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AMENDMENT TO CONTRACT FOR SERVICES

Between

State of Wisconsin Department of Health Services (DHS)

and

Dane County

for

Children Come First Prepaid Inpatient Health Plan

This Contract Amendment is between the State of Wisconsin Department of Health Services (DHS), at 1 West Wilson Street, Madison, Wisconsin 53703, and Dane County at 1202 Northport Drive, Madison, WI 53704. 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: 435500-G22-ChildrenCC-00 M1
Contract Amount: See capitation rates in this amendment
Contract Term: July 01, 2020-June 30, 2022
Optional Renewal Terms: N/A

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

Contractor Contract Administrator: Marykay Wills
Contractor Telephone: 608.242.6404
Contractor Email: Wills.marykay@countyofdane.com

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

Effective July 1, 2021

Article I: Definitions and Acronyms

Amend Article I (A) to include the following definitions:

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

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

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.

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.

Article IV: Functions and Duties of the County

Amend Article IV(A) to add Article IV (A)(11) to read:

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

Amend IV(X)(3)(f) to read:

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

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periodically. These guidelines shall include the County's policy on the use of restraint on members.

Amend the 11th paragraph of Article IV(GG) to read:

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

Add new section Article IV(LL) to read:

LL. National or State Emergency

1. Declaration of National or State Emergency

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

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

   By June 30, 2022, and annually thereafter, DHS will require health plans to submit a plan to maintain business operations in the event of a state or federal declaration of disaster or State of Emergency. The health plan must cooperate with DHS' efforts to ensure minimal disruption to the ForwardHealth program and the members served.

   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:
         1. A description of how the health plan will organize and assign the urgency with which activities and processes will need to be resumed in the event of a disruption including:

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a. Member's access to services. The health plan must:
    i. Establish provisions to ensure that members are able to see Out-of-Network Providers if the member has a permanent address in the federal or state declared disaster areas and are unable to access In-Network providers.
    ii. Establish provisions to ensure that members are able to use telehealth services if the member has a permanent address in the federal or state declared disaster areas.
    iii. Provide detailed plans it will use to ensure that prior authorizations are extended and transferred without burden to new providers if directed by DHS, and the means by which the health plan will identify the location of members who have been displaced.
    iv. Report status of members and issues regarding member access to covered services as directed by DHS.

2. Claims Payment
    a. The health plan must ensure timely provider claims processing and payment consistent with DHS contract requirements and health plan-provider contract policies.
    b. The health plan must establish provider contract language that addresses relaxed health plan timely filing requirements for provider service claims provided in good faith with reasonable submission delay due to a Federal or State declared disaster or emergency and submit to DHS for review.
    c. The health plan must honor unauthorized provider claims consistent with ongoing treatment due to demonstrated patient need or urgent patient need occurring during a Federal or State declared disaster or emergency period where heath plan authorization communications and processes were delayed or failed.
    d. The health plan will provide a communication and interim plan for approval by DHS should they experience a disruption that risks the ability to meet the claims processing/payment timeline requirements.
3. Inclusion of a business impact analysis and risk assessment. This will address each continuity management strategy both at the corporate and key functional area separately and will identify, quantify and qualify areas that will be used to continue the organization's business impacts of a disruption to determine at what point in time

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the disruption exceeds the maximum allowable recovery time, activities and processes after an interruption.

4. Inclusion of a risk assessment that reviews the probability and impact of various threats to the health plan's operations. This involves stress testing the health plan's business processes and business impact analysis assumptions with various threat scenarios. The results of the risk assessment should assist the health plan in refining its business impact analysis and in developing a business continuity strategy.
5. Clearly identified roles and responsibilities within the organization during the implementation of the business continuity plan.
    a. Health Plans must ensure that proper training is provided for each role under this provision.
6. Criteria for executing the business continuity plan, including escalation procedures.
    a. A detailed communication plan with members, employees, providers, the Department, and other stakeholders including: Coordinating with DHS or any other local, state, or federal agencies as needed during the disaster or emergency response. This coordination may vary based on type of situation; however, anticipated coordination includes, but is not limited to:
        i. Designating a Point of Contact (POC) for continuity of operations specifically related to disaster preparedness in order to communicate the health plan's response to the DHS emergency preparedness POC.
        ii. Designating a POC to support members residing in Tribal Lands where applicable.
        iii. Participating in meetings with DHS or other agencies.
        iv. Assisting with impacted member or provider communications.
        v. Facilitate effective communication with members, providers and staff regarding the impact of the disaster as well as a process by which inquiries may be submitted and addressed.
        vi. Implementing policy, process, or system changes at the direction of DHS, keeping DHS informed on the progress of the implementation.
        vii. Additional communication and/or reporting requirements through the duration of the emergency.

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viii. The health plan must notify DHS of any contract flexibilities or extensions needed during the course of the emergency or disaster. DHS will maintain a health plan emergency/disaster response guide to document any such approved flexibilities or revised deadlines, outside the contract amendment process.

ix. Permission from DHS, contingent on approval of content, to do one-time member outreach via text message to those who have not opted into text messaging, to inform members about the disaster or emergency, offer PIHP resources or contact information, and instructions on how to opt into text messaging.

7. Business functions and dependent functions that must be maintained and services that must be restored, including key business information that would be required within 24 to 48 hours of a declared disaster or event.
    a. Including the ability of providers and suppliers to provide ongoing services for maintaining critical operations, and
    b. The level of ongoing monitoring and oversight provided by the PIHP.
8. Recovery time for each major business function, based on priority.
9. Business workflow and workaround procedures, including alternate processing methods and performance metrics.
10. Recording and updating business events information, files, and data, once business processes have been restored.
11. Documentation of security procedures for protection of data through web-based cloud application.
12. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
13. A description of an annual testing and evaluation plan.
14. A description of the health plan familiarity with and involvement in the emergency government plan of the counties in which they are providing services. The health plan will negotiate the role of the health plan and the county roles in emergency response.
    a. Health plans must ensure annually the readiness of the plan by conducting exercises carrying out the plan's provisions, evaluate its performance and make necessary updates. The health plan must coordinate with local emergency management departments, local agencies and DHS prior to an event to understand local emergency management departments or agencies, and identify mechanisms for assistance at the local level.

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15. A description of the steps that will be taken to ensure and preserve member safety and wellbeing in the event of a disruption or disaster.
    a. Care Coordination
        i. The health plan must ensure that care coordination for all members are compliant with the health plan's emergency recovery plan. In particular, care coordination for members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if covered service are disrupted or interrupted.
16. Emergency Recovery Plan
    a. The Emergency Recovery Plan shall address, at a minimum, the following recovery aspects related to the management information system and where appropriate, use web-based cloud applications:
        i. Verification of adequate back-up and recovery systems in compliance with federal and state rules and regulations.
        ii. Communication plan for critical personnel, key stakeholders and business partners involved in the health plan's management information system.
            1. Including the health plan's ability to provide continuous services to members and maintain critical operations in the even employees are unavailable to work remotely for extended periods of time.
        iii. Periodic back-up which is adequate and secure for all computer software and operating programs; databases; files; and system operations, and user documentation (e.g., electronic, non-electronic, incremental, full).
        iv. Full and complete back-up copies of all data and software.
        v. Verification that back-up copies are stored in a secure off-site location and tests are routinely performed on back-up copies.
        vi. Policies and procedures for purging outdated backup data.
        vii. Plan that supports the immediate restoration and recovery of lost or corrupted data or software resulting from the event of a disaster.

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

Article VI: Payments to County

Amend Article VI(A) to include supplemental payment for Psychosocial Rehabilitation Services:

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

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

1. Supplemental Payment for Psychosocial Rehabilitation Services

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

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

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

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Article VII: Reports and Data

Amend Article VII(C) to include excluded costs:

The following costs are excluded from rate setting:

a. Advertising and Marketing, unless permissible as part of the HMO 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 operations 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.

Amend Article VII(D) to read:

D. Encounter Data and Reporting Requirements

The PIHP is responsible for complying with the Department's data storage and reporting requirements and must submit compliant encounter data files. PIHP staff will participate with the Department in the planning and development of data reporting requirements for implementation during the term of this contract consistent with all HIPAA and MSIS/TMSIS requirements applicable to the PIHP. This participation includes attending technical calls, contract administrator meetings, workgroup meetings, and individual PIHP meetings with the Department to address changes in requirements, local applications or databases. The PIHP must cooperate with the Department on data submission protocol and testing. The Department or its designees reserves the right to conduct on-site inspections and/or audits prior to awarding the Contract and anytime thereafter. Per 42 CFR 438.602(e), the Department will conduct an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, the PIHP no less frequently than once every three years.

1. Data Management and Maintenance: The PIHP must have a system that is capable of providing information on utilization, processing claims, submitting compliant encounters, monitoring enrollment and disenrollment, grievance and appeals, and

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meeting reporting requirements. The required formats and timelines are specified in Article XII, Section J. The PIHP must:

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

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

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

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

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

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

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

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

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

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

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

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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.

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

5. Performance Requirements: The PIHP must submit accurate and complete encounter data that the Department can use for rate-setting, Federal Reporting, special programs and any other purpose deemed necessary by the Department. The PIHP must track metrics used by the Department to confirm that data is accurate and complete. Any deficiencies in the metrics must be reported to the Department within 15 days of the PIHP identifying the problem. The PIHP must complete a quarterly progress report due on December 30th, March 31st, and June 30th. The Progress Report and Template is posted to the Managed Care Section in ForwardHealth. The completed progress report and/or any deficiencies in the metrics should be submitted to DHSDMSBRS@dhs.wisconsin.gov.

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

Add new section Article VII(I) to read:

I. Supplier Diversity Reporting

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

The State of Wisconsin is committed to the promotion of MBEs and DVBs in the State's purchasing program. The 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 Contractor shall report to DHS any amount of this contract that was subcontracted to DOA certified MBEs and DVBs.

DHS shall have the right to request any information regarding the use of subcontractors including, but not limited to, MBEs and DVBs. The 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 your contract administrator.

Article X: Termination and Modification of Contract

Add a new Article X(B) and shift current Articles(B-D) down a letter:

B. Automatic Termination by the Department

1. Foreign Entities

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

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

Article XIV: County Specific Contract Terms

Amend Article XIV to read:

1. COUNTY IN WHICH ENROLLMENT IS ACCEPTED: Dane.

2. CAPITATION RATE: The monthly capitation rate for each member is $1,809.09 (daily rate is $59.48) for the period from July 1, 2021 – June 30, 2022.

3. THE CONTRACT SHALL BECOME EFFECTIVE ON JULY 1, 2020 AND SHALL TERMINATE ON JUNE 30, 2022.

Addendum VI: Reporting Requirements and Due Dates

Add to reporting grid:

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WEEKLY REPORTS		
Provider Network	List of all providers in the PIHP network. Submit via the SFTP. (See the File Submission Specification Guide)	Article IV, KK
MONTHLY REPORTS		
Supplier Diversity Report	Send monthly reports regarding the PIHPs subcontract with DOA certified MBEs and DVBs	Article VII(I)
QUARTERLY REPORTS		
1ST QUARTER: (Jan-March); 2ND QUARTER: (April – June); 3RD QUARTER: (July – Sept); 4TH QUARTER: (Oct – Dec)		
Attestation Form	Send quarterly attestation form to the BRS. Due date schedule is: 1st Quarter – April 30 2nd Quarter – July 30 3rd Quarter – Oct 30 4th Quarter – Jan 30	Article IV, FF; Addendum XII
Encounter Data Coordination of Benefit Report	Send quarterly Coordination of Benefit reports to your BCS contract monitor, by password protected attached email. Due date is 45 days within end of quarter.	Article VII, D Use form in contract
Grievance & HMO Appeal Summary Report	Send quarterly summary grievance and appeal reports to BCS by password protected attached email. Report includes PHI. Due date is within 30 days of end of quarter.	Article VIII Use form in Grievance and Appeal Guide.
Utilization Data Report	Due date: January 1st, 2022 (for DOS January 1, 2021 through June 30, 2021). Encounters with DOS after June 30, 2021 will be submitted via 837 process.	Article VII, D
ANNUAL REPORTS		
Member Communication and Education / Outreach Plan	Send to your BCS contract monitor via password protected email attachment. Marketing Plan due on second Friday of January.	Article IV, V
Performance Improvement Project (PIP) Final Project	Send to your BCS contract monitor and EQRO contact by password protected email attachment. Report due on the 1st business day of July for the prior calendar year.	Article IV, X
Annual Financial Report	Financial report for the previous calendar year to BRS by SFTP. Report is due on April 1.	Article VII, C
Initial Performance Improvement Project (PIP) aka PIP Proposal	Send to your BCS contract monitor and EQRO contact by password protected email attachment. Topic Selection on first business day of December for the next calendar year.	Article IV, X
QA/ Plan, QA Staff, QA Committee, etc.	Submit to DHS annually by April 1st.	Article IV, X
OTHER REPORTS		
Affirmative Action Plan Submit every 3 years	AA/CRC Office in the format specified on Vendor Net. Send to dhscontractcompliance@dhs.wisconsin.gov	Article IV, S
Civil Rights Compliance	AA/CRC Office in the format specified in Article IV, S. Send to AA/CRC Coordinator dhscontractcompliance@dhs.wisconsin.gov	Article IV, S

Letter of Assurance and Plan		
Encounter Data File in (837I, 837P, 837D) format.	Send to Fiscal agent on SFTP.	Article VII, D
Fraud, Waste and Abuse Investigations.	The PIHP must report allegations of fraud, waste, and abuse (both provider and member) to the Department within 15 days of the suspected activity coming to the attention of the PIHP. Submit on an as needed basis.	Article IV, GG
MOUs for Emergency Services	Report to DHS within 30 days after the award of contract.	Article IV, J
New Subcontracts/Changes in Approved Subcontracts or MOUs	Report to DHS 15 days prior to effective date.	Addendum I
Outcome Indicator Data	Report to DHS the previous calendar year by June 15.	Addendum VIII
Privacy and Security Incidents	Send information to your BCS contract monitor the same day an incident occurs. Submit on an as needed basis.	Article XI, A
CMS Drug Utilization Reports	PIHPs are required to submit timely responses to report and survey requests as required by federal and/or state law or program policy.	County PIHP Guide to Covered Services, Coding, and Reporting Guide

Addendum VII: BadgerCare Plus-Covered Services Provided by County

Amend Addendum VII to read:

The County is required to provide all medically-necessary, Medicaid-covered services as detailed in the *County PIHP Guide to Covered Services, Coding, and Reporting* for this contract period, which is fully incorporated herein by reference.

ForwardHealth covered services in scope for the Children Come First contract include the following benefits, as further described in ForwardHealth Online Handbooks, WI Medicaid State Plan, DHS 107.13 Wis. Adm. Code, the County PIHP Guide, and/or max fee schedules:

- Adult Mental Health Day Treatment
- Child/Adolescent Day Treatment
- Hospital Services, which includes coverage of:
  - The facility component of all inpatient admissions and outpatient visits to a psychiatric hospital

  - The facility component of inpatient admissions to an acute care hospital for behavioral health, as identified by the Diagnosis-Related Group (DRG) code assigned to the inpatient admission
  - The facility component of outpatient visits to an acute care hospital for behavioral health, as identified by a primary diagnosis code indicating a behavioral health diagnosis
  - The professional component of inpatient hospital admissions and outpatient hospital visits for behavioral health, as identified by a primary diagnosis code indicating a behavioral health diagnosis
- Intensive In-Home Mental Health and Substance Abuse for Children
- Narcotic Treatment Services (NTS)
- Outpatient Mental Health and Substance Abuse
- Psychosocial Rehabilitation Services, which includes coverage of:
  - Employment-Related Skill Training Services
  - Individual Skill Development and Enhancement Services
  - Peer Support Services
  - Physical Health Monitoring Services
  - Psychoeducation
  - Wellness Management and Recovery Services
- Substance Abuse Day Treatment
- Targeted Case Management

All other ForwardHealth covered services will be reimbursed by ForwardHealth to the provider for CCF-enrolled members on a fee-for-service basis.

PIHP Name **Children Come First**	**Department of Health Services**
Official Signature DocuSigned by: Shawn Tessmann 5182C14AB928430...	Official Signature DocuSigned by: James D. Jones 7BD4E56017A7425...
Printed Name Shawn Tessmann	Printed Name James D. Jones

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Title	Title
Director, Dane County	State Medicaid Director
Date	Date
11/19/2021	11/19/2021