, birth family, and primary care medical home providers. The health care coordinator, who oversees all aspects of health care for a child in out-of-home care, is responsible for ensuring frequent, effective communication and collaboration with the DMCPS or the county child welfare agency, out-of-home care family, birth family, and other service providers.

A. Coordination Goals

1. To review the results of either the developmental or mental/behavioral health screens as they relate to the Comprehensive Initial Health Assessment for each child, based on their age and history, including any prior evaluations.
2. To coordinate and arrange for all developmental or behavioral health assessment and/or treatment services recommended from the out-of-home care health screen, the CANS, comprehensive initial health assessment, or other periodic re-examination.
3. To ensure that all periodic reassessments and reviews are done according to protocol, including any additional developmental and mental health services needed as the result of changes in placement.
4. To ensure that the out-of-home caregiver (and birth family when appropriate) is educated regarding the child's developmental and mental health needs.
5. To facilitate coordination and communication among developmental and mental health providers involved in an individual child's care.
6. To communicate and coordinate developmental and behavioral/mental health services with the DMCPS or county child welfare agency.
7. To assure that identification and ongoing oversight of children who are prescribed psychotropic medications is occurring regularly, including recommended metabolic testing for children on antipsychotic medication.

B. Treatment Service Options

1. Developmental services may include but are not limited to:
    a. Head Start.
    b. Early Intervention, Birth to Three and/or community-based PT, OT, or Speech therapies.
    c. Pre-school or school-age therapy services.
    d. Speech and language therapy.
    e. Occupational therapy.
    f. Physical therapy.

2. Mental/behavioral health services may include but are not limited to:
    a. Psychotherapies (individual, group, cognitive-behavior, social skills training);
    b. Psychoeducational services;
    c. Infant mental health services;
    d. Psychopharmacological treatment;
    e. Substance abuse treatment;
    f. Peer support for children/adolescents specifically related to issues of foster care placement such as separation and loss, loss of autonomy and control, etc.; and
    g. In-Home Therapy services.

ADDENDUM

III. Example Memorandum of Understanding

BETWEEN [PIHP NAME] [or its subcontractor] AND THE (INSERT DIVISION OF MILWAUKEE CHILD PROTECTIVE SERVICES OR COUNTY CHILD WELFARE AGENCY)

Purpose

This document represents an agreement between PIHP and the {insert child welfare agency name]. Specifically, this memorandum is written to identify roles and responsibilities between the PIHP and the [Insert County Agency] who have entered into an agreement for the purpose of providing and paying for services to Members enrolled in Care4Kids program under the State of Wisconsin Foster Care Medical Home (FCMH), and for the further specific purpose of promoting coordinating and continuity of preventative health services and other medical care and to ensure prompt and appropriate payment for services provided between agencies.

The [insert child welfare agency name] works with families to ensure the safety and wellbeing of children. With its many community partners, [insert agency name] provides service to families in crisis that help keep children safely in the home. When it is necessary, [insert agency name] looks to foster and adoptive families to provide appropriate temporary and permanent homes for children who cannot live with their parents.

The PIHP is responsible for the management of the complex medical, dental, vision, psychosocial, and developmental needs of children in out-of-home care including those with special health care needs. The PIHP will establish a health care management structure that assures coordination and integration of all aspects of the child's health care needs and promotes effective communication between the individuals who are instrumental to the child's care.

Definitions

Care Coordination: The integration of all processes in response to a child's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.

Child in Out-of-Home Care: Refers to a child taken into custody and determined by a judge to meet the need for continuation of custody under s. 48.21(4)(b) or a parent/legal guardian signs a Voluntary Placement Agreement with DMCPS or the county Child Welfare Agency. A child in out-of-home care may reside in a variety of different placement settings, including a foster home, a group home, or a relative's home.

Comprehensive Initial Health Assessment: A comprehensive initial health assessment is required for all children entering out-of-home care who are enrolled in the foster care medical home program and must occur within 30 days of removal. This assessment should be comprehensive with respect to the identification of possible acute and chronic physical health, behavioral/mental health, oral health, and developmental problems; and, must be in compliance with Wisconsin Health Check requirements. This assessment should include components of both developmental and behavioral/mental health screenings as indicated for each child based on

his/her age and history, including any prior evaluations. This assessment should be performed by a clinician who is knowledgeable about the trauma-informed evaluation and treatment of children in out-of-home care.

Member: A child in out-of-home care who has been certified by the state as eligible to enroll under this Contract, and whose name appears on the Enrollment Reports that the Department transmits to the PIHP according to an established notification schedule. Children born to members of the PIHP will be enrolled in the PIHP if covered under the out-of-home care court order unless disenrolled at the request of the parent.

Out-of-Home Care Health Screen: The screening is completed no later than 2 business days after the child enters out-of-home care. The purpose of the screen is to identify any immediate medical, urgent mental health, or dental needs the child may have and any additional health conditions of which the out-of-home providers and child welfare professional should be aware of. This screen may also be referred to as the "Foster Care Health Screen".

Out-of-Home Care Provider: The Care4Kids program will serve children placed with providers that are Court Ordered Kinship, Level 1 – Level 5 Foster homes and Group Homes.

Parent/Legal Guardian: Biological parent, parent by adoption, or has a person named by the court having the duty and authority of guardianship.

A. PIHP Rights and Responsibilities

1. PIHP will provide contact information for the Lead Care Coordinator who will serve as the primary contact for the agency for care coordination issues on behalf of individual members.
2. PIHP will provide contact information for the Health Care Coordinator(s). Each child will be assigned a Health Care Coordinator at the time of their enrollment in the medical home. The Health Care Coordinators will serve as the clinical specialist who oversees all aspects of the child's health care.
3. PIHP will provide all Medicaid-covered mental health and substance abuse services to children identified as clients of the [insert agency]. Disputes in the medical necessity of services identified in the Family Treatment Plan will be adjudicated using the dispute process outlined in this MOU, except that the PIHP will provide court ordered services in accordance with the contract.
4. PIHP's responsibilities related to the enrollment process includes the following activities:
    a. Review eReports from eWISACWIS daily to identify children enrolled in the Care4Kids program.
    b. Send informational packets to the parent/legal guardian and the out-of-home care provider within 5 business days of the receipt of enrollment.
    c. Coordinate with the child welfare professional to obtain any necessary consent(s) for screenings and evaluation from the parent/legal guardian.

d. Other activities required by the contract.

5. PIHP's responsibility related to the Out-of-Home Care Health Screening includes the following:

    a. If needed, PIHP will provide support in identifying CAC's and scheduling the Out-of-Home Care Health Screen.

    b. Ensures transfer of Out-of-Home health screen finding to the primary care provider who will perform the Comprehensive Initial Health Assessment.

    c. Other activities required by the contract.

6. PIHP's responsibilities related to the Comprehensive Initial Health Assessment includes the following:

    a. Following up with the Out-of-Home Care provider to assist with scheduling the Comprehensive Initial Health Assessment.

    b. PIHP will obtain the child's past medical history, available health records and ensures the primary care provider has timely access to existing health information prior to the Comprehensive Initial Health Assessment.

    c. Other activities required by contract.

7. PIHP's responsibilities related to the Comprehensive Health Care Plan

    a. Development of the Comprehensive Health Care Plan with input from the child/youth, the parent/legal guardian, caseworker, out-of-home care providers and medical professionals. Ensures the results of the Comprehensive Initial Health Assessment form the basis for the Comprehensive Health Care Plan.

    b. Ensure that the initial Comprehensive Health Care plan is developed within 60 days of enrollment in the Care4Kids program.

    c. Ensure that the child's primary care physician and child welfare professional are primary participants in the development and periodic reviews of the comprehensive care plan. The child's primary care physician is the lead for the child's overall health care needs, and the child welfare professional has the overall responsibility for all aspects of the child's care.

    d. Identifying the responsible team member for each of the health care needs outlined in the Comprehensive Health Care Plan.

    e. Provide an opportunity for the parents/legal guardians an opportunity to review and sign off on the care plan. Evidence of this action will be reflected in the care plan.

    f. Other activities required by contract.

8. PIHP's responsibilities related to the Mental Health Screening and Evaluation includes the following:

a. Review the Out-of-Home Care Health Screen, the recommendations from the CANS, and the mental health screen from the Comprehensive Initial Health Assessment for any identified mental health needs.

b. Provides support in identifying and scheduling appointments with mental health providers in a timely manner, as needed.

c. Works with mental health provider in developing the Comprehensive Health Care Plan, including a crisis plan if indicated.

d. Sharing the crisis plan with the team.

e. Other activities required by the contract.

9. PIHP's responsibilities related to the comprehensive Oral Evaluation include:

a. Provide support in identifying and scheduling appointments with dental providers in a timely manner.

b. Ensure that each child 12 months of age and above receives a comprehensive oral evaluation by a dentist.

c. Ensures that the oral evaluation happens within 3 months of enrollment, or a re-call exam if a comprehensive oral examination was conducted within 6 months prior to enrollment.

d. Works with the dental provider in developing the Comprehensive Health Care Plan.

e. Other activities required by the contract.

10. PIHP's responsibilities related to the Ongoing Monitoring of Care4Kids member success includes the following:

a. Hold regular, and as needed meetings with the child, parent/legal guardian and out-of-home care provider, child welfare professional, health care provider staff and others involved in the delivery of services to the child to monitor and evaluate progress/success, prioritize necessary services for the child including care that will be obtained external to the PIHP network (e.g. County-based services).

b. Assists new Out-of-Home care providers with identifying and scheduling needed appointments with a new primary care provider if needed.

c. Establishing measurable healthcare goals and periodically re-evaluating progress towards established goals and outcomes.

d. Development of a system to track changes in the health care status of the child which are reflected through periodic review and updating of the health care plan at least every six months.

e. Monitoring the child's case in eWiSACWIS to keep informed of the child's ongoing needs.

f. Monitor the child's continued enrollment in Care4Kids.

g. Annual metabolic screening and measurement of growth parameters (including BMI) for any child who is prescribed one or more antipsychotic medications.

h. Monitoring of the rate and types of psychotropic medication usage among members, stratified by age and number of medications prescribed.

i. Other activities required by the contract.

11. PIHP's responsibilities related to the Discharge from Out-of-Home Care includes the following:

a. Prior to discharge from out-of-home care, the PIHP will work with the team including the parent/legal guardian to create a transition health care plan.

b. Ensure that health information is transferred to a new primary care provider when a child is discharges from out-of-home care.

c. Monitor the child's continued enrollment in Care4Kids.

d. Other activities required by the contract.

12. PIHP's responsibilities related to the 12-month extension include:

a. Monitor the status of the 12-month extension.

b. Prior tot eh end of the extension, work with the parent/legal guardian to develop a transition health care plan.

13. PIHP's liaison, or other appropriate staff as designated by PIHP, will participate in case conference with [insert agency] upon the request of [insert agency]. The planning session may be done through telephonic or other means of communication when attending a formal case conference is not feasible.

14. The PIHP liaison and [insert the agency] will determine who will be responsible for ensuring that the Member receives the services authorized and provided through PIHP. PIHP will have a mechanism in place for notifying [insert the agency] of missed appointments, or crisis situations that could potentially lead to a change in placement by [insert the agency]. The notification will be within three business days for missed appointments or sooner if possible and as soon as possible for crisis situations.

15. PIHP agrees to participate in dispute resolution using the following process:

a. PIHP will provide the agency with contact information for the designated personnel who will respond to disputes.

b. The [Insert agency name] and PIHP designated personnel will meet or teleconference to discuss the case and attempt to resolve issues of dispute.

c. If the [insert agency name] designees and the PIHP designees (known as the team) are unable to resolve the issues, the [insert agency name] and the PIHP will schedule a meeting or a teleconference of representatives with

expertise in the area of dispute to look at outstanding issues within two days of the teleconference, or sooner if indicated.

d. If the team is unable to resolve the issues to both parties' satisfaction, either party may appeal to the Department. It will be the disputing parties' responsibility to supply the necessary documentation for the Department to adjudicate the dispute.

16. PIHP will work with the [insert agency name] in developing lists of providers and fostering a provider network which has expertise in:

    a. Working with children in out-of-home care effectively.

    b. Working with children who may have developmental, behavioral health or other special health care needs effectively.

    c. Recognizing the interrelationship of the problems [insert agency name] children in out-of-home placement experience and therefore, the value of close collaborative relationships among the various service providers working with the caregivers and child.

17. PIHP will share with the [insert agency name] the process and procedure for prior authorization and out-of-plan referrals.

18. Annually and when requested by the [insert agency name], PIHP will provide training to [insert agency name] staff and contract providers on a variety of subjects related to the Care4Kids program. Subject areas may include but are not limited to, PIHP's provider network, how the out-of-home care provider can appropriately access services including any referral and/or prior authorization processes and Member/caregiver grievances.

19. PIHP will participate in the [insert agency name] site managers' meetings when requested by [insert agency name].

20. The PIHP will share client specific information to assist [insert agency name] in any court-related proceedings.

B. [Insert agency name] Rights and Responsibilities:

1. [Insert agency name] will provide contact information for the staff person who will serve as the primary contact for the agency for care coordination issues on behalf of individual members.

2. [Insert agency name] will ensure the accurate contact information for the supervisors and the caseworkers who will be working with the Health Care Coordinator assigned to each child will be updated timely in eWiSACWIS.

3. It is the [insert agency name]s' responsibility to initiate contact with the PIHP regarding children in need of immediate services. [Insert agency name] will provide (through court order and/or signed release of information) completed assessment information which supports the request for PIHP services.

4. [insert agency name] will involve PIHP in the development of a comprehensive child welfare case plan, which identifies the outcomes to be achieved, the services to be provided and the measures to be used for evaluation. [Insert agency name] will be responsible for developing and periodically updating the child welfare case plan.
5. [Insert agency name] will utilize PIHP's provider network for routine services and will attempt to utilize PIHP's provider network for emergency services. [Insert agency name] will obtain criteria from the PIHP concerning [insert agency name]'s ability to utilize non-participating providers and the mechanism for authorizing non-participating providers.
6. [Insert agency name]'s responsibilities related to the enrollment process includes the following activities:
    a. Provide Care4Kids informational handout to the child's parent/legal guardian.
    b. Enter the child's placement into eWiSACWIS within 5 calendar days of placement.
    c. Complete Enrollment process outlined in the Enrollment policy.
    d. Obtain any necessary consent(s) for screening and evaluation.
    e. Other activities agreed upon by [insert agency name] and the PIHP.
7. [Insert agency name] responsibilities related to the Out-of-Home Care Health Screening includes the following:
    a. Ensure that the child is scheduled for and completes the Out-of-Home health Screening within 2 business days of entering out-of-home care.
    b. Ensure that the child receives the Out-of-Home Health Screening at a Child Advocacy Center when possible.
    c. If the Out-of-Home Health Screening is not completed within 2 business day, [Insert agency name] will document the reason in eWiSACWIS.
    d. Other activities agreed upon by [Insert agency name] and the PIHP.
8. [Insert agency name]'s responsibilities related to the Comprehensive Initial Health Assessment includes the following:
    a. Ensure the child is scheduled for comprehensive initial health assessment within 30 days of entering care.
    b. Ensure eWiSACWIS is up to date with all medical information and documentation of removal reasons when possible.
    c. Other activities agreed upon by [Insert agency name] and the PIHP.
9. [Insert agency name]'s responsibilities related to the Comprehensive Health Care Plan:

a. Identifies key team members to participate in the development of the Comprehensive Health Care Plan, including the child welfare professional.

b. Scans initial and updated Comprehensive Health Care Plan into eWiSACWIS.

c. Ensures the health care needs identified in the Comprehensive Health Care Plan are being executed.

d. Other activities agreed upon by [Insert agency name] and the PIHP.

10. [Insert agency name] responsibilities related to the Mental Health Screening and Evaluation includes the following:

a. Complete CANS within 30 days out-of-home care placement.

b. Ensure child is scheduled for and completes mental health evaluation if needed.

c. Other activities agreed upon by [Insert agency name] and the PIHP.

11. [Insert agency name] responsibilities related to the comprehensive Oral Evaluation include:

a. Ensures all children 12 months or older are scheduled for a comprehensive oral evaluation within 30 days of entering care.

b. Ensures that within 3 months of enrollment, all children 12 months or older complete a comprehensive oral evaluation or a re-call exam if a comprehensive oral evaluation was completed within the last six months.

c. Other activities agreed upon by [Insert agency name] and the PIHP.

12. [Insert agency name] responsibilities related to the Ongoing Monitoring of Care4Kids member success includes the following:

a. Notify the Health Care Coordinator of any new health concerns or changes in child's health status.

b. Works with the team to ensure that recommended follow up appointments are attended.

c. Update eWiSACWIS with any change of placements and determines if the child remains eligible for Care4Kids, following enrollment policy.

d. Informs the Health Care Coordinator of any court-ordered health services and assists in the scheduling of services.

e. Assists the Health Care Coordinator with any issues affecting the child's ability to receive appropriate health services such as the parent/legal guardian being unresponsive, or the Comprehensive Health Care Plan not being followed.

f. Monitors child's continued enrollment in Care4Kids, per Enrollment Policy.

g. Other activities agreed upon by [Insert agency name] and the PIHP.

13. [Insert agency name] responsibilities related to the Discharge from Out-of-Home Care includes the following:

    a. When possible, prior to discharge, notifies the Health Care Coordinator of the discharge plan.

    b. Update placement information in eWiSACWIS.

    c. Participate in the development of the transition health care plan.

    d. Monitor the child's continued enrollment in Care4Kids, per the enrollment policy.

14. [Insert agency name] agrees to participate in dispute resolution using the following process:

    a. Monitors the child's active participation in health care plan during the time the case remains open.

    b. Coordinates with Health Care Coordinator to assist in transition planning prior to case closure to ensure child's identified health care needs will be addressed.

    c. Other activities agreed upon by [Insert agency name] and the PIHP.

15. [Insert agency name] agrees to participate in dispute resolution using the following process:

    a. [Insert agency name] and PIHP designated personnel will meet or teleconference to discuss the case and attempt to resolve issues of dispute.

    b. If the [Insert agency name] designees and PIHP designees (known as the team) are unable to resolve the issues the [Insert agency name] and PIHP will schedule a meeting of representatives to look at outstanding issues within two days of the meeting or teleconference (or sooner if indicated).

    c. If the team is unable to resolve the issues to both parties' satisfaction, either party may appeal to the Department. It will be the disputing party's responsibility to supply the necessary documentation for the Department to adjudicate the dispute.

16. [Insert agency name] will assist PIHP in providing outreach to caregivers who are non-compliant with the child's treatment, HealthCheck, medication regimes, or who have multiple missed appointments for a child in out-of-home care.

17. [Insert agency name] agrees to provide training to PIHP staff or PIHP's provider network on child welfare issues at the request of the PIHP.

This Memorandum of Understanding (MOU) is in effect from [insert date] through [insert date] unless revised by mutual agreement. If changes in Federal or State requirements impact the current MOU, [PIHP] and the [Agency] agree to renegotiate the pertinent section within 90 days of receiving new instructions from the State.

Name	Title	Agency	Date

Name	Title	Agency	Date

THIS DOCUMENT IS TO BE USED AS A SAMPLE. Nothing in this document precludes CCHP or the Agency from adding other requirements to this MOU if it is in the best interest of the children they have in common and does not violate any of the agreements between the State agency and the PIHP.

ADDENDUM

IV. Report Forms and Worksheets

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

In order to comply with CMS reporting requirements, the PIHP must submit a Coordination of Benefits (COB) report regarding their WI FCMH members. For the purposes of this report, the PIHP member is any BadgerCare Plus and Medicaid SSI member listed as an ADD or CONTINUE on the monthly PIHP enrollment report(s) that are generated by the Department's Fiscal Agent.

THIRD PARTY LIABILITY (TPL)

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

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

1. In Medicaid, there are two primary functions related to detecting TPL obligations:
    a. Cost-avoidance – Determining the presence of TPL obligations before the claim is paid.
    b. Pay-and-chase – Identifying TPL obligations after the claim is paid.
2. The following definitions apply to TPL:
    a. Coinsurance – A portion or percentage of the cost for a specific service or item for which the individual is responsible when the service or item is delivered.
    b. Cost Avoidance – A method of preventing inappropriate payments under Medicaid and reducing improper Medicaid expenditures. Whenever the Medicaid agency is billed first and a potentially liable third party exists, the Medicaid agency rejects the claim and returns it to the provider to be billed to the primary payer to determine the third party's liability (42 CFR 433.139(b)).
    c. Deductible – A fixed dollar amount that an individual must pay before the costs of services are covered by an insurance plan.
    d. Estate – Property (real or personal) in which one has a right or interest at time of death.
    e. Health Insurer – Includes a group health plan, as defined in §607(1) of the Employee Retirement Income Security Act (ERISA) of 1974, a service

benefit plan, and a Managed Care Organization (MCO). (The inclusions are explanatory and not mutually exclusive.)

f. Insurer – Any private insurer or public insurer

g. Post Payment Recovery (Pay and Chase) – A method used where Medicaid pays the member's medical bills and then attempts to recover from liable third parties. Pay and Chase waivers are based on specific services as determined by procedure code or type of service.

h. Third Party – Any individual, entity, insurer, or program that is, or may be, liable to furnish health care services or to pay for all or part of the costs of medical assistance covered under a Medicaid State plan. Medicaid is generally the payer of last resort. Examples of a third party are employment-related health insurance, medical child support from non-custodial parents, and Medicare. Every Medicaid jurisdiction is required by §1902(a)(25) of the Act to take reasonable measures to determine the legal liability of third party payers.

Birth costs or delivery costs (e.g., routine delivery and associated hospital charges) are not to be included in the report.

The report is to be for the PIHP's entire service area, aggregating separate service areas if the PIHP has more than one service area. PIHPs are not required to report BadgerCare Plus and SSI COB separately. The report must be completed on a calendar quarterly basis and submitted to your DHS managed care analyst and the Department's fiscal agent within 45 calendar days of the end of the quarter being reported.

FAX To:

(608) 266-1096

ATTN: Birth Costs

STATE OF WISCONSIN
BADGERCARE PLUS AND MEDICAID SSI
PIHP REPORT ON COORDINATION OF BENEFITS

Name of PIHP Mailing Address
Office Telephone
Provider Number

Please designate below the quarter period for which information is given in this report.
_____, 20____ through _____, 20

A. Cost Avoidance – The amount reported should be the amount paid by TPL for "Dates of Payment" in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus and/or SSI program should not be reported.

Amount Cost Avoided:_____

B. Recoveries (Post-Pay Billing/Pay and Chase) – The amount reported should be the amount paid by TPL for "Dates of Recovery" in the quarter covered by this report. Coinsurance and deductible amounts associated with the BadgerCare Plus and/or SSI program should not be reported.

Subrogation/Workers' Compensation Amount:_____
(e.g., a recovery associated with physical injury).

Other Recoveries Amount:_____
(e.g., All other Third Party Liability (TPL) not specifically noted above.)

I HEREBY CERTIFY that to the best of my knowledge and belief, the information contained in this report is a correct and complete statement prepared from the records of the PIHP, except as noted on the report.

Signed:

Original Signature of CEO or CFO

Printed Name: _____

Title:

Date Signed:

B. Court Ordered Birth Cost Requests

County Child Support Agencies (CSA) obtain court orders requiring fathers to repay birth costs that have been paid by FFS as well as the PIHP. In some counties, judges will not assign birth costs to the father based upon average costs. Upon request of the Fiscal Agent Contract Monitor, the PIHP must provide actual charges less any payments made by a third party payer for the use by the court in setting actual birth and related costs to be paid by the father. Birth cost information must be submitted to the DHS within 14 days from the date the request was received by the PIHP.

The birth cost report forms follows this page.

BADGERCARE PLUS PIHP BIRTH COST REQUEST

PART 1: Local Child Support Agency Portion

PART 1: To be completed by the Local Child Support Agency. Please type or print, in a legible manner.

1. PIHP Name _____

2. Mother's Name _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Address _____
(Street Address)

_____
(City) (State) (Zip Code)

3. Newborn's Name _____
(First) (M.I.) (Last)

BadgerCare Plus ID Number _____

Date of Birth _____ Sex _____

Note: In cases of multiple births, a form must be completed for each newborn. In addition, the form(s) should not be submitted to the DHS until 60 days after the birth.

4. I certify this information is accurate to the best of my knowledge.

Name of Local Child Support Agency	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

5.

PART II: PIHP Portion

Part II: To be completed by the PIHP. Please type or print in a legible manner.

1. The actual payment for birthing costs for the mother and her baby.

Mother's Name _____ID#_____

Baby's Name _____ID#_____DOB_____

Hospital/Birthing Center Payment (Mother) $_____

Hospital/Birthing Center Payment (Newborn) $_____

Physician Payment (Mother) $_____

Physician Payment (Newborn) $_____

Amount Paid by Other Insurance $_____

2. Comments: (i.e., retroactively disenrolled from [PIHP NAME] effective [DATE], services denied)

[State Denial Reason]: _____

3. I certify this information is accurate to the best of my knowledge.

Name of PIHP	
Name (Please Print)	
Signature	
Title	
Date	
Telephone Number:	FAX Number:
Email Address:	

4. Mail or FAX Part I and Part II within 14 days of receipt to:

C. PIHP Newborn Report

The newborn report should be completed for infants born to mothers who are BadgerCare Plus eligible and enrolled in the PIHP at the time of birth of the infant. PIHPs are encouraged to use the online form to submit newborn information for more expedited processing.

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

Hospital Access Payment

* Total payments made to all hospitals should be equal to the total amount the PIHP received from the Department. The distribution of these funds by the PIHP to hospitals shall be based on eligible discharges and claims in the prior month paid by the PIHP to eligible hospitals.

PIHP Name	
Month, Year payment was received from the Department	
Month, Year from which hospital discharge and claims data is being reported (i.e. previous month)	
Date the last hospital access payment was sent	
* Grand Total Payment	

MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of Hospital Qualifying Inpatient Discharges Paid to the Individual Hospital	Number of Total Inpatient Discharges Paid by PIHP to All Eligible Hospitals	Percent of the Hospital's Total Inpatient Discharges Paid by the PIHP (Column 5 / Column 6)	Payment to Hospital for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of Hospital Qualifying Outpatient Claims Paid to the Individual Hospital	Number of Total Outpatient Claims Paid by PIHP to All Eligible Hospitals	Percent of the Hospital's Total Outpatient Claims Paid by PIHP (Column 10 / Column 11)	Payment to Hospital for Outpatient Claims (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

_____ _____

(Signature) (Date)

D. Summary Critical Access Hospital (CAH) Access Payment Report to Department of Health Services

This report will be provided to the PIHP electronically in the current PIHP contract for completion. Payments must be sent to the hospitals within 15 calendar days after the PIHP receives the monthly amounts from the Department. PIHPs must submit to the Department the following information for each paid CAH:

Critical Access Hospital (CAH) Access Payment

PIHP Name	
Month, Year payment was received from the Department	
Month, Year from which CAH discharge and claims data is being reported (i.e. previous month)	
Date the last CAH access payment was sent	
* Grand Total Payment	

* Total payments made to all CAH(s) should be equal to the total amount the PIHP received from the Department. The distribution of these funds by the PIHP to CAH(s) shall be based on eligible discharges and claims in the prior month paid by the PIHP to eligible CAH(s):

1	2	3	4	5	6	7	8	9	10	11	12	13
MA ID	NPI	Hospital Name	Inpatient Funding Received from DHS	Number of CAH Qualifying Inpatient Discharges Paid to the Individual CAH	Number of Total Inpatient Discharges Paid by PIHP to All Eligible CAHs	Percent of the CAH's Total Inpatient Discharges Paid by the PIHP (Column 5/ Column 6)	Payment to CAH for Inpatient Discharges (Column 4 x Column 7)	Outpatient Funding Received from DHS	Number of CAH Qualifying Outpatient Claims Paid to the Individual CAH	Number of Total Outpatient Claims Paid by PIHP to All Eligible CAH(s)	Percent of the CAH's Total Outpatient Claims Paid by PIHP (Column 10 / Column 11)	Payment to CAH for Outpatient Claims (Column 9 x Column 12)
		Total:										

I hereby attest and affirm that the information being submitted is complete, factual and correct to the best of my knowledge. I furthermore attest and affirm that no material facts have been omitted from this form. I understand that payment and satisfaction of this/these claim(s) will be from federal and state public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements, or documents, or concealment of a material fact. I furthermore understand that state or federal authorities may inspect all claims, records or documents pertaining to the provision of these services.

(Signature) (Date)

(PIHP Signature) (Date)

ADDENDUM

V. Benefits and Cost Sharing Information

A. Benefits and Cost Sharing Information

For current information about Wisconsin Medicaid covered services and allowable cost-sharing, please refer to ForwardHealth Online Handbooks, Provider Updates, and interchange. A summary of covered services for member audiences is available in Appendix B of the ForwardHealth Enrollment and Benefits Handbook (available at https://www.dhs.wisconsin.gov/library/p-00079.htm).

ADDENDUM

VI. Fraud, Waste and Abuse Strategic Plans

A. Fraud, Waste, and Abuse (FWA) Strategic Plans General Guidelines

1. PIHPs 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. PIHPs 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 located on the DHS OIG SharePoint site and provide feedback to the PIHP regarding any necessary changes.
    a. The PIHP must make the necessary edits and submit the plan to the DHS OIG SharePoint site for additional review. This cycle will continue until a compliant FWA strategic plan is submitted.
    b. PIHPs must ensure that DHS OIG's feedback, including any requested corrections or revisions, are incorporated into their strategic plans.
3. PIHPs are required to have approval of their annual FWA strategic plan prior to December 31.

B. FWA Strategic Plan Components

1. Data Analysis - Provide an overview of the data analysis that will be conducted to determine which fraud, waste or abuse issues the PIHP will prioritize in their FWA strategic plan. The PIHP 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

    Each program integrity initiative must:

    a. Identify the program integrity issue or risk the PIHP is attempting to address with each initiative.
    b. Identify the goal of each initiative.
    c. Identify the expected results of the initiative.
    d. Identify the objectives or strategies that will be used to achieve the goal of each initiative.

e. Describe the planned tasks for each quarter that are intended to achieve the identified goal.

f. Identify the anticipated completion date of the initiative.

g. Identify the personnel responsible for the completion of the initiative.

h. Identify the method by which the PIHP 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 as a 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 PIHP 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. Must be equal to or greater than 100 verifications per quarter;

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.

C. FWA Strategic Plan Approval Process

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

1. PIHPs will draft their annual FWA strategic plans in accordance with the requirements of this addendum.

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

3. DHS OIG will use the rubric below 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 PIHP for changes based on DHS OIG feedback from the rubric assessment.

5. DHS OIG will upload the FWA Strategic Plan Feedback Form to the PIHP SharePoint site indicating whether the plan has been approved or needs additional work completed.
6. If the FWA Strategic Plan needs correction, the PIHPs 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. Steps 4-6 are to be repeated until DHS OIG approves the FWA strategic plan.
8. Each PIHP must have an FWA strategic plan approved by DHS OIG by December 31.

D. FWA Strategic Plan Implementation Process

PIHPs 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 PIHPs indicate that they will be measuring their compliance with their FWA strategic plan. DHS OIG representative will contact PIHPs periodically during the year to offer support and technical assistance, and to ensure the PIHP is on track with their FWA strategic plan. If an updated FWA strategic plan is needed, DHS OIG can assist the PIHP in making the needed updates.

E. DHS OIG Audit of PIHP Compliance with the FWA Strategic Plan

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

1. An PIHP has refused to engage in technical assistance provided by DHS OIG in response to a determination that the PIHP is out of compliance with their FWA strategic plan; or
2. An PIHP has refused to engage in the audit process.

VII. Rates

Exhibit 4
Wisconsin Department of Health Services
CY 2024 Care4Kids Non-Risk Prepayment Rate Development
CY 2024 Non-Risk Prepayment Rates

		Milwaukee Adjustment			Southeastern Adjustment					
	Regional Variation	1.112	1.112	1.112	0.823	0.823	0.823			
		CY 2024 Milwaukee PMPMs			CY 2024 Southeastern PMPMs			CY 2024 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 2024 PMPM	Age 0	$918.59	$2,816.15	$1,889.75	$679.93	$2,084.48	$1,398.77	$826.27	$2,533.12	$1,699.82
	Ages 1-5	386.47	570.00	480.09	286.06	421.90	355.36	347.63	512.71	431.84
	Ages 6-14	439.25	481.77	464.86	325.12	356.60	344.08	395.10	433.35	418.14
	Ages 15-20 F	523.92	628.54	604.06	387.80	465.24	447.12	471.26	565.37	543.35
	Ages 15-20 M	329.61	543.97	497.37	243.97	402.64	368.14	296.48	489.30	447.38
CY 2024 PMPM Total		**$452.20**	**$675.99**	**$582.01**	**$334.71**	**$500.36**	**$430.80**	**$406.75**	**$608.05**	**$523.52**
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	$64.18	$64.18	$64.18	$64.18	$64.18	$64.18	$64.18	$64.18	$64.18
	Ages 1-5	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18
	Ages 6-14	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18
	Ages 15-20 F	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18
	Ages 15-20 M	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18	64.18
Access Payments Add-On Total		**$64.18**	**$64.18**	**$64.18**	**$64.18**	**$64.18**	**$64.18**	**$64.18**	**$64.18**	**$64.18**
Non-Risk Prepayment Rates	Age 0	$1,065.97	$2,963.53	$2,037.13	$827.31	$2,231.86	$1,546.15	$973.65	$2,680.50	$1,847.20
	Ages 1-5	533.85	717.38	627.47	433.44	569.28	502.74	495.01	660.09	579.22
	Ages 6-14	586.63	629.15	612.24	472.50	503.98	491.46	542.48	580.73	565.52
	Ages 15-20 F	671.30	775.92	751.44	535.18	612.62	594.50	618.64	712.75	690.73
	Ages 15-20 M	476.99	691.35	644.75	391.35	550.02	515.52	443.86	636.68	594.76
Non-Risk Prepayment Rates Total		**$599.58**	**$823.37**	**$729.39**	**$482.09**	**$647.74**	**$578.18**	**$554.13**	**$755.43**	**$670.90**