CONTRACT FOR SERVICES

Between

State of Wisconsin Department of Health Services (DHS)

and

Children's Hospital and Health System, Inc.

For

Foster Care Medical Home

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

Contract ID Number: 435400-O24-FosterCare-01 M1
Contract Amount: See rate exhibits included in this amendment
Contract Term: January 1, 2024 to December 31, 2025
Optional Renewal Terms: N/A

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

Contractor Contract Administrator: Heather Swider
Contractor Telephone:
Contractor Email:

Modification Description:
The following changes are made to the contract through this amendment

Article I: Definitions

Amend the following definitions to read:

Clean Claim: A claim that can be processed without obtaining additional information from the provider of the

service or from a third party. It includes a claim with errors originating in a state's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Individually Identifiable Health Information (IHI): Pursuant to 45 CFR § 160.103, information that is a subset of health information, including demographic information collected from an individual, and:

a. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
b. Relates to past, present, or future physical or mental health or condition of an individual; the provision of health care to an individuals; and
    i. That identifies the individuals; or
    ii. With response to which there is reasonable basis to believe the information can be used to identify the individual.

In addition, to any information that mees the above definition, individually identifiable health information also include the following categories of information:

a. Individuals' names and addresses
b. Medical services provided to individuals
c. Individuals' social and economic conditions or circumstances
d. Agency evaluation of personal information
e. Medical data, including medical diagnosis and past history of disease or disability
f. Any information received for verifying income eligibility and amount of medical assistance payments (see § 435.940 through § 435.965 of this subchapter). Income information received from SSA or the internal Revenue Service must be safeguarded according to the requirement of the agency that furnished the data, including section 6103 of the Internal Revenue Code, as applicable.
g. Any information received in connection with the identification of legally liable third-party resources under 42 CFR § 433.138.
h. Individuals' social security numbers.

Individually identifiable health information may be de-identified when the requirements of 45 CFR § 164.514 are met.

Article II: Enrollment and Disenrollment

Article II, Section B: Disenrollment

Add the following language to the end of the introductory paragraph:

PIHP should report if a member has been incarcerated and has not been disenrolled from the PIHP to the Enrollment Broker by sending an email to specializedmanagedcare @maximus.com.

Update Article II, section B(2)(d) to read:

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 42 CFR 435.1010 for more than 30 days. The PIHP must provide documentation that shows the member's placement to the Department's PIHP Enrollment Specialist. The disenrollment will be effective upon the member's incarceration date if they have been incarcerated for more than 30 days.

Article IV: Services

Article IV, section C: In Lieu of Services (former section C)

Remove section. Update the numbering of the contract to reflect the removal of the service.

Article IV, section C: The PIHP is not responsible to provide the following Medicaid services to its members (new section C)

Add Child Care Coordination Services as a carved in benefit in Article IV, section C(3)

Targeted Case Management (TCM), except the PIHP must work with the TCM case manager as indicated in Addendum III and the PIHP is responsible to provide Child Care Coordination services.

Article IV, section E: Additional Information Regarding Services

Update the Orthodontic Payment chart in Article IV, section E(6) to read:

	Who pays for completion of orthodontic and prosthodontic treatment when there is an enrollment status change		
	First PIHP	Second managed care plan	FFS
Person converts from one status to another: 1. FFS to the PIHP covering dental.		N/A	X
2a. PIHP covering dental to the Managed Care Plan not covering dental.	X		
2b. PIHP covering dental to the Managed Care Plan not covering dental, and person's residence changes to greater than 50 miles of the person's residence when in the first PIHP.			X
3. PIHP covering dental to the same or another Managed Care Plan covering dental.	X		
4. .PIHP with dental coverage to FFS because person exempted from PIHP enrollment.		N/A	X
5. Person's medical status changes to an ineligible PIHP code.	X	N/A	
6. PIHP with dental to ineligible for WI FCMH.	X	N/A	

Add Article IV, section E(12):

Child Care Coordination

Child Care Coordination (CCC) is a Targeted Case Management benefit designed to provide enhanced care coordination for eligible children. Providers are community-based and have local relationships to culturally appropriate resources and services to address members' needs. Services include assessment, care plan development, and ongoing care coordination and management. CCC services are only offered in Milwaukee County and the City of Racine.

Article IV, section F: Mental Health and Substance Abuse Coverage Requirements/Coordination of Services with Community Agencies

Amend Article IV, section F to read:

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

The PIHP must provide Medicaid covered services. The PIHP may provide additional or alternative treatments if the other treatment modalities are more appropriate and result in better outcomes than Medicaid covered services.

1. Mental Health/Substance Abuse Treatment:

   The PIHP must have an adequate network to provide Medicaid covered mental health and substance abuse treatment, including but not limited to services identified in Wis. Admin. Code s. DHS 107.13(1)-(4), s.107.22(4),Mental Health Parity Compliance (BadgerCare Plus and Medicaid SSI)

   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.

   When mental health or substance abuse treatment is deemed medically necessary, the PIHP cannot impose any of the following:

   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 must comply with 42 CFR § 438.910 (d) when establishing prior authorization requirements for parity in mental health and substance abuse benefits.

   Generally, the PIHP cannot impose non-quantitative treatment limits (NQTL) for mental health or substance abuse benefits in any classification. The PIHP can only NQTL when the PIHP's processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance abuse benefits 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.

   The PIHP must the Department a parity analysis as part of the initial PIHP certification application process and upon request.

2. Mental Health/Substance Abuse Assessment Requirements:

   When a member requests or a provider refers to a member for mental health or substance abuse treatment services, the PIHP must complete an assessment of services. The PIHP's assessment must: .

   a. Be conducted by qualified staff who are experienced in mental health/substance abuse treatment;

   b. Include a review of the effectiveness of the treatment for the condition (including best practice, evidence based practice);

   c. Include the medical necessity of treatment;

   d. Be based on the American Society of Addiction Medicine (ASAM) as mandated for substance abuse care providers in DHS 75, as well as the Wisconsin Uniform Placement Criteria (WI-UPC); and

   e. Not consider the member's motivation to participate in treatment.

3. SUPPORT Act Compliance

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, requires that behavioral health services be available to Children's Health Insurance Program (CHIP) populations. These services include mental health treatment, substance use disorder treatment, and interventions for developmental delays.

Per section 5022(d) of the Act, the PIHP must ensure that providers use age appropriate, validated screening tools 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 ensure that provider 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.

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

The PIHP must cover examination and treatment services and have an adequate network of providers with expertise for:

a. Members who are victims of child abuse, incest, and/or neglect;

b. Members diagnoses with post-traumatic stress syndrome;

c. Members who are victims of domestic violence; and

d. Members who are perpetrators of child abuse, incest, neglect, and/or domestic violence.

The PIHP must also cover court-ordered physical, psychological, and mental or developmental examinations and medical and psychiatric treatment for victims and perpetrators of child abuse and neglect.

The PIHP must ensure that PIHP employees and providers who are required by law to report suspected child abuse and neglect know and understand the laws, identification requirements, and reporting procedures.

5. Court-Related Children's Services

a. The PIHP must covers assessments provided under the Children's Code, Wis. Stats. s. 48.295, and must reimburse for the medically necessary treatment. The medical necessity of court-ordered evaluation and treatment is assumed to be established.

b. The PIHP may provide the treatment through its network.

c. The PIHP cannot withhold or limit services unless or until the court has agreed to the withholding or limit.

6. Court-Related Substance Abuse Services

a. The PIHP must cover medically necessary substance abuse treatment ordered in the member's Driver Safety Plan, pursuant to Wis. Stats., Ch. 343, and Wis. Adm. Code DHS 62. The PIHP must

assume the medical necessity of services specified in the Driver Safety Plan, and the PIHP must provide those services.

b. The PIHP may cover substance abuse educational programs and/or the initial assessment used to develop the Driver Safety Plan.

c. The PIHP must respond within five days from receipt of the referral or request when a providers sends a written referral or request for treatment authorization. The referral or request is retroactive to the date of the request. If the PIHP does not respond by the fifth day, the provider may assume the service is authorized until the PIHP responds in writing. The PIHP may apply the mental health and substance abuse coverage limitations specified in the ForwardHealth Provider Updates.

7. Emergency Detention and Court-Ordered Mental Health Services

a. The PIHP must cover all court-ordered services during an emergency detention, including services provided by out-of-network providers.

i. Care is assumed medically necessary, and the PIHP must cover care provided prior to the Emergency Detention probable cause hearing.

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. Court-Ordered Mental Health Services

The PIHP must cover all court-ordered mental health/substance abuse treatment, including stipulated and involuntary commitment and services provided by out-of-network providers. The extent of the PIHP's liability for appropriate emergency treatment is the current FFS rate for such treatment.

i. The PIHP may provide an alternative treatment plan for the county to submit at the probable cause for hearing. The PIHP must submit the name of a network 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.

c. The PIHP must cover court-ordered evaluations and/or treatment when the member is defending themself against a mental illness or substance abuse commitment when one or more of the following circumstances exists:

i. Services are provided in the PIHP facility; or

ii. PIHP approves services in a non-contracted facility; or

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

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

8. 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.

9. Transportation Following Emergency Detention

The PIHP must cover medical transportation to an emergency detention or commitment when the PIHP requires the member to be moved to an in-network provider. The PIHP is not responsible for the transfer of a member when it is determined by a county agency or law encourcement that a secure transfer is required and conducted by local law enforcement officials.

10. 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. The PIHP must work with the agency 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.

11. Memoranda of Understanding (MOU) with Community Agencies

The PIHP must coordinate services received through Medicaid Fee-for-Services or through community and social support providers. The PIHP is encouraged to develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services to members.

The PIHP must negotiate either an MOU or a contract with the counties in its service area. The MOU(s) or written documentation of a good faith attempt must be available during the certification process and when requested by the Department.

MOUs must be signed every two years as part of certification. If no changes have occurred, then both the county and the PIHP must document that no changes have occurred. PIHPs must conduct outreach to agencies that do not have a MOU with the PIHP, at a minimum, every two years. The PIHP must submit evidence that it attempted to obtain a MOU in good faith.

12. 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.

Article V: Provider Network and Access Requirements

Article V, section A: Availability and Accessibility

Remove Article V, section A (1)(h) due to redundancy.

Article VI: Marketing and Member Materials

Article VI, section H: Supplemental Contact Information

Amend Article VI, section H(1)(a) to read:

The PIHP is allowed to use additional telephone numbers included on the Supplemental Demographic Information Report for members enrolled in the PIHP.

Article VI, section I: Contacting Former Members

Re-title section from For “CY2024 Only” to “Contacting Former Members.”

Article VII: Member Rights and responsibilities

Article VII, D: Primary Care Provider Selection and Designation

Update reference to appeals guide in Article VII, section D(2) to the appropriate article.

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 Article XI.

Article VIII: Provider Appeals

Article VIII, section B: PIHP Responsibility

Remove data summary requirement from Article VIII, section B(7) to now read:

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.

Article VIII, section D: Provider Selection (Credentialing) and Periodic Evaluation (Recredentialing)

Add a new section Article VIII, section D(3) to include a new quarterly reporting requirement and move the rest of the numbers in the section down one. The new section reads:

The PIHP must submit a quarterly report to their Managed Care Analyst that includes the following information:

a. Date a provider requested to join the PIHP network;

b. Date the provider supplied all necessary documents to the PIHP;

c. Date the provider was credentialed by the PIHP.

Note: If the credentialing process is covered by the parent health plan, the parent health plan's submission may meet the requirement of this report.

Article X: Quality Assessment and Performance Improvement (QAPI)

Article X, section G: Utilization Management (UM)

Update the last sentence of Article X, section G(4)(a) to remove reference to the policy guide and replace it with reference to the contract so that it now reads:

The notice(s) must adhere to the timing and content requirements detailed in Article XI.

Article X, section H: Accreditation

Add Article X, section H(1) and renumber the rest of the section as section Article X, section H(2). Article X, section H(1) reads:

1. The PIHP must be accredited by the National Committee for Quality Assurance (NCQA) in their Medicaid lines of business and have the NCQA Health Equity Accreditation for the entire term of this contract.
    a. The parent health plan's NCQA Accreditation and Health Equity Accreditation status, if in good standing, meet this contractual requirement.

Article X, section L: FCMH Quality Measures

Rewrite the section so that it now reads:

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.
        iv. Well-Child Visits in the First 30 Months of Age (HEDIS Measure).
        v. Child and Adolescent Well-Care Visits (HEDIS Measure).
    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. Oral Evaluation, Dental Services (OED). Assess the percentage of members under 21 who receive a comprehensive or periodic oral evaluation with a dental provider.

e. Topical Fluoride for Children. The percentage of children ages 1-4 who receive at least two fluoride varnish applications during a given year

f. 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.

g. Chlamydia Screening in Women. The percentage of women 16-24 year of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

h. 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.

i. Asthma Medication Ratio: Ages 5 to 18. Percentage of children within that age range diagnosed with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater.

j. 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.

k. 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.

l. Metabolic Monitoring for Children and Adolescents on Anti Psychotics. Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.

m. Use of the First Line Psychosocial Care for children and Adolescents on Antipsychotics. The percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

n. Follow-Up Care for Children Prescribed ADHD Medication. The two rates of this measure assess follow-up care for children prescribed an ADHD Medication:

    i. *Initiation Phase*: Assess children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

    ii. *Continuation and Maintenance Phase:* Assesses children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.

o. 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.

Article XI: PIHP Administration

Article XI, section B: Organizational Responsibilities and Duties

Remove contract citation from Article XI, section B(7).

Update Article XI, section B(11)(i)'s second paragraph to clarify Multiple Procedure Payment policy so that it now reads:

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. The PIHP may not apply Multiple Procedure Payment Reduction (MPPR) logic to payments for Medicaid reimbursable services on a member's IFSP.

Article XII: Reports and Data

Article XII, section I: Financial Template

Update Article XII, section I(3)(a) to remove reference to policy guide and include contract citation so that it now reads:

Advertising and Marketing, unless permissible under Article VI.

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

Remove reference to policy guide from the Grievance and PIHP Summary Report line on the reporting grid.

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 available ForwardHealth.

Article XII, section L: Program Integrity

Rewrite Article XII, section L to read:

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. Compliance Program Requirements

The PIHP's arrangements must at a minimum include the following:

i. An organizational chart depicting the designation of a Compliance Officer and a Regulatory Compliance Committee that is accountable to senior management.

1) The Compliance Offer is responsible for the following activities:

a. Operating the PIHP's compliance program and overseeing PIHP and employee compliance with all provisions.

b. Assessing the PIHP's operations, policies and reporting and oversight system to mitigate risk and ensure the PIHP and network providers are performing their duties in compliance with its respective contracts.

c. Developing a risk profile that evaluates current risks facing the PIHP.

d. Working with the organization's employees to develop appropriate internal controls to mitigate identified risks.

e. Coordinating and audits with appropriate organization employees.

ii. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management. The Regulatory Compliance Committee must at a minimum:

a) Oversee the PIHP's compliance program, including enforcement of the compliance plan, and its compliance with contract requirements.

b) Include governing board members and other senior management (including either or both the Chief Financial Office and/or the Chief Operating Officer), and include individuals with a variety of backgrounds, including auditing, clinical, legal, and statistical experience.

c) Reflect the size and scope of the PIHP's responsibilities under its contract with the state.

d) Clearly articulate its role in the Compliance Plan.

e) Have consistent and objective, oversight of the PIHP and function with the PIHP's overall compliance and the program integrity activities.

f) Meet at least quarterly to ensure reasonable oversight of the compliance program.

g) Develop strategies to promote compliance and the detection of any violations.

h) Review and approve compliance and training on fraud, waste and abuse and ensure that training and education are effective and appropriately completed.

i) Assist with the creation and implementation of a compliance risk assessment and compliance monitoring and auditing work plan.

j) Review the effectiveness of the system of internal controls and designed to ensure compliance with federal and state requirements in daily operations.

k) Support the Compliance Officer's needs for sufficient staff and resources to carry out duties.

l) Ensure that the PIHP has up to date compliance policies and procedures.

m) Ensure that the PIHP has a method for members to report potential fraud, waste and abuse.

n) Ensure that the PIHP has a system for employees and contractors to seek assistance with compliance issues and report noncompliance or potential fraud, waste and abuse confidentially without fear of retaliation.

o) Review and address reported issues and focus audits on at risk areas for the PIHP and ensure associated corrective action plans are implemented and monitored for effectiveness.

p) Provide the PIHP's governing body with regular and ad hoc reports on the status of compliance, including recommendations for improvement.

iii. 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).

2. Written Policies, Procedures and Standards of Conduct

The PIHP's written policies, procedures, and standards of conduct must include:

a. Articulation of 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. The Department may request formal audit or review by the PIHP of specific providers for FWA issues identified by DHS OIG.

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.

a. 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.

xi. 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).

xii. The PIHP is responsible for ensuring employees have access to this information.

xiii. Policies and Procedures to implement all payment suspensions imposed by DHS OIG.

3. Compliance Plan

a. The PIHP is responsible for developing an annual compliance plan which must, at minimum, covers the requirements in Article XII.L.1. and L.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.

b. The compliance plan must be approved annually by December 31st or the last day of the calendar year.

xiv. The PIHP must submit their compliance plan for the following year and a crosswalk identifying any changes from the previous year no later November 15th via the DHS OIG SharePoint site.

xv. The DHS auditor will review the compliance plan according to the requirements outlined Article XII.L.1 and L.2 of this contract and either approve the plan or return it to the PIHP for changes.

xvi. If changes are necessary, the PIHP must implement the changes and resubmit the compliance plan back to the DHS auditor via the DHS OIG SharePoint site for additional review.

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 the last business day of the calendar year.

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.

a. 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.

b. 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.

c. The PIHP must implement their first annual FWA strategic plan on January 1, 2023 and will implement a new plan annually thereafter.

d. 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.

e. 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.

f. 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 Evaluation

g. The Department will evaluate, 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.

h. The Department will evaluate 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.

i. 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.

a. 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. 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. Prompt Reporting of 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 through the hotline (877-865-3432) or online portal (https:www.reportfraud.wisconsin.gov/RptFrd) within 2 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 to DHS OIG, 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 to DHS OIG through 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.

a. 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 can use the DHS OIG SharePoint site as a secure method to upload the referral form and exhibits. Referrals and exhibits may also be emailed securely to DHSOIGManagedCare@wisconsin.gov or upload directly to the open OIG case through the DHS OIG portal.

iv. Upon receiving an allegation of substantiated fraud, DHS OIG will conduct a preliminary review to determine whether there is sufficient basis to warrant referral to the DOJ.

v. 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.

vi. 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.

vii. 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.

viii. 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 benchmark 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.

a. 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 2 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.

a. 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.

b. 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.

d. The PIHP recovers the overpayments and retains the funds for all overpayments identified by the PIHP, provider or DHS OIG.

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

f. The PIHP is responsible for determining the actual overpayment amount.

g. 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 that resulted in an overpayment to the PIHP from the State must be reported to OIG within 60 days after the close of the capitation month. 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.

a. 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.

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

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

c. 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;

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

b. 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."

a. 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.

b) 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).

vi. Data Program Integrity Log: This optional tab captures any data activities that have not developed into a case and have not been captured on the Program Integrity Log. If the Program Integrity Log captures all of your data activities, then this tab does not need to be completed.

a. 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.

a. 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. PIHP Technical Assistance Check-In Meetings

In support of the relationship building and accountability, DHS OIG will facilitate meetings with the PIHP.

b. Meeting topics will focus on collaborating and providing technical assistance on QPIRs, fraud referrals, Annual Fraud, Waste, and Abuse Strategic Plans, Compliance Plans and issues identified through network provider audits.

i. Prior to the meeting, DHS OIG will collaborate with the PIHP to identify topics for discussion.

c. The PIHP's Compliance Officer or representative must attend.

16. Records Retention

The PIHP must retain records pertaining to all program integrity activities, including but not limited to audits, investigations, review, Quarterly Program Integrity Reports, FWA Strategic Plans, Compliance Plans, 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.

17. Special Investigation Unit (SIIU) Reviews

OIG reviews and provides feedback regarding the quality of the PIHP's SIU work through the portfolio of the following activities described in Section L. This phased approach allows for continuous monitoring throughout the year. There is not a specific SIU review document as Section L.3, L.5, L.11, and L.13 describe the documentation strategies for each of the individual components of the SIU reviews.

a. Compliance Plan Reviews (Section L.3)

b. Evaluations of compliance with the Fraud, Waste, and Abuse Strategic Plans (Section L.5)

c. Network Provider Audits (Section L.11)

d. Reviews of the Quarterly Program Integrity reviews (Section L.13)

Article XII, section P: Out-of-Network Utilization Report

Remove summary requirement to now read:

PIHPs shall submit to the Department an Out-of-Network Utilization Report. The log 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.

Article XIV: Contractual Relationship

Article XIV, section B: Subcontracts

Clarify "regular basis" in Article XIV, section B(5)(c)(i) to mean in the last 18 months:

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 the terminated provider in the last 18 months.

Article XV: Fiscal Components/Provisions

Article XV, section A: Billing Members

Rewrite Article XV, section A to read:

1. Prohibition on Billing Members for Covered Services

   The PIHP, its providers and subcontractors shall not bill a member for covered services in the benefit package provided during the member's enrollment in the PIHP except if the PIHP elects to charge copays to members pursuant to 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). The PIHP must provide at least a 6 month notice to DHS and submit a member communication plan for approval before implementation to apply copays to covered services.

   This provision pertains even if the:

   a. PIHP becomes insolvent;

   b. Department does not pay the PIHP for covered services provided to the member;

   c. Department or the PIHP does not pay the provider that furnishes the services under a referral or other arrangement; and

   d. Payment for services furnished under a subcontract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the PIHP provided the service directly.

2. Prohibition on Billing in Insolvency

   In the event of the PIHP's insolvency, the PIHP shall not bill members for debts of the PIHP or for covered services in the benefit package and provided during the member's period of PHP enrollment.

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.

Article XV, section C: Payment Requirements/Procedures

Update Article XV, section C(7)(d) to clarify payment responsibilities when member is hospitalized at time of enrollment and disenrollment so that it now reads:

The PIHP is not financially responsible for the portion of a hospital claim after the date of disenrollment. When the PIHP receives a hospital claim that spans dates of PIHP enrollment and after the date of disenrollment, the PIHP shall contact VEDS for special handling of the encounter.

When Calculating the PIHP liability for the member, the PIHP should take the total stay allowed divided by the total number of days hospitalized to determine a daily rate. The daily rate would then be multiplied by the number of days the member was enrolled in the PIHP.

Remove BadgerCare Plus and Medicaid SSI Plans from section title and language of Article XV, section C(8) so that it now reads:

Members Living in a Public Institution

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 the PIHP which is then 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 the PIHP. 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.

Remove Article XV, section C(9) and re-number the rest of the section start with C(10) as now C(9) and so on.

Article XVII: PIHP Specific Contract Terms

Article XVII, section B: Disclosure Statement(s) of Ownership or Control in a PIHP and Business Transactions

Rewrite Article XCII, section B(1)(g) to read:

As described by 42 C.F.R. §§438.608 and 438.610, the PIHP must retain, preserve, and make available upon request data, information, and documentation related to disclosure of any prohibited affiliations, including:

i. Individuals, entities, or their affiliates (as defined in 48 C.F.R. §2.101) acting as: a director, officer, partner, or subcontract (as defined by 42 C.F.R. §438.230) of the PIHP; a person with beneficial ownership of five percent or more of the PIHP's equity; or a network provider or person with employment, consulting, or other arrangement with the PIHP for the provision of items and services that are significant and material to the PIHP's contractual obligations with the state if those individuals, entities, or affiliates are debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non procurement activities under regulations issued under Executive Order No. 12549 or under associated implementing guidelines;

ii. Individuals or entities excluded from participation in federal health program under 1128 or 1128A of the Social Security Act.

Addendum I: PIHP Standard Member Handbook

Remove.

Addendum IV: Report Forms and Worksheets

Addendum IV, section C: PIHP Newborn Report

Remove.

Addendum VII: Rates

Replace rates chart with the CY25 rates chart.

Exhibit 4
Wisconsin Department of Health Services
CY 2025 Care4Kids Non-Risk Prepayment Rate Development
CY 2025 Non-Risk Prepayment Rates

		Milwaukee Adjustment			Southeastern Adjustment					
	Regional Variation	1.051	1.051	1.051	0.918	0.918	0.918			
		CY 2025 Milwaukee PMPMs			CY 2025 Southeastern PMPMs			CY 2025 PMPMs		
	Age Group	Title IV-E	Non Title IV-	Total	Title IV-E	Non Title IV-	Total	Title IV-E	Non Title IV-	Total
CY 2025 PMPM	Age 0	$978.41	$2,288.80	$1,685.80	$854.32	$1,998.50	$1,471.98	$931.08	$2,178.07	$1,604.24
	Ages 1-5	375.36	371.98	373.57	327.75	324.80	326.19	357.20	353.98	355.50
	Ages 6-14	423.51	409.62	414.84	369.79	357.66	362.22	403.02	389.80	394.77
	Ages 15-20 F	474.56	630.84	604.21	414.37	550.83	527.58	451.60	600.32	574.98
	Ages 15-20 M	409.76	546.95	524.32	357.79	477.58	457.81	389.94	520.49	498.95
CY 2025 PMPM Total		$444.77	$543.58	$504.76	$388.36	$474.63	$440.74	$423.25	$517.28	$480.34
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	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29
	Ages 1-5	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29
	Ages 6-14	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29
	Ages 15-20 F	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29
	Ages 15-20 M	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29	65.29
Access Payments Add-On Total		$65.29	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29	$65.29
Non-Risk Prepayment Rates	Age 0	$1,126.90	$2,437.29	$1,834.29	$1,002.81	$2,146.99	$1,620.47	$1,079.57	$2,326.56	$1,752.73
	Ages 1-5	523.85	520.47	522.06	476.24	473.29	474.68	505.69	502.47	503.99
	Ages 6-14	572.00	558.11	563.33	518.28	506.15	510.71	551.51	538.29	543.26
	Ages 15-20 F	623.05	779.33	752.70	562.86	699.32	676.07	600.09	748.81	723.47
	Ages 15-20 M	558.25	695.44	672.81	506.28	626.07	606.30	538.43	668.98	647.44
Non-Risk Prepayment Rates Total		$593.26	$692.07	$653.25	$536.85	$623.12	$589.23	$571.74	$665.77	$628.83

PIHP Name **Care4Kids**	**Department of Health Services**
Official Signature DocuSigned by: Mark Rakowski 32478A34E1174FB...	Official Signature Signed by: William Hanna 6102AAE9B4E0488...
Printed Name Mark Rakowski	Printed Name William Hanna
Title Sr Vice President, Children's Wisconsin	Title Medicaid Director
Date 3/11/2025 Click here to enter a date.	Date 3/11/2025 Click here to enter a date.